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Broken: A Disability History of Veterans' Healthcare

by
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time, she was supportive of a wide-ranging project like this, and even encouraged me to take this approach—to pull a thread through a massive history that that addresses the salient points and highlights my perspective. As a dissertation chair, I could not ask for better. As a new professor, interested in paying forward my education and finding ways to maximize both learning and pedagogy, Dr. Medeiros sets an admirable example I am eager to follow. And as a person, she has been supportive of me and empowering throughout this process and in other endeavors. For that, she shall ever have my gratitude.

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Of course, as a combat veteran—and particularly as one dealing with the effects of chronic PTSD—the support of my Brothers in Arms, meaning the members of the 1/501st Parachute Infantry Regiment (Geronimo!) who served with me between 2002 and 2006, and particularly those of Delta (Delaware) Detachment/Company and the Anti-Tank/4th Platoon has been a major influence in this work. We served together between 2002 and 2006. Ever since, we have carried the weight of that service on our shoulders. Some of it fills us pride. Some of it weighs us down. All of it was part of my motivation to study veterans' healthcare. We have given enough to our country. We need not give our lives to despair simply because the mission was too idealistic or perhaps too naïve.

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**ABSTRACT**

BROKEN:

A DISABILITY HISTORY OF VETERANS' HEALTHCARE

AARON J. JACKSON

The Veterans Health Administration (VHA) currently oversees the nation's largest and only fully-subsidized healthcare system—a system that also happens to be one of the most successful by nearly any measure. And yet, in some ways, this system is fundamentally broken, exacerbating ongoing health crisis in the veteran community like suicide and persistent health and healthcare disparities. This dissertation examines the history of this system and how those who administer it utilize concepts of disability to determine care access, how that framing of disability has changed over time, and the potential ramifications of using disability as a precursor to care.

This dissertation examines the history of the veterans' healthcare system, how it came to rest on medical authority to make disability—and thus access—determinations to create a federally-subsidized, initially hospital-based, healthcare system. It examines the role of public, political, and patient pressures in shaping that system and their implications for access. And it demonstrates how these historical forces continue to shape and affect modern issues like health and healthcare disparities and the persistent problem of veteran suicides.

While the VHA, like most modern medical organizations, is a forward-looking enterprise, this dissertation demonstrates that there is significant value in a historical perspective in examining and shaping health policy decisions in the future.

TABLE OF CONTENTS

CHAPTERS

# DUTY OF CARE: AN INTRODUCTION TO THE U.S. VETERANS' HEALTHCARE SYSTEM

## "Currently in Crisis"

December 2019, Sacramento VA Medical Center (VAMC)

As I walked from my care towards the entrance of the VA hospital in Sacramento, I couldn't suppress my intellectual curiosity about the place. I had been studying the history of the Department of Veterans Affairs (VA) and the Veterans Health Administration (VHA) for some time at this point, but this was my first experience stepping inside one of these hospitals. I quickly noted the similarities between this and other hospitals I had visited in the past.

The main building boasted contemporary architectural features providing both form and function. Rows of solar panels shaded the parking lot from the California sun and contributed power to the facility. The grounds were well-appointed and manicured, with plenty of signs to help patients and visitors navigate the facility. I followed those signs through a set of large, sliding glass doors that opened into the main receiving area. An information desk sat across form the doors, staffed by friendly volunteers. The admissions desk was off to the left, near a waiting area furnished with comfortable and stylish furniture. To the right, a small gift shop and coffee stand saw steady commerce. Hallways to either side of the information desk had signs directing folks to the restrooms, cafeteria, and various departments of the hospital. All the while, healthcare professionals, hospital staff, and patients passed each other as they went about their business—just like they do in any hospital. Of course, I also noticed the differences.

For starters, parked on the lawn out front of the main entrance was a decommissioned F-105 Thunderchief fighter bomber, paying homage to the history of Mather Air Force Base, upon whose grounds this hospital had been constructed. And where the walls of a civilian hospital would be decorated with banners and posters proclaiming the medical missions of the institution, here,

the walls were decorated with various flags, banners, and posters that celebrated the armed forces and iconic imagery of the American veteran. These decorations applied to the patients and staff, as well. Baseball caps often broadcast the wearer's status as a veteran, their branch of service, or the conflicts in which they served. The juxtaposition of healthcare and military imagery struck me as a bit strange in that moment.

Here was an institution dedicated to preserving and restoring health and wellness for a patient population whose professions, at one point, involved potentially meting out death and destruction. I found that an odd pairing, even as I hoped this place would be able to heal me from what I suspected to be the fallout of my own service. You see, I was not visiting the Sacramento VAMC as a historian; rather, I was hoping to become a patient.

I turned toward the admissions desk. The man behind the counter—the Admissions Officer—was wearing a baseball cap indicating he was a veteran of the U.S. Navy. "How can I help you?" he asked.

"Yes," I said, hesitating a bit and trying to buy some time. I didn't know what to say, really. So, I decided to just say what brought me in and go from there. "I called the Crisis Line yesterday and they referred me here. I'd like to talk to someone—to a psychiatrist, I suppose—but I don't know where to begin."

I had my paperwork with me. Every military record and form in my possession was in a binder. One of my sergeants called it an "I Love Me Book" and recommended I keep it in order, just in case I ever needed those papers. I'm glad I followed his advice. The Admissions Officer asked for a copy of my DD-214—a form given to service members when they get out of the military and which contains a summary of all of one's military service. I fished out a copy and exchanged it for an admissions form.

"Fill that out and let me get your information in the computer. I'll call you back up to the desk in a bit," the Admissions Officer said. I took a seat with my back to the wall, where I could keep an eye on the entrance, the hallways, and the admissions desk all at once. I filled out the form, turned it in, returned to my seat, and did my best to stay seated. Part of me wanted to leave.

A few minutes later, he called me back to the desk. The look on his face told me it was bad news. "I'm sorry," he said, "but you got out of the Army too long ago, you don't have a disability rating, and you make too much money to qualify that way. We can't make an appointment today."

I was expecting this, even though some small part of me hoped that there may have been an exception—that I would be able to talk to a doctor based on the virtue of my service and the nature of my symptoms. I'm a combat veteran, having served in Afghanistan from 2003 to 2004, and I received an honorable discharge in 2006. That meant that the U.S. Army essentially said that I had faithfully performed my duties and conducted myself in a manner beneficial to the Army. Vets like me tend to receive preferential treatment from the government, and I hoped that might be the case here. But I also knew that the VA was a bureaucracy, and those require the paperwork to be in order, first, which was essentially what the Admissions Officer was saying. I would have to apply and be approved for benefits before I could get care at the VAMC. That process can take months.

"Unless…" the Admissions Officer continued, dragging out the word to indicate that while there was another option, he was hesitant to mention it.

"Unless?" I prompted him to continue.

"Unless you are currently in crisis," he finished. "Then, you can go to the Emergency Department—the door is right over there—and ask to talk to someone right now."

This seemed to be precisely what I wanted. But I hesitated again as I processed what he said. What did it mean to be "currently in crisis," I wondered.

At the time, without a better definition, I thought of "crisis" as whether or not I was actively entertaining thoughts of suicide—of planning to carry it out or thinking how I could do it. Standing there, in front of the admissions desk, I wasn't having such thoughts. I was trying to get help. Wasn't that the opposite of being "in crisis?" Then again, the only reason I was there at all was that I had recently experienced suicidal ideation. I was an emotional wreck, couldn't sleep, couldn't work, and could barely find the motivation to get out of bed, let alone do anything else. So, while unsure about whether or not I was "currently in crisis," I was certain that I was not well.

Since returning from Afghanistan in 2004, I had experienced varying levels of depression, anxiety, and rage over the years. Looking back, I was pretty much angry all the time—so much so that being angry simply felt normal. And occasionally, I'd experience what I called "episodes," where things got really bad. But I always seemed to get through them sooner or later. I'd tie one on, drink myself to sleep, and tuck away the dark thoughts. When I woke up, I'd push through and go back to being "normal." The transient nature of these episodes convinced me that I had it all handled—that whatever I was experiencing wasn't that bad, that others had it worse, and that I could keep muscling through. That worked for years.

But it wasn't working this time.

For weeks leading up to my visit to the VAMC, I was barely holding myself together. It felt like my world was collapsing around me. I couldn't sleep for more than a few minutes at a time. And when I did sleep, I had vivid nightmares in which I relived things that happened, or worse, experienced things that could not have happened but which nonetheless felt quite real. I'd wake up in a cold sweat, somehow more exhausted than when I fell asleep. But with my heart and

mind racing, going back to sleep was impossible. I noticed just how bad it was when, after startling myself awake from one nightmare, my wife laid her hand on my shoulder and tried to calm me down even as *she* was asleep. How often do you have to do something like that to be able to do it in your sleep?

The lack of sleep made it impossible to work. It's hard to do research or write when you're exhausted. It's even harder when you're depressed and can't find the motivation to take a shower, let alone work on a dissertation. I was simultaneously depressed and anxious all the time. My moods swung from one extreme to another, and my temper was on a hair trigger. I'd explode about trivial things then spend days beating myself up for my outbursts, for not being able to push through, and everything else. It felt like one of my episodes but amplified to extreme new dimensions. And it just kept getting worse. And the truly frustrating part was that I had no idea why it was happening. Why now?

I had been back from the war for more than fifteen years. In all that time, I had been relatively successful. I achieved a Bachelor's degree, a Master's degree, and was pursuing a doctorate. That education allowed me to have a job that I love and find fulfilling—teaching history at the college level. I was happily married with an amazing family, a comfortable home, and had plenty of quality friends. Everything seemed to be going right. Yet, I was still falling apart.

I started lashing out at my family. I would yell at my son over small things and get in arguments with my wife—often because I perceived insults that were not there. It was during one of those disputes over a perceived slight that I threatened to kill myself.

The truly scary part about that moment was that it was *not* frightening. Quite the opposite, in fact. It seemed like it would be a relief to just end it all. The rational part of my brain recognized that I *should* be afraid of that, that I *should* be worried about how it would affect my family and

friends—the pain it would cause them. But that was a small part of me by then. The rest of me wasn't concerned about any of that. I felt empty and isolated—like I was treating water in the middle of the ocean on a cloudy night, no landmarks in sight, treading water and doing my best to prevent the next wave from pulling me under. I was in a great deal of pain and just wanted it to stop.

From my research, I knew that the VA was best suited to address what I suspected was post-traumatic stress. Reading the symptoms of that disorder was like running down a list and checking all the boxes. So, I called the Veterans Crisis Line (988, today). The operator helped me develop a safety plan and referred me to services in my area, including the VAMC. I still felt adrift in that dark and stormy sea, but this seemed like a potential landmark on the horizon—something I could swim towards, at least.

But now, I was being asked if I was "currently in crisis" without a definition of what that meant. Was I just supposed to know? Why didn't I know? What were the implications?

"What happens if I do that?" I asked, meaning if I went to the Emergency Department.

"Well," the Admissions Officer replied, "they will have someone come talk to you. You will probably be admitted for observation for a few days, and they'll go from there."

That sounded great. It was precisely what I wanted. But then a doubt crept in. What if I'm *not* in crisis? What if they tell me that I'm just being hysterical, to go home, get some sleep, and stop wasting their time because others had it worse? I had been telling myself precisely those same things for weeks, and I was suddenly afraid of being seen as a fraud. Then another thought hit me. What if, while I was talking to the VA psychiatrist about my problems, another veteran—one who *really was* in crisis—came in and ended up hurting themselves or others because the doctors were busy with me? I didn't want to be responsible for that.

“So, if I’m not ‘in crisis’ right now, I could be taking up resources meant for someone else who is?” I asked.

The Admissions Officer winced as if he could read my doubts and fears. I’m fairly sure I was not the first veteran he had encountered in this situation. “That’s not how it works..” he began, but I had already made up my mind and didn’t want to introduce any more doubts.

“No, I’m not ‘in crisis’ right now,” I said, cutting him off. At that moment, I told myself I could handle it. I could muscle through one more time. I had been an infantryman. A paratrooper. I had navigated and managed the manifold stresses of both the military and combat. If I could do all that, I could hold myself together long enough to get a disability rating, right? Sure I could.

Maybe.

“I’ll file for a disability rating and come back when I’ve got that,” I said, trying to make myself sound confident.

The Admissions Officer nodded, but the look on his face expressed concern. “In that case,” he said, “I know someone who can help with the paperwork. Here’s his card. Tell him I sent you and he’ll take good care of you.”

I took the card, thanked the man in the Navy cap, and shook his hand. He looked me in the eye and asked, “Are you sure?”

I nodded, but my voice caught in my throat before I could answer. Suddenly ashamed and hoping he didn’t notice, I quickly turned and left before I fell apart again. Walking back to my car, I asked myself the same question. Was I sure I wasn’t “in crisis” right now?

No. No, I was not.

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My personal experiences with the Department of Veterans Affairs (the VA) and my journey to becoming a disabled veteran have been sources of some concern for me as I worked on this dissertation. Would these experiences enhance my analysis or undermine my credibility? The answers, I suppose, are up to the reader.

As a disabled combat veteran, I cannot claim perfect objectivity. I am directly affected by and have a vested interest in the systems I analyze in my work, here. That said, as a historian, I can certainly state that my work is based on verifiable historical facts in the documentary record. In this way, I believe that my personal experiences add to my analysis by demonstrating at least a small part of the human realities associated with what can otherwise be a confluence of impersonal processes and developments.

This is strange territory for many historians—at least those of my generation and our predecessors. We have been exhaustively trained to seek professional separation and objectivity in the subjects we study—to portray the past "as it really was," to paraphrase the still-influential Leopold von Ranke. And indeed, that is one of my goals in this work. But I also recognize that we are all products of our individual histories, each of which connects us to common threads that shape the warp and weft of the historical tapestry that shapes the contours of our present. And when we witness or experience problems in the present, it is natural that we should seek out those things that made these problems possible. We want to find out what went wrong, and perhaps, come up with ideas about how to address it in the future. In this way, all historians have a vested interest in the subjects we study. It is a necessary requirement for historical inquiry, and such is the nature of my investigation of the history of the veterans' healthcare system in the United States.

While my personal experiences guided me to this subject and informed my avenues and angles of investigation, I have learned that the history of the veterans' healthcare system—and

particularly its role in defining disability as an administrative category—holds the potential to unlock insights into the provision of healthcare beyond veterans as well. At a time when health policymakers are contemplating the future of American healthcare in the hopes of delivering quality, affordable care to more people, the veterans' healthcare system serves as a laboratory to test the possibilities of that expansion. In fact, in many ways, it has always played that role.

The heart of this study is the concept of veterans' worthiness to care through the VA—a malleable notion that is both mutable and gradient. The standards against which veterans are measured—the determination of disability—have been and continue to be determined by multiple, relatively independent but interrelated actors including lawmakers, the military, veterans' organizations, the Department of Veterans Affairs, public opinion, and of course, medical practitioners who have been charged with providing the scientific medical basis for the determination of disability. In this context, disability is less a determination of a person's capabilities, limitations, or care regimens; rather, it is an administrative category utilized to provide access to care at taxpayer expense. Thus, understanding the history of the VA requires an examination of how disability has been defined in this context, how that changed, and its influence on care delivery.

Such an examination may, I hope, help policymakers and officials better understand and address persistent problems like veteran suicide, substance abuse, homelessness, and access to mental health services. In some ways, the system itself contributes to the persistent nature of these problems as it carries forward historical biases and interpretations even as it strives to address the same. Perhaps as important, it is my hope that a holistic view of the history of the system and its interfaces with related actors will help highlight areas and ways to enact effective reforms.

## The Veterans Health Administration Today

As of this writing, the Department of Veterans Affairs (VA) and the Veterans Health Administration (VHA) oversee the nation's largest integrated healthcare system. It is also one of the few such systems to be fully-subsidized by federal taxpayers. It provides care at nearly 1,300 healthcare facilities, including 171 medical centers and 1,113 outpatient clinics of varying complexity, providing a wide range of medical services to more than nine-million enrolled veterans.[1] And even more than its size, the VHA is notable as one of the nation's most successful healthcare systems by practically any measure. Since the late 1990s, with regard to patient satisfaction, health outcomes, transparency, safety, and costs of care delivery, the VHA routinely outperforms other healthcare systems.[2] And the VHA's influence on American medicine is not limited to the veteran population.

Through its more than 75-year partnership with academic medical institutions across the nation, the VA supports research programs that have contributed to important developments in biomedical science, clinical practice, health services, and rehabilitation. Notable results include the development of outpatient antibiotic regimens, advanced prosthetics, and CAT scan imagery; the invention of the cardiac pacemaker, nicotine patch, and organ transplants; and the refinement of therapeutics for diseases ranging from tuberculosis to HIV/AIDS, diabetes, Alzheimer's, and osteoporosis. All of which benefit people the world over, not just American veterans. Moreover, the VA serves as the nation's largest medical training system, with more than two-thirds of all

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[1] Veterans Health Administration, "About VHA," https://va.gov/health/aboutVHA.asp

[2] Ashish K. Jha, Jonathan B. Perlin, Kenneth W. Kizer, and R. Adams Dudley, "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," *The New England Journal of Medicine* 348 (2003):2218-2227; Peter S. Hussey, et al, "Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans," RAND Corporation, September 1, 2015.

healthcare professionals in the United States receiving at least some training in a VA facility since 1946.[3]

Yet, despite these facts, the VHA is rarely held up as a foundational piece of American healthcare; rather, both health policymakers and historians have tended to treat it as an exceptional case. This is unfortunate because this system offers a wealth of valuable lessons and possibilities for development in both health policy and historiography. When seeking ways to expand health care access for Americans, modern politicians tend to focus on how to pay for that care more than ensuring such care is effective, efficient, and safe. The VHA offers examples in these areas, and it does so more affordably, too. And for historians seeking to parse the development and administration of large, intersectional, and complex healthcare systems, the VHA serves as an excellent example because, rather than being shielded by corporate policies, its records are public and relatively open for investigation. At the very least, the VHA offers a useful comparative point. It stands to reason, then, that exploring the history of the veterans' healthcare system, how it developed, and how it continues to influence the shape and possibilities of American health care is an effort that will bear useful fruit.

This is not to say that the VHA is perfect by any means. Indeed, in at least one fundamental way, the system is broken. This flaw is perhaps most evident in the persistent problem of veteran suicides. In 2012, veteran suicide rates garnered national attention when the VA released the results of an exploratory study on suicides occurring between 1999 and 2010 that estimated between 18 and 22 veterans died of suicide every day over that period.[4] Subsequent reports noted that by 2014,

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[3] Suzanne Gordon, *Wounds of War: How the VA Delivers Health, Healing, and Hope to the Nation's Veterans* (Ithaca and London: Cornell University Press, 2018).

[4] Phil Stewart, "U.S. military veteran suicides rise, one dies every 65 minutes," *Reuters*, February 1, 2013; Janet Kemp and Robert Bossarte, Department of Veterans Affairs Mental Health Services Suicide Prevention Program, "Suicide Data Report, 2013," https://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf. Kemp and Bossarte

the average daily suicide rate was dropping, but these deaths were still occurring at rates roughly twice that found in the civilian population.[5] This persistence is alarming in part due to the significant allocation of resources and funding to address the issue.

Perhaps the most ominous number related to veteran suicides is not the extraordinarily high rate but the fact that only about one in four veterans who commit suicide have ever had any contact with the VHA and its services.[6] The implications being that the VHA is relatively helpless to address the majority of the problem, and that the issue of veteran suicide is bigger than the VHA, or even the VA, alone. And that, to be frank, is one of the ways in which the veterans' healthcare system is broken. It is being tasked with tackling a problem beyond its scope. Yet, the mere existence of the VHA, and the fact that it caters to disabled veterans, has the effect of shifting responsibility for veterans' health entirely onto this system and only this system.

And then there is the question of which veterans receive care through the VHA and which do not. There are roughly 18 million living veterans in the United States today. The VHA boasts of providing service and care to 9.2 million registered veterans, meaning that roughly half of the American veteran population is not even registered with the VHA.[7] This is true despite the fact that the VA was implemented "to care for him who shall have borne the battle," to quote the institution's motto. If three out of every four veterans who commit suicide had no contact with the

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noted that their study was not research-based and had significant gaps in the data, but this served as the spark of several veteran suicide awareness campaigns that latched onto the number 22.

[5] Office of Suicide Prevention, Department of Veterans Affairs, "Suicide Among Veterans Other Americans 2001-2004," August 3, 2016, https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf. Office of Mental Health and Suicide Prevention, Department of Veterans Affairs, "2021 National Veteran Suicide Prevention: Annual Report,"https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf.

[6] Rajeev Ramchand, "Suicide Among Veterans: Veterans' Issues in Focus," Santa Monica, CA: RAND Corporation, 2021. https://www.rand.org/pubs/perspectives/PEA1363-1.html.

[7] U.S. Census Bureau, "Census Bureau Releases New Report on Veterans," https://census.gov/newsroom/press-releases/2020/veterans-report.html. VA, "Veterans Health Administration," http://va.gov/health.

VHA and its services before their deaths, doesn't that speak to a fundamental problem in care access in the veteran population?

Part of the problem—likely a large part—has to do with the interplay of the VA's bureaucratic requirements and veterans' sense of self, particularly as influenced by prevailing military cultures. You see, access to VHA requires veterans to meet Congressionally-mandated eligibility standards.[8] These prerequisites include length of service, status and recency of discharge, and income.[9] If eligible, veterans are then sorted into one of eight priority groups based on service history, assigned disability rating, income level, and more. This, in a very real sense, requires veterans to swallow their pride and submit to the judgment of a system that is organized in ways quite alien or even opposed to the military cultures from which the veterans transitioned. It is entirely possible, then, that the appearance of the VHA's success is due in part to a stringent selection process that results in service for only those veterans who meet the relatively narrow criteria established in the Code of Federal Regulations.[10] This is somewhat ironic given that the principles upon which the VA was founded and the assumptions that many Americans hold that all veterans are or should be eligible for benefits by simple merit of their service.

What's more, the future of the veterans' healthcare system has implications for the future of American healthcare in general. The National Health Expenditure Accounts—the official estimates of total health care spending in the United States, which has been tracking healthcare costs since 1960—recently estimated that healthcare costs accounted for roughly 19.7% of the

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[8] VA, "Eligibility for VA health care," https://va.gov/health-care/eligibility.

[9] VA, Health Benefits, Annual Income Limits, "2022 VA National and Priority Group 8 Relaxation Income Thresholds," https://www.va.gov/healthbenefits/annual_income_limits_health_benefits.asp. Veterans, with no dependents, making less than $36,659 are eligible for Priority Group 5 assignment and cost-free VA health care.

[10] Specifically 38 CFR.

nation's Gross Domestic Product in 2020.[11] That's nearly $12,530 spent per person, per year, by everyone in the United States—a figure that includes the roughly 31.6 million Americans who lack insurance. And while direct comparisons are difficult, the Congressional Budget Office's examination of VHA care utilization demonstrated that "the health care provided by VHA generally cost less than would equivalent care provided in the private sector, even though the comparison used Medicare's relatively low payment rates for private-sector doctors and hospitals."[12] So, at the least, the VHA offers an opportunity to improve costs at precisely the time that growth in healthcare expenditures continues to outpace growth in the economy. In other words, the veterans' healthcare system holds examples about how to make care more affordable, and the implications go well beyond cost.

Today, the Veterans Health Administration follows safety and transparency standards established by the National Transportation Safety Board to ensure that medical accidents lead to process improvements and fewer accidents in the future. This is something that private care providers simply cannot afford to do, given their exposure to malpractice litigation. The modern VHA's policies, then, essentially result in higher quality care at lower costs. At a time when policymakers and healthcare professionals scramble to achieve precisely these results, it's clear that the VHA has lessons to offer, which raises several fundamental questions.

If the VHA is emblematic of a successful, socialized healthcare system—and in many ways, it is—then how does one reconcile that success with its apparent and highly publicized struggles? Beyond its public image, why does a system that most Americans believe serves all

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[11] Centers for Medicare & Medicaid Service, "National Health Expenditure Data," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical, accessed July 15, 2022.

[12] Congressional Budget Office, "Comparing the Costs of the Veterans' Health Care System with Private-Sector Costs," December 10, 2014.

veterans restrict access to these services to roughly half the veteran population? And what are the costs of failing to serve the rest?

This dissertation will attempt to address these questions by examining the historical development of the veterans' healthcare system, its role in defining the "disabled veteran" who is worthy of care at taxpayer expense, and by extension, notions of disability in general. Specifically, it will examine how disability as an administrative category operates in determining access to care, how that category has changed over time, and the implications for the questions above.

## Historiography

Medical historians have long noted the significance of wartime innovations in shaping the development of modern medicine and rightly so. Wars represent periods of dramatic change, with battlefield necessities driving innovations in research and care delivery, often resulting in enduring transformations of the medical landscape. But regarding veterans' varying ability to access care, however, the scholarship remains lamentably thin. This is extraordinary given the facts that medical care has been a staple of veterans' benefits for more than a century, that the veterans' healthcare system is the largest and one of the oldest such systems in the United States, and that innovations in veterans' care significantly influenced the shape of modern medicine.

Those innovations include extensive research efforts that provide unique benefits. For example, the VA's cooperative research programs developed after the Second World War leveraged the system's large patient data pool to develop effective outpatient treatment regimens for tuberculosis that eliminated variables in locality. No other contemporary healthcare system could have provided such data. While this served pragmatic contemporary concerns for the VA, who wished to address hospital bed shortages after the war, it also resulted in the widespread

adoption of treatment regimens by military and civilian hospitals alike.[13] Similarly, VA-sponsored research efforts contributed to advancements in cardiology, endocrinology, neurology, oncology, psychiatry, and psychology; yet, few works examine how the veterans' healthcare system changed since it was established and the implications of those long-term changes. None explore how changing definitions of disability affected care access and the potential influences and ramifications of those changes.

This dissertation thus addresses a gap in the historiography by episodically exploring developments in the veterans' healthcare system at key points throughout the twentieth century, paying special attention to changing conceptions of disability in the context of those changes. This study is informed primarily by four historiographical categories: existing scholarship pertaining to veterans' care, disability history, the history of hospitals and healthcare systems, and the social history of veterans' experiences.

## Scholarship Pertaining Directly to the VA

While the historiography about veterans' benefits is relatively slim by way of monographs, a handful of select works provide useful insights. The most notable is a 1967 report to the U.S. House of Representatives Committee on Veterans' Affairs by Robinson Adkins, a longtime official in the Veterans' Bureau and Veterans' Administration.[14] Due to his long tenure in the administration of veterans' medical benefits, Adkins had personal insights into the development of the institution and particularly to the provision of health care from the founding of the Veterans' Bureau in 1921 to the time of his report to Congress in 1967. More recently, a four-volume

[13] Rodney R. Baker, "Historical Contributions to Veterans' Healthcare," in Thomas W. Miller, ed., *The Praeger Handbook of Veterans' Health: History, Challenges, Ideas, and Developments* (Santa Barbara, CA: 2011), 16-17.

[14] Robinson E. Adkins, "Medical Care of Veterans," Report to Committee on Veterans' Affairs, U.S. House of Representatives (Washington, D.C.: Government Printing Office, 1967).

collection of essays written by VA insiders and edited by career VA psychologist Dr. Thomas W. Miller provides a comprehensive monograph of the modern VA system.[15] This collection is useful in exploring obstacles and perspectives that VA professionals found to be significant in shaping the VA in the twenty-first century. And an as-yet-unpublished history of the Veterans Health Administration since 1989 by James Rife titled *Not Your Father's VA* fills in some of the gaps in the institutional history since Adkins made his report in 1967.[16] Combined with a relative wealth of article-length publications written by VA professionals in leading medical journals and internal bulletins, such scholarship provides insight to internal VA perspectives but often lacks critical examination.

Medical historians Beth Linker, John Kinder, Jessica Adler, and Rosemary Stevens all examined the post-First World War origins of the veterans' hospital system in the United States. Linker's work provides invaluable insight into Progressive era reformers' motives and efforts to utilize modern medicine to rehabilitate soldiers disabled on the battlefield into productive citizens, contributing to the medical model of disability and exploring how officials and experts sold these reforms to both the public and to veterans through contemporary gendered frames.[17] Kinder's scholarship examines how officials believed that modern medicine would make military intervention safer despite the existence of disabled veterans as living symbols of long-term suffering and thus serves to explore the interplay between perception and reality.[18] And Jessica Adler's work overlaps that of her predecessors and adds to it by exploring veterans' activism

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[15] Thomas W. Miller, ed., *The Praeger Handbook of Veterans' Health: History, Challenges, Issues, and Developments* (Santa Barbara, CA: Praeger, 2011).

[16] James Rife, *Not Your Father's VA* (unpublished). It's worth noting that this volume was not published due to its planned release coinciding with a VA scandal about wait times and access.

[17] Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago: The University of Chicago Press, 2011).

[18] John M. Kinder, *Paying with Their Bodies: American War and the Problem of the Disabled Veteran* (Chicago: The University of Chicago Press, 2015).

through veterans' service organizations like the American Legion and Disabled American Veterans to demonstrate how veteran agency helped transform the temporary rehabilitation hospital system established during the First World War into a permanent fixture of veterans' benefits.[19] Stevens's scholarship first examined how the federal government became involved in the provision of healthcare for veterans and how early scandals shaped that system.[20] Each of these works touches on the ways in which gendered notions of service and capability contributed to an understanding of disability, something that Joanna Bourke's study of British efforts to address veteran disability covers rather well by exploring the boundaries of this gendered frame.[21] This scholarship provides invaluable insight into understanding the origins of the veterans' healthcare system and thus provide a useful foundation against which long-term changes and trends can be measured.

More contemporary analyses of the VA have come not from medical historians but from popular audience authors and journalists. Philip Longman's seminal monograph *Best Care Anywhere* remains quite pertinent today, particularly regarding the post-Vietnam Era veterans' experience of healthcare.[22] And health journalist Suzanne Gordon picks up where Longman left off, framing the ongoing political debate about whether veterans would be better served through

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[19] Jessica Adler, *Burdens of War: Creating the United States Veterans Health System* (Baltimore: Johns Hopkins University Press, 2017).

[20] 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): 281-305; and Rosemary Stevens, *A Time of Scandal: Charles R. Forbes, Warren G. Harding, and the Making of the Veterans Bureau* (Baltimore: Johns Hopkins University Press, 2017).

[21] Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War* (Chicago: The University of Chicago Press, 1996).

[22] Philip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Beret-Koehler Publishers, 2012).

the VA or through private care by exploring the development of the VHA's integrated healthcare system since the 1990s.[23]

## Disability History

The historiography of disability is a growing field in general and one given particular weight in the history of medicine. Beth Linker's work serves in this category as well, particularly her work in academic articles, including her 2013 article on medical and disability history, which provides an excellent survey of the field.[24] Deborah Stone's work in *The Disabled State*, while older, still provides a fundamental example of applying disability studies to administrative systems.[25] And a collection edited by Susan Burch and Michael Rembis offers an array of essays that integrate critical analyses of race, class, and gender in historical context pertaining to disability history, including an important section on citizenship and belonging.[26] Adding to the conversation by contributing understanding of veterans' disability and care access can provide significant insight into the role of government and policy in shaping matters of disability and care access.

## Hospital Historiography

Due to the hospital-centered focus of veterans' care for most of the twentieth century, hospital historiography provides insights into the context of the development of the veterans' healthcare system. Charles Rosenberg's study of the role of social considerations in the development of the modern hospital provides a blueprint for examining sociocultural influences in medicine as reflected in sites of healing.[27] Rosemary Stevens's history of American hospital

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[23] Gordon, Wounds of War.

[24] Beth Linker, "On the Borderland of Medical and Disability History: A Survey of the Field," *Bulletin of the History of Medicine* 87, no. 4 (December 2013):499-535.

[25] Deborah A. Stone, *The Disabled State* (Philadelphia: Temple University Press, 1984).

[26] Susan Burch and Michael Rembris, eds., *Disability Histories* (Urbana: University of Illinois Press, 2014).

[27] Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987).

developments in the twentieth century provides similar insight into the fiscal and social welfare considerations of that development.[28] And Guenter Risse's work serves as an example of episodic examination of the development of modern hospitals over a large timeframe.[29] Unfortunately, none of these works critically examine the ways in which veterans' care informs, integrates into, and subsidizes wider American healthcare or the critical role played by the administrative designation of disability. This dissertation will address this gap.

## Veterans' Social Histories

Thankfully, the historiography of the social history of veterans' experiences is rich in both breadth of scope and depth of analysis, providing many relevant examples to utilize in the examination of shifting contexts that affected the veterans' healthcare system. The following represent an abbreviated list of relevant works. David Serlin's history of body engineering in the wake of the Second World War, and particularly his chapter on prosthesis development, provides insight into both the optimistic outlooks regarding the capabilities of contemporary medicine as well as how evolutions in the VA influenced more than just veterans.[30] Omar Bradley's autobiography details his experiences as the reluctant but revolutionary head of the Veterans' Administration from 1945 to 1947 and the efforts to establish mutually-beneficial partnerships between the VA and the nation's leading medical schools.[31] Lawrence Friedman's history of the infamous (at least in psychiatric circles) Menninger Clinic demonstrates how what Dr. William Menninger learned in the Army during the Second World War and his subsequent work with

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[28] Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Harper Collins, 1989).

[29] Guenter Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York: Oxford University Press, 1999).

[30] David Serlin, *Replaceable You: Engineering the Body in Postwar America* (Chicago: The University of Chicago Press, 2004).

[31] Omar N. Bradley and Clay Blair, *A General's Life: An Autobiography by General of the Army* (New York: Touchstone Press, 1984).

veterans in the VA eventually helped establish the diagnostic definition of post-traumatic stress disorder and informed its official designation in the *Diagnostics and Statistical Manual-III*.[32] Similarly, there exists a wealth of historiography related to veterans activism during the Vietnam War, all of which provide contextual insights and demonstrate how concerns about veterans' health played a significant role in shaping the VA after Vietnam.[33] Other scholarship provides examples of changes in specific relevant areas over the entire century. Ben Shephard explores the development of psychiatry in military settings,[34] Allan Horowitz provides a concise and informative history of PTSD,[35] and Army Medical Department historian Sanders Marble's edited collection regarding military personnel acquisitions speaks to the populations that would become veterans.[36]

These works and others have proven helpful in tracing the historical development of disability as an administrative category, which determines which veterans are deemed worthy of care at taxpayer expense. At the same time, developments in the veterans' healthcare system had significant impacts for these adjacent and intersecting fields, as this dissertation demonstrates.

## Defining Disability and Care Worthiness

The statement "thank you for your service" has become a ubiquitous courtesy paid to veterans, and it is often offered without qualification, demonstrating the apparent high esteem in

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[32] Lawrence J. Friedman, *Menninger: The Family and the Clinic* (Lawrence, KS: University Press of Kansas, 1990).

[33] Notable monographs include: Johnathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York: Maxwell Macmillan, 1994); Jerry Lembcke, *The Spitting Image: Myth, Memory, and the Legacy of Vietnam* (New York: New York University Press, 1998); Andrew E. Hunt, *The Turning: A History of Vietnam Veterans Against the War* (New York: New York University Press, 1999); Gerald Nicosia, *Home to War: A History of the Vietnam Veterans' Movement* (New York: Carroll & Graf Publishers, 2001).

[34] Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, Mass.: Harvard University Press, 2001).

[35] Allan V. Horwitz, *PTSD: A Short History* (Baltimore: Johns Hopkins University Press, 2018).

[36] Sanders Marble, ed., *Scraping the Barrel: The Military Use of Substandard Manpower, 1860-1960* (New York: Fordham University Press, 2001).

which most Americans hold their veterans.[37] This esteem is given concrete form in the VA and VHA. With an annual budget surpassing $100 billion in 2022, the government invests significant funds and resources into veterans' healthcare.[38] Given this, it is a safe assumption that most Americans believe that *all* veterans have access to this system, but of the nation's 22 million living veterans, less than half are even enrolled with the VHA, and as many as one quarter are not eligible for benefits at all due to the complex and numerous requirements for care access. Essentially, this means that the government currently determines that only seventy percent of all veterans are worthy of healthcare benefits at taxpayer expense.[39] And historically speaking, veterans have never had the type of access that the public assumes—they have always been subjected to meeting certain standards before receiving benefits.

With regards to medical benefits, the chief requirement—other than being a veteran—is the determination of a disability. A veteran must first file a claim, essentially asking for an official review of their qualifications. That in itself is a significant barrier that goes against the grain of predominant military and societal cultural norms. Then, once a claim has been filed, it has to be corroborated—both medically and bureaucratically—to verify the existence of a disability and its connection to the veteran's military service. If so established, the veteran is then sorted into a hierarchical structure that determines priority of care access, implying that some forms of military service and some forms of disability are more valuable than others.

This claim and verification process is all rather curious as, once in the system, veterans may utilize medical benefits without regard to the nature or extent of their official disabilities. Care

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[37] John Worsencroft, "The Sting of 'Thank You for Your Service,'" *The Washington Post*, April 29, 2020. https://www.washingtonpost.com/outlook/2020/04/29/sting-thank-you-your-service/.

[38] VA, "FY 2023 Budget Submission: Budget in Brief," March 2022.

[39] VA, "Veterans 'Deep Dive' Presentation," Terrence Stinton, Director of Policy Analysis, VHA Office of the Assistant Deputy Undersecretary for Health Policy and Planning, Washington, D.C., 2017.

regimens within the system are determined along traditional lines of consultation with physicians and other healthcare professionals. For example, if a veteran gains access to the system for a PTSD claim but then seeks treatment for diabetes or an appointment with a dermatologist, they receive this care, no questions asked—primarily because it would be bureaucratically exhausting to go through the verification process for every single medical complaint of a qualified veteran. But that raises the question: why does the system go to such lengths to determine access in the first place? Isn't that also bureaucratically tedious?

The bureaucratic filtration process has significant and potentially harmful effects on many veterans and on the system itself, particularly since it is based on notions of disability. Many veterans who would qualify for benefits do not want to see themselves as disabled or believe that others have greater need of the benefits and are therefore unlikely to submit to the application process. For others, the VHA represents the best chance at improved health outcomes due to its familiarity with conditions common to the veteran population, but they are barred access due to administrative barriers like the characterization of their discharge, the lack of legislation authorizing their claims, the availability of corroborating evidence, or even the biases of examining physicians—most of which is outside the control of the VA. And regardless whether veterans refuse to seek or are denied care access, their health outcomes can reflect on the VA and influence the system, as is happening with veteran suicides, where as many as three out of four such cases have no contact with the VA.

This raises several fundamental questions. Why is the system built this way? If the goal is to "care for him who shall have borne the battle," as the VA motto says, is this the best way to achieve that goal? Is it really in the veterans' best interests or keeping with the public's desired

goals? Given that the system effectively excludes more than half of American veterans, what burden does that impose on other healthcare and social systems?

These questions are worth exploring if only to better understand what has become an enormous and complex government bureaucracy that plays several important roles in American healthcare development and delivery. And in that, it holds the potential to identify ways to improve not only veterans' care but also healthcare for all Americans. At the heart of these questions is the concept of disability in the context of veterans' healthcare access. How has it changed over time? And how have those changes shaped a system that is in many ways enormously successful and yet in others still fundamentally broken?

## Review of Chapters

The first chapter examines the definition of disability through the medical model. While veterans' benefits have been a feature of American government from the earliest days, the notion that such benefits should be based on the determination of medical experts is only about a century old. Prior to that, legal determinations of disability entitled veterans to ever more generous pensions, raising concerns about corruption and fueling calls for reform. Ostensibly objective, medical science offered not only a way to reform what many considered a flawed system, it promised the potential to rehabilitate those disabled on the battlefield into productive, independent civilians—a promise that appealed not only to budget conscious officials but also to veterans' own senses of masculine self-sufficiency—opening the door to the establishment of federal medical institutions that would specialize in veterans' healthcare.

Established in 1921, the Veterans' Bureau was intended to administer benefits promised to First World War veterans, including the construction of a dedicated hospital network to see to their health. But in the event, the new administration was less attuned to veterans and more sensitive to

political, social, and medical pressures. The second chapter explores the early administrations of the Veterans' Bureau and Veterans' Administration, how changing perceptions of medical science affected the development of a hospital-centric healthcare system, and how academic medicine came to occupy a central place in veterans' healthcare.

While definitions of disability tended to focus primarily on readily apparent physical impairments, psychological and other "hidden" disabilities were sorted into something of an administrative gray area. With less clearly defined boundaries, such disorders were subject to more variability in classification and treatment and in veterans' ability to acquire benefits. As the Veterans' Administration adjusted to constricting budgets and the growing needs of aging Second World War veterans, many Vietnam Era vets—particularly those dealing with psychological trauma—felt impelled to take matters into their own hands. The third chapter thus explores how veteran/patient advocacy influenced and expanded care access at a time when medical science worked to define the boundaries of hidden disabilities.

The development of the veterans' healthcare system did not follow a straight line of progress, of course. The system has been subjected to the fickle whims of political and public perceptions and pressures, which often resulted in a mixed-message environment that complicated the delivery of consistent, quality care. In the 1990s, as Administrator of the Veterans Health Administration, Dr. Ken Kizer set out to restore faith in the system by adopting safety and transparency standards that held the promise of revitalizing and elevating veterans' care. These efforts paid dividends, but they also highlighted persistent problems. Chapter four examines the development of the modern VA's medical culture and how it has responded to public perceptions, the availability of pharmaceuticals, persistent prejudices, and of course, politics and notions of patriotism.

Finally, the fifth chapter examines how the VA bureaucracy itself can be—and all too often is—a barrier to care, contributing to persistent problems like veteran suicide, homelessness, substance abuse, and the system's struggles to achieve positive health outcomes. Despite the allocation of considerable resources and the well-intentioned and selfless efforts of VA care providers, the VA has barely made a dent in these issues. I argue that this is due in large part to a lack of understanding about the historical factors and developments that shaped the current, rigid bureaucratic framework of the VA and the need for reorientation.

There is hope that the veterans' healthcare system can not only better serve veterans but also be a model for expanding quality care to all Americans. But for that to happen, officials, providers, and policymakers need to understand the history of the problems facing the VA today, and specifically how notions of disability have perpetuated and exacerbated those problems.

## 1) Defining Disability through the Medical Model

### "Disability Rating"

January 2020 - Disabled American Veterans Office, Sacramento, California

It had been a long day to this point. This was my third stop, and the last one before going home. After calling the Veterans' Crisis Line the night before, I had driven the fifty or so miles to Sacramento, determined to try to get some help. I had all the relevant paperwork with me—my DD-214, which summarized my service and stated the character of my discharge, my enlistment contract, my medical records. I even had my last PT test scores. Everything was organized in a binder in the passenger seat of my car.

I had just come from the Sacramento VAMC. The man in the Navy cap gave me a card for a VSO that could help me file a disability claim. VSO stands for either "veteran service officer," meaning an individual, or "veterans service organization" meaning a non-profit organization, usually run by volunteers, which may or may not be federally chartered. The VSO in this case was an individual who worked for Disabled American Veterans, a federally-chartered nonprofit that had an office in a business park near the VAMC. I grabbed my binder and walked inside.

The office practically shouted veteran pride. Posters plastered the walls alongside plaques of appreciation from various veterans' groups and organizations. I went to sign in. Next to my name, the form asked for a reason for the visit. Not knowing what else to put, I wrote down "enrollment" since I was ultimately hoping the VSO would be able to help me enroll in VA medical care for treatment.

An hour or so later, an older man called my name and escorted me back to his office—a messy affair with file folders blanketing his desk and plenty of Marine Corps regalia on the walls.

“What brings you in today?” he asked, glancing down at the form he held. “Enrollment? What does that mean?”

I explained that I didn’t know what else to write, that I had called the Crisis Line, been referred to the VAMC and then to him because I apparently needed a disability rating to enroll for care. So, “enrollment” made sense to me, but I admitted that I had no idea what I was doing or how to navigate this system.

“Why didn’t you file a claim when you were getting out?” he asked, meaning when I got out of the Army back in 2006.

I laid out my reasons. At the time, I had my suspicions about the Army and the VA. During my last few months in the service, I served as the Training Room NCO for my company. That meant I primarily processed paperwork, including helping soldiers file their ETS (expiration term of service) packets. That meant I saw several buddies who were getting out of the Army get medically screened by the VA, receive low or no disability ratings, and subsequently get called back up by the Army. Those who received higher ratings, and those who skipped the VA step—it wasn’t mandatory at the time—never got called back up, curiously enough.

I suspected the Army was using VA medical screening to select candidates for call up. It made sense in a way. If the Army could identify relatively health veterans, they could skip a lot of hassle in calling those vets back up to duty. This was 2005. The war in Iraq was not going well, a lot of experienced soldiers were getting out of the Army, and recruiting couldn’t keep up with the demand for manpower, nor could training replace the experience of these soldiers. So, the Army ended up calling back to active duty a lot of recently separated soldiers.

These guys would almost always end up getting assigned to short-staffed National Guard or Reserve units that didn’t have nearly the same level or training we had in the regular Army.

Worse, these units were made up of soldiers that trained together for months and years, meaning they weren't likely to listen to the "new guy," even if that new guy had actually been to combat before. Experienced soldiers, like I was at the time, saw that situation as a recipe for disaster. A call up meant assignment to a unit that was definitely deploying for at least a year, and likely one that wasn't properly trained or equipped nor very likely to listen to our experience. No thanks.

More than that, though, I explained that I didn't sign up for VA benefits in 2006 because I didn't think I qualified for or needed the benefits back then. Sure, my ears rang all the time (and have ever since), my joints hurt and didn't work as well as they once did, I was a full inch shorter than I was when I enlisted, and I had the occasional nightmare or emotional outburst. But these things applied to every paratrooper I knew, and none of these issues stopped us from doing our job. None of this was, in my mind, a "disability." And for years, I felt that I managed these issues just fine and that other veterans who had things worse than I did needed the benefits more than me—that I was somehow making it easier for others to get the care they needed.

"That's bullshit," the VSO said, obviously agitated.

I was confused. Was he saying that he meant my reasons were bullshit, that the situation was bullshit, or did he think I was lying to him? In that moment, as low and depressed as I was, I was almost certain that someone would tell me I was overreacting, being soft or weak—that they'd tell me to toughen up or accuse me of lying to try to get benefits, which often come with compensation payments. I could give a shit about the money. I just wanted help. But I was afraid that someone would accuse me of shamming—of trying to get something for nothing—and in this moment, I thought this VSO might be doing just that.

I must have looked as confused as I felt because the VSO continued. He explained that he was a veteran himself, a former Marine. I almost sarcastically quipped that it was hard to tell from

the way his office was decorated—most Marines, in my experience, aren't exactly subtle about their association with the Marine Corps. Had I been in a better mental state, I probably would have ribbed this former Marine a bit. But in the event, I just bit my tongue.

The VSO continued, explaining that after he got out of the Marine Corps, he worked for the VA for decades, much of that time spent as an outreach specialist trying to get servicemembers to enroll in VA services. "I heard that stuff all the time," he said, holding up his fingers to put quotation marks around his next words. "'Someone else has it worse,' or 'I'm not disabled.' Listen, your benefits—or potential benefits—are yours. They aren't tied to anyone else's situation. You're not taking money from anyone by signing up for them or helping anyone by not taking them. The government owes you these things. You should have registered."

I wasn't exactly reassured by this lecture, even if I agreed with his logic.

"Well, I'm here now," I said. "What do I need to do?"

We covered my complaints and the steps I would have to take to file claims for them. He reviewed my paperwork, noting which forms would be helpful in the process, and he covered the VA forms in depth. They seem simple enough. The primary form, the VA 21-526EZ even had the letters "EZ" attached to it to imply how easy it should be to fill out. But the forms rarely provided enough room for a proper description of an event or complaint. The VSO explained that there were other VA forms that could be attached to the 21-526EZ to give more room for explanations, and he urged me to be as detailed as possible, but also to use the right terminology.

"The point is to make sure you have to wording right. That speeds up the process. For instance, your ears ring, right?"

I nodded.

"Both ears?"

"Yeah, but it's more pronounced on the right side."

"Okay then. In this box, you write 'tinnitus, subjective, bilateral,'" he said.

"I can't just write that my ears ring?"

"You can, but then they'll likely send you to get certain tests to come up with a medical diagnosis," he said. "They might send you to get the tests anyway—they probably will, in fact. But if you use the medical terminology in the first place, it speeds up the paperwork."

That made sense, I supposed. But it wasn't exactly intuitive and seemed to go against the whole idea of easy care access for veterans.

"Most important," the VSO said, "is to get a letter from your doctor. You have a family doctor that would be willing to write a letter of support for your claim? Who would say that these complaints of yours are legitimate? If not, I can get you in touch with a few doctors who can give you an exam and will be happy to write a letter. Those letters from doctors carry a lot of weight with the VA."

Our conversation continued until we had a solid plan. I wrote everything down in my notebook and the VSO gave me a checklist to follow. Fill out a few dozen forms, get my family doctor to review everything and write a letter of support, then get everything back to the VSO, who would file everything on my behalf in the proper order to maximize my chances of a positive decision in my case.

If all went well, I'd have a decision from the VA in six to ten months. The VSO assured me that would be fast. I'd just have to hold things together until then, I supposed.

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My experience in filing a claim was somewhat uncommon. Most veterans who file a claim with the VA do so in the first few weeks or months after getting out of the service. The VA has

dedicated significant resources over the years in outreach efforts to encourage early enrollment because it makes things easier. The VA is legally obligated to corroborate information in every claim, and that task becomes much more difficult as the interval between a veteran's separation from service and filing a claim gets longer. If that interval is short, the VA can often contact the veteran's last unit and receive all the information they need relatively quickly. If it's longer, the VA often has to go to the records center for the various branches and hope that the veteran's records can be found. So it's easier for the VA if the veteran files early.[40]

In 2007, Congress authorized the VA to provide healthcare services for recently separated veterans who served in a combat theater for up to five years from the date of their discharge without having to go through the regular records verification process.[41] And in 2019, the VA began the Solid Start program, which enables VA officials to contact recently separated veterans several times in the first year since discharge to inform them about the benefits and support services available.[42] Unfortunately, these efforts didn't apply to my case. I had to jump through a different set of hoops. But even with these recent changes to the process, the fact remains that veterans must apply for VA benefits, and many veterans feel exactly as I did back in 2006. They don't see themselves as "disabled" and believe that others have it worse. It's not that veterans are ignorant

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[40] U.S. Department of Veterans Affairs, "Evidence Needed for Your Disability Claim," https://va.gov/disability/how-to-file-claim/evidence-needed/.

[41] Congress established a special period of enrollment eligibility for VA health care in 1998 and expanded it in 2007 with the passage of the 2008 National Defense Authorization Act (NDAA). The Veterans Programs Enhancement Act of 1998 (P.L. 105-368) provided a 2-year coverage period after discharge for veterans of the Persian Gulf War. And the Clay Hunt Suicide Prevention for American Veterans Act created a one-year window from February 12, 2015 to February 12, 2016 out of concerns that the five-year eligibility period established by the 2008 National Defense Authorization Act was not enough, but the period of eligibility reverted to five years after the Clay Hunt bill's provisions expired.

[42] Leo Shane III, "Newly separated veterans will now get phone calls from the VA to talk about benefits and support services," *Military Times*, Dec. 27, 2019.

of the existence of benefits, it's that the application process requires vets to do something that often goes against military indoctrination: to ask for help.

Why do we make veterans go through that? And why does the VA put special emphasis on medical expertise? What's the history behind that?

What is today called the Department of Veterans Affairs began as the Veterans' Bureau, founded in 1921. It was the fulfillment of a campaign promise by President Warren G. Harding to nearly five million veterans of the First World War. The new agency was sorely needed at the time because, at the time, veterans' benefits were handled by four different government agencies that didn't communicate well with each other, creating a bureaucratic mess, which the Veterans' Bureau was intended to clean up and streamline. But why was it such a mess before the Bureau? Well, that has to do with how veterans' benefits were handled before the First World War. The United States has provided benefits to veterans disabled in military service since the earliest days of the Republic. Congress was and remains the ultimate authority on the provision of these benefits, and for more than a century, Congress alone made determinations about who would receive such benefits, often on a case-by-case basis early on. The idea being that someone who sacrificed his health in the nation's service should be afforded benefits—often a pension—to ensure their livelihood and independence thereafter. But as the United States expanded and more veterans were created through its military enterprises, Congress created several agencies to which it delegated some of its authority through legislation.

Of course, Congress also wanted to ensure that taxpayer funded benefits went only to cases of genuine need—that the government would not be fleeced by grifters. To that end, in the nineteenth century, Congress required any veteran applying for benefits to consult a physician who would testify under oath to a genuine need. Ostensibly, a physician's testimony would sort out

cases of genuine need from the rest. But in practice, this meant that local physicians—who generally had vested interests in maintaining their community standing—were often understandably happy to sign off on local veterans' disability pension claims.

As pension claims rolled in, government officials began to notice an alarming number of what they considered to be bogus claims. The solution seemed simple enough: have the federal government hire physicians to review applications and sort out questionable or unsubstantiated claims from the rest. This, of course, required coordination with the Army and Navy to secure corroborating evidence, and occasionally it required the veteran in question to submit a sworn statement before a judge. Only after such evidence had been satisfactorily submitted would the veteran's name be added to the pension rolls.[43]

For nearly a century, this pension system worked well enough fo0r most veterans. But after the Civil War, some folks began to complain about the cost, and for good reason. By 1915, the cost of the Civil War veterans' pension program was greater than the cost of the war itself.[44] Calls for reform came from multiple angles. Southerners resented the pension system because it was a concrete reminder of the Civil War and because Confederate veterans were barred from receiving pensions. Critics of ballooning federal spending pointed out that pensions made up the largest share of the federal budget at the time.[45] Progressive era activists for social reform saw in veterans' benefits an opportunity to expand workman's compensation insurance frameworks at the federal level. And a nation on the brink of passing a constitutional amendment to prohibit alcohol worried

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[43] Claire Prechtel-Kluskens, "'A Reasonable Degree of Promptitude' Civil War Pension Application Processing, 1861-1885," *Prologue Magazine* 42, no. 1 (Spring 2010).

[44] Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago: The University of Chicago Press, 2011).

[45] United States Census Bureau, *Statistical Abstract of the United States: 1915* (Washington, DC: Government Printing Office, 1916).

about the number of veterans who spent their pensions at the saloon and ended up becoming public burdens anyway.

It's important to note that most veterans likely weren't drinking their pensions, but there were enough that there was plenty of fodder to help shape public opinion. Combined with scandalous but anecdotal stories of politically-connected veterans receiving enormous pensions for minimal service making their way through the press, public pressure aligned behind the groups above and the administration of President Woodrow Wilson was keen to respond—particularly as it looked ever more imminent that the United States would enter the largest war in human history to that point. In that response, President Wilson turned to modern medicine.[46]

You have to understand that modern, scientific medicine was still on a relatively rough footing in the early 20th century. It was gaining stature, but many Americans still relied on herbal remedies, folk medicine, and other "alternative" sources. Medical schools and board certifications had only started to take on their modern character in the fifty years since the end of the Civil War.[47] So, when the government asked physicians to take a leading role in making disability determinations and to come up with the means of medically rehabilitating soldiers disabled on the battlefield, it represented a professional opportunity many were loath to turn down, even if some correctly argued that scientific medicine was not able to define disability in all cases.[48]

And so, practitioners of modern medicine were placed in the role of being the ostensibly objective arbiters of disability with regard to veterans' bodies. They would examine veterans, determine the existence of a legitimate disability, prescribe rehabilitative interventions, and in the

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[46] Linker, *War's Waste*, 35.

[47] Shauna Devine, *Learning from the Wounded: The Civil War and the Rise of American Medical Science* (Chapel Hill: The University of North Carolina Press, 2014).

[48] Carol Byerly, *Fever of War: The Influenza Epidemic in the U.S. Army during World War I* (New York: New York University Press, 2005).

process, they would elevate the status of their profession. Understanding the history of that development—how medical determinations of disability became the cornerstone of veterans' benefits—is thus key to understanding how the veterans' healthcare system continues to operate today.

## War and the Clinical Gaze

Modern, scientific medicine began to emerge during the Enlightenment—roughly the timeframe spanning from Descartes's championing the powers of reason over inherited traditions to the French Revolution. Physicians like Andreas Vesalius began to question the foundations of the medical traditions passed down since antiquity and to develop new practices of building knowledge through direct observation.[49] This meant, in some cases, bucking contemporary social mores, conducting dissections, and observing the physiological pathology as diseases progressed. All of this required access to bodies—both living and dead—and the emergence of secular hospitals presented just that type of access, especially for aspiring physicians who sought professional and social advancement by catering to wealthy clients who happened to patronize local hospitals.

Eminent historian Charles Rosenberg explored the ways in which the early modern hospital served as a means of social advancement and professionalism for physicians in the United States.[50] He effectively demonstrated that while physicians desired access to patients to advance pathological and medical knowledge, early modern hospital patrons often resisted these efforts, holding to traditional notions that hospital inmates were to receive charitable care and

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[49] Peter Dear, *Revolutionizing the Sciences: European Knowledge and Its Ambitions, 1500-1700* (Princeton: Princeton University Press, 2001).

[50] Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: The Johns Hopkins University Press, 1995).

rehabilitation, not to be objects of study. If physicians wanted access to the patients—and to the wealthy hospital patrons—they would only do so on the patrons' terms. Rosenberg argued that these conditions shaped medical culture by ensuring that physicians either came from the gentry or made every effort to conform to it and that hospitals retained a strict hierarchical structure that reflected the prevailing social order. But there was more to the practice of medicine in hospitals than social dynamics.

Ivan Waddington and others have argued that the advent of modern medicine really occurred in Paris after the French Revolution. The secularization of French society swept the old social order aside and created opportunities for physicians to have relatively unfettered control of hospitals and thus access to patients' bodies—the source of medical knowledge. This led to localized pathological studies based on physical examinations, the regular performance of autopsies, and keeping records to track the progression of various diseases.[51] Erwin Ackerknecht described this phase of the development of modern medicine as "hospital medicine" to differentiate it from preceding types of academic and bed-side learning and subsequent laboratory science.[52] The French Revolution thus created the circumstances wherein physicians could wrest control of the hospitals from the patron class and operate them purely for their own scientific, professional, and medical interests—generally in that order. Without any real barriers to the fulfillment of their desires to study their patients as they saw fit, physicians throughout Europe and the Americas flocked to Parisian hospitals, turning these institutions into the great medical laboratories in the

[51] Ivan Waddington, "The role of the Hospital in the Development of Modern Medicine: A Sociological Analysis," *Sociology* 7 (1973):211-224.

[52] Erwin Ackerknecht, *Medicine at the Paris Hospital, 1794-1848* (Baltimore: The Johns Hopkins University Press, 1967).

early years of the nineteenth century. This had the effect of improving medical knowledge by leaps and bounds, but it often took decades for that knowledge to translate into useful therapeutics. Renowned philosopher Michel Foucault explored this period of history and, only somewhat ironically, named the epistemological process that took place. He called it the "medical gaze"—the process of producing knowledge from the patient's body by observing and naming what was already there.[53] Essentially, Foucault argued that physicians established the possibilities of medical knowledge through the language they constructed from their observations. Parisian hospitals were ideal environments for such epistemology as physicians could control the variables and limit environmental factors. And physicians from across Europe and the Americas who pursued medical educations in Paris took these practices—this new and radical medical culture of the clinic—back home with them.

Paris-trained clinicians went to work in American and British institutions that retained traditional models of patronage, but the balance of power began to shift. Patrons recognized the superior medical training of Parisian clinicians and were thus obliged to cede some of their authority to these doctors. It of course helped that physicians who were able to pursue an education in Paris were, almost without exception, members of the gentry themselves—no one else could afford the expense involved.

Still, it is important to remember that while doctors viewed hospitals as vital sites of medical knowledge production, patients and society continued to view the institutions through traditional lenses. These were not yet the homes of advanced medicine, either. They were, instead, places of last resort. Hospitals and almshouses had distinctly negative social reputations—only the

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[53] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Random House, 1973).

truly desperate who lacked any other means would enter these places, and only then out of dire necessity, as Rosenberg's examination of the state of New York City's hospital in 1810 well demonstrates.

Rosenberg noted that "self-respecting New Yorkers were naturally ashamed to find themselves in such surroundings; it meant their abandonment by family, by employers, even by congregations if they were churchgoers."[54] The added indignities of subjection to the clinical gaze and the likelihood of dissection after death, in addition to hospitals' already poor reputation, threatened to undermine the institutions' traditional social role, and it may well have done so if their patients had any other alternative.

The emergence of the Parisian clinics may well have been the event that ushered in the era of modern medicine, as Waddington and others argue. But it would take decades before the accumulation of medical knowledge paid dividends in care delivery. In the meantime, other factors—most notably the wars in Crimea and the United States—would leave indelible marks on the forms and functions of hospitals and medical care, demonstrating the importance of war and conflict on the development of modern medicine.

Perhaps the most significant development regarding institutional care delivery in the nineteenth century was the professionalization of the nursing profession. While Florence Nightingale often receives credit for this development, the origins of nursing go back well before her time. Indeed, the story of modern nursing predates that of modern medicine.

During the early stages of the Enlightenment, while academics and physicians were beginning to question inherited, traditional knowledge, their rebellion caused a reaction in the Catholic Church, which had been the stewards of such knowledge since antiquity. In medieval

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[54] Rosenberg, *The Care of Strangers*.

times, church scholars and monks kept the traditions of Galen and Hippocrates alive in the West by dogmatically copying their works and even practicing humoral medicine in church-sponsored hospices—the precursors to modern hospitals. Similarly, Catholic nunneries developed and established traditions of nursing in these same hospices.

While the monastic orders retreated from humoral medical practice due to Church reforms in response to the Enlightenment, many nunneries carried on with and zealously defended their traditional nursing duties, even winning recognition from the Parisian clinicians who otherwise demanded complete control of the hospitals. When the nuns at Paris's Hotel-Dieu refused to take orders from secular physicians appointed to run the institution, they were ordered to leave. The nuns refused and managed to successfully force the recognition of their authority over care delivery through a sit-in strike.[55]

Nightingale learned her craft through an institute that trained Lutheran nuns in nursing, meaning her methods were not new. But when she became a celebrity in the papers due in large part to her gentrified social standing and the patriotic nature of her work, her popularity and influence spurred an effort that simultaneously fit nursing into rational modern frameworks and made it acceptable as a profession for middle- and upper-class women.[56] Nightingale's efforts in the Crimean War resulted in hospitals—both military and civilian—adopting certain standards that had a dramatic effect on improving patient outcomes. Hospitals came to adopt Nightingale's principles of hygiene, nutrition, ventilation, and light.[57] This at a time when modern medicine still adhered to miasmic theories of contagion—the idea that disease was transmitted through bad air.

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[55] Victoria Sweet, *God's Hotel: A Doctor, a Hospital, and a Pilgrimage to the Heart of Medicine* (New York: Riverhead Books, 2012).

[56] Patricia D'Antonio, *American Nursing: A History of Knowledge, Authority, and the Meaning of Work* (Baltimore: Johns Hopkins University Press, 2010).

[57] Florence Nightingale, *Notes on Nursing: What it is and What it is Not* (Pall Mall: Harrison, 1859).

It did not matter that contemporaries did not understand bacteriology; it simply mattered that these practices worked.

The American Civil War brought further enhancements to the form and functions of hospitals. Historian Margaret Humphreys argued that the war, and Nightingale's example, established nursing as a socially-respectable field for middle-class women and provided a way to bring the traditional feminine role of caretake in the home—the type of care described so well by Laurel Thatcher Ulrich's examination of Martha Ballard—into the hospital.[58] Humphreys argued that it was up to women to "recast the hospital as the home, their patients as family, and their roles as nurses and even doctors as endorsed by a moral perspective shaped by traditional domestic expectations."[59] And considering that tens of thousands of sick and wounded men—used to receiving care at home and conditioned to see hospitals as places of last resort—had positive experiences in British and American military hospitals, public opinion regarding these institutions began to gradually shift.

Modern medical knowledge and professionalization efforts also benefited enormously from the American Civil War, as historian Shauna Devine pointed out. The appointment of Dr. William Alexander Hammond to the post of U.S. Surgeon General was instrumental in these regards.[60] Hammond was a career Army officer who received extensive medical training in Europe. Hammond was a firm supporter of the clinical process, and he used the authority of his

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[58] Laurel Ulrich, *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812* (New York: Vintage Books, 1991).

[59] Margaret Humphreys, *Marrow of Tragedy: The Health Crisis of the American Civil War* (Baltimore: The Johns Hopkins University Press, 2013).

[60] Bobby A. Wintermute, *Public Health and the U.S. Military: A History of the Army Medical Department, 1818-1917* (New York: Routledge, 2011).

position as Surgeon General to take steps to standardize medical practice throughout the United States Army.[61]

First, Surgeon General Hammond restricted military medical commissions to practitioners of orthodox medicine. This had a dramatic effect in both the military and civilian practice. Before the war, orthodox doctors competed with homeopathic and sectarian practitioners for clients. With Hammond's decree, only orthodox physicians could serve as doctors in the U.S. military, which simultaneously elevated orthodox medicine by putting the official weight of the government behind it and created a de facto network of orthodox physicians from across the country who worked together during the war and remained in contact after it ended and they dispersed to their various homes.

Next, Hammond required Army and Navy physicians to meet high standards requirements through board examination—a precursor to modern medical licensing practices. Then, mindful of the opportunity the war represented for the advancement of scientific knowledge, Hammond ordered all military physicians to collect and preserve pathological samples for the establishment of the National Medical Museum. These efforts not only established a repository of medical knowledge, they established and reinforced professional networks and connections that survived well after the war ended and continued to influence the development of professional medical practice and scientific research. Essentially, Hammond's relatively short tenure as U.S. Surgeon General during the war enabled him to do more in a few years to advance the professionalization of American medicine than nearly two decades worth of concerted efforts by the American Medical Association (AMA).[62]

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[61] Devine, *Learning from the Wounded.*

[62] Hammond was appointed Surgeon General by President Lincoln on April 25, 1862 and remained in that post until August 18, 1864—he ran afoul of Secretary of War Edwin M. Stanton, who had Hammond court martialed on

For most Americans, the end of the war marked the beginning of a concerted effort to return to antebellum life. The military hospitals constructed during the war were, for the most part, torn down or turned over to local concerns and repurposed.[63] Most of the war's nurses returned to traditional roles in the home, and the Army Medical Department—so central and essential during the war—returned to a relatively obscure organization in the wider medical field. The one exception was the establishment of hospitals by the Freedman's Bureau, which served to provide at least some medical care to the nation's roughly five million formerly enslaved people, but by 1872, all but one of those institutions also closed.[64]

Medical historians generally agree that the Civil War was a point of historical confluence that set the stage for subsequent developments.[65] In effect, then, most of the dramatic shifts in the medical landscape that emerged from the Civil War took several more years to develop but are no less noteworthy for this incubation period.

Surgeon General Hammond's requirements for board examinations for military doctors provided a blueprint for states to implement similar exams for medical practice certification after the war. No longer could an aspiring physician simply pay tuition at any medical school and claim the title of doctor—now they had to prove their capability to their peers. Doctors who served together during the war retained correspondence with one another, strengthening professional medical associations like the AMA, which would become very influential in subsequent decades.[66]

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falsified charges of "irregularities" in the purchase of medical equipment after Hammond and Stanton argued on several occasions, but his reforms remained in place. In contrast, the American Medical Association was established in 1847 and was just under two decades old when the Civil War ended on April 9, 1865. During that time, they tried but failed to achieve many of the reforms Hammond was able to implement through the military.

[63] D'Antonio, *American Nursing*.

[64] Devine, *Learning from the Wounded.*

[65] Wintermute, *Public Health and the U.S. Military*.

[66] Devine, *Learning from the Wounded.*

The military hospitals erected during the war were clean, orderly, and professional, but few remained as operational hospitals after the war. Most were demolished or repurposed as the nation reverted to its traditional preference of care taking place in the home. But tens of thousands of American soldiers from across the nation experienced these new hospitals—experiences that certainly undermined prevailing notions of hospitals as dirty, dangerous places of last resort and helped spur the patronage of civilian institutions in subsequent years.

Indeed, contemporary medicine during the Civil War was relatively effective considering the circumstances. Most of the military deaths of the Mexican American War, by comparison, came from disease.[67] And the combination of the large number of participants, advancements in weaponry, and medical interventions left an indelible mark on the American landscape. The disabled veteran—often an amputee—became a living symbol of the war's cost and soldiers' sacrifice. It was a symbol that inspired the nation to give back to those who served.

## A Dedication to Sacrifice

When President Lincoln gave the Gettysburg Address on November 19, 1863, he ultimately tied the cause of the war—indeed the fate of democracy—to a debt owed to those who fought it. The idea that the nation owed something to those disabled in its service was not new, but Lincoln's framing and his veneration of "the brave men, living and dead" revitalized America's commitment to its veterans and their care after the war.

Before the Civil War, veterans disabled in the service could receive pensions from the government, but usually, these pensions were issued well after the fact and often on a case-by-case

[67] Michael Clodfelter, *Warfare and Armed Conflicts: A Statistical Encyclopedia of Casualty and Other Figures, 1492-2015*, 4th ed. (Jefferson, North Carolina: McFarland & Co., 2017), 249.

basis. Applicants also generally had to demonstrate financial hardship and lack of familial support.[68] The Civil War altered this landscape.

When it became clear that the initial wave of volunteers who filled out the Union Army would not be sufficient to meet the war's demands, Congress passed the General Pension Act of 1862, also known as the "General Law" that created a new pension system. This law allowed anyone who served in the United States military since March 4, 1861 and who was "disabled by reason of any wound received or disease contracted while in the service of the United States, and in the line of duty" to submit a pension claim against the U.S. government.[69] Congress hoped that this move would encourage more volunteers for the Union Army by removing the uncertainty of a veteran's ability to take care of himself and his family. In that hope, the law failed. The Union was still forced to enact a draft. But the law nevertheless applied to all Union veterans, whether they volunteered or were drafted.

While the General Law mentioned disability, it failed to clearly define what that term meant. Officials in the federal Pension Bureau, therefore, followed the precedent of earlier pension laws that stated disability meant "losing a limb in any engagement, or being so disabled in the service of the United States as to render him incapable of earning a living."[70] This standard was what government officials came to view as "total disability."

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[68] Peter Blanck and Larry M. Logue, *Race, Ethnicity, and Disability: Veterans and Benefits in Post-Civil War America* (New York: Cambridge University Press, 2010). The Continental Congress enacted the first pension law providing half pay for life for disabled veterans in 1776 but was generally unable to fund and enact this law; In 1818, Congress provided pensions to poverty-stricken veterans who had served at least 9 months in the Revolutionary War and ended up requiring sworn statements of income for applicants; and between 1832 and 1848, Congress continued to refine pension laws and requirements for both veterans and widows of veterans.

[69] *General Pension Act of 1862*, Statutes at Large, 37th Congress (Washington, D.C.: Government Printing Office, 1862).

[70] Library of Congress, *Journals of the Continental Congress, 1774-1789*, Vol. V. (Washington: Government Printing Office, 1906), 702.

Shortly after the war ended, veterans began to complain about the inadequacies of the General Law pension system, particularly the low compensation rates. The General Law provided veterans experiencing "total disability" with $8 monthly payments—roughly the compensation for manual labor at the time. But not all disabled veterans had been manual laborers before their service. For many, then, this pension represented significantly less income, which went against the spirit of the law that those disabled in the service should be made whole again to the extent possible. Further, the law only provided pensions for cases of total disability, meaning veterans with significant ailments that failed to be qualified as total disabilities were simply left out.

In response to these and other concerns, Civil War Veterans formed the Grand Army of the Republic (GAR), which became the largest veterans' lobbying group in the nation. Indeed, the GAR was the largest single-issue political lobby of the late nineteenth century.[71] Framing itself as a patriotic institution, the GAR was responsible for pressuring Congress to adopt May 30 as Memorial Day, worked to provide mutual support networks for veterans, promoted the voting rights of Black veterans, and of course advocated for better veterans' benefits—particularly regarding pensions. With hundreds of thousands of members and more than two million living veterans who tended to agree with the GAR's positions, the Grand Army of the Republic became instrumentally influential in federal politics, particularly with the Republican Party.

Pressured by the GAR, Congress repeatedly updated and liberalized its pension laws and benefits. In 1866—the same year that the GAR was founded—Congress expanded pension payments to $20 a month for disabilities that affected the performance of "any manual labor."[72]

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[71] Stuart McConnell, *Glorious Contentment: The Grand Army of the Republic, 1865-1900* (Chapel Hill: University of North Carolina Press, 1997).

[72] Claire Prechtel-Kluskins, "'A Reasonable Degree of Promptitude': Civil War Pension Application Processing, 1861-1885," *Prologue Magazine* 42, No. 1 (Spring 2010).

An 1872 Act increased the pension to $24 per month and allowed veterans who had not yet applied for pensions to claim back payments of as much as $953.62—roughly two-and-a-half times the average American salary at the time.[73] By 1890, pension laws dropped service connection and poverty requirements, essentially doubling the number of veterans on the pension rolls from 537,944 in 1890 to 966,012 in 1893.[74] This set the stage for President Theodore Roosevelt to issue an Executive Order in 1904 that declared all veterans over the age of 62 eligible to receive a pension as old age itself was considered a disability.[75] Essentially, after the General Law pension system went into effect in 1862, it was continually expanded until, by the early 20th century, pensions for Civil War veterans were the largest federal expenditure. And the system was rumored to be rife with fraud.

Pension Bureau officials recognized early on the potential for fraud and malfeasance, but they were more concerned about how to make legitimate claims work—specifically, how to make disability determinations. Cases of "total disability" were relatively easy to identify—the loss of a limb or an eye was automatically considered to be a total disability case. But other claims proved more difficult to sort. Was the disability permanent? Could it be treated? Was the disability the result of an unavoidable service-related circumstance or carelessness? The law simply stated that disability meant the inability to perform manual labor. This left significant room for interpretation and the government wanted to ensure that taxpayer funded benefits were only going to genuinely deserving cases.

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[73] Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge: Harvard University Press, 1992), 116.

[74] McConnell, *Glorious Contentment*, 153.

[75] Linker, *War's Waste*, 21.

The Pension Bureau turned to physicians to address this ambiguity. Pensioners with less than total disability ratings were required to submit to biennial examinations by federally-appointed physicians. Ostensibly, these doctors and surgeons would both clarify questions of disability and sort out fraudulent applications at the same time.[76] And though the government strived to ensure it appointed competent and meticulous physicians to this task, it soon became apparent that this method had flaws.

Medical assessment on a Surgeon's Certificate became the heart of the claim process. Bureau officials relied on these reports to make decisions about pension claims and the amount to be awarded. The problem was, from an administrative perspective, that many of these exams were conducted by "neighborhood practitioner[s], whose professional interest it is to please the claimant at the expense of the Government."[77] Essentially, the government was hiring local physicians who relied on their good standing in their local community for the rest of their business. These doctors were more likely to see the applying veteran as their client than the government and thus do everything they could to secure a favorable decision. The Pension Bureau was thus flooded with what some officials characterized as questionable medical reports.

To address this, the Bureau established a Medical Division to "rigidly inspect all returned certificates and to correct and adjust all medical questions."[78] They launched a "special service" to investigate potential fraud.[79] By 1883, the Bureau required medical exams to be conducted by

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[76] Prechtel-Kluskins, "A Reasonable Degree of Promptitude." Pension commission appointed physicians received Surgeon's Certificates—standardized forms that further allowed for the sorting and justification of disability claims. Examples of these certificates are available in the Records of the Department of Veterans Affairs, RG 15, National Archives and Records Administration.

[77] Report of the Commissioner of Pensions [1876], House Executive Document 1, 44th Congress, 2nd Session, p. 701.

[78] Report of the Commissioner of Pensions [1874], House Executive Document 1, 43rd Congress, 2nd Session.

[79] Fraud, or the implications of it, was always a concern for the Pensions Bureau, and there was fraud to be found. In 1874, the special service's work resulted in "direct saving to the Treasury… many times greater than the sum expended in maintaining it." But it was not widespread. That 1874 report found 411 fraudulent pensions and

a board of "three first-class physicians and surgeons" to eliminate or at least curb the neighborhood bias.[80] Each of these efforts was intended to streamline pension administration, but the shifting political environment essentially undermined the need for scrutiny. As pension laws became more generous, the need for medical justification decreased even as external criticisms increased.

## The Problem with Pensions

Criticisms of the pension system came primarily from one of three areas. The first consisted of southerners who resented the system for obvious reasons. Confederate veterans were denied pensions that primarily benefited populations in the northern states while all Americans paid the taxes that supported them.[81] Many in this camp saw the pension system as sustaining the sectarian divisions that kept the nation from moving past the Civil War.

The second camp was concerned with the readily apparent political corruption of the system, especially the cozy relationship between the GAR and the GOP. These critiques were not without merit. In 1884, for example, the Pension Commissioner sent a group of special service investigators to Ohio, ostensibly to investigate fraudulent claims. Instead, the examiners urged veterans to vote Republican "with the express understanding that their pensions would be withheld in case they did otherwise."[82] Combined with continuous lobbying for more generous benefits by the GAR and the GOP's willingness to provide the same, the pension system appeared to be little more than an extension of the Republican political machine. But while stories like the Ohio case were scandalous, the Pension Bureau was hardly exceptional in its political cronyism.

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rejected another 133 pending claims. But these 544 cases were relatively small considering there were 213,309 military pensioners in 1874.

[80] Report of the Commissioner of Pensions [1883]

[81] William Henry Glasson, *Federal Military Pensions in the United States* (New York: Oxford University Press, 1918). Glasson noted that three states in New England received $5.8 million in pension payments in 1910 while South Carolina, with a similar population to the combined totals of all three, received only $292,000.

[82] John William Oliver, "History of the Civil War Military Pensions, 1861-1885," *Bulletin of the University of Wisconsin* 4 (1917), 112.

The third camp based their arguments on contemporary notions of social justice. While not directly opposed to government intervention to address social issues, these reformers saw the pension system as being fundamentally un-American by creating a privileged class in veterans at the expense of everyone else and dangerously flirting with socialism besides. "What masquerades today as justice," wrote historian William M. Sloane in *The Century Illustrated Monthly Magazine* in 1891, "is simply the distribution to one class in the community of what belongs to another… [it is] inequality through taxation."[83] Essentially, they argued that the pension system was a threat to the social order.

By 1910, all three camps helped shape a full-fledged Progressive Era reform effort of the Civil War pension system. Public pressure for reform was coordinated in large part by muckraking journalists like Walter Hines Page and his *World's Work* magazine, which had garnered a readership of over 100,000 subscribers and established a reputation for investigative journalism.[84] Page was born after the Civil War in North Carolina, believed that the pension system contributed to continued sectarian divisions, and most importantly that they undermined contemporary values.[85] It was this last point that Page emphasized with his criticisms by flipping the masculine military ideal on its head.

In 1911, *World's Work* published "The Pension Carnival" by William Bayard Hale—a widely read reporter who usually wrote for *The New York Times*. Hale's article extensively criticizes the issuance of lifetime pensions to cases like that of John E. Farrell of Concord, New

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[83] William M. Sloane, "Pensions and Socialism," *The Century Illustrated Monthly Magazine* 42, no. 2 (June 1891): 179-188.

[84] *World's Work* made a name for itself with a 1906 series about the state of the meatpacking industry published to coincide with the release of Upton Sinclair's *The Jungle* and contributing to the passage of the 1906 Pure Food and Drug Act—the first major federal legislation of the Progressive Era.

[85] Linker, *War's Waste*, 25.

Hampshire. Farrell enlisted during the Civil War as a drummer-boy but was discharged after a few weeks—the implication being that he deserted his post, which was not uncommon. In 1910, however, Farrell was granted a pension by the Senate Committee on Pensions on the basis that "Mr. Farrell enlisted from patriotic motives. His early discharge was necessitated by no fault of his own." Hale noted that the Farrell case was "probably the most liberal and enlightened interpretation of a nation's duty toward *potential* patriots thus far enunciated. We learn from it that we should reverence and reward not merely needs, but desires."[86] Hale noted that many Civil War pensioners were genuinely worthy of their benefits, but due to the corruption of the system, by 1910, "the pensioner is a suspect. The common presumption is against his being a hero. The presumption, cynical perhaps, but not unjustified, is that he is likely to be a crook or a hustler or a peddler."[87]

Critiques like Hale's were common appearances in Page's publications, and it becomes clear that Page was shaping a particular narrative that undermined masculine sensibilities regarding veterans and pensions. Contemporary social values clung to the male breadwinner ideal—that a man should be able to care for himself and his family without government support. By framing the pension system as they did, Page and Hale made a strong case that, rather than being icons of masculinity, many pensioners were encouraged to become grifters on society. And the experience of the Spanish-American War drove this point home and reinforced the associated fiscal implications.

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[86] William Bayard Hale, "The Pension Carnival," Walter H. Page ed., *World's Work* (Garden City, NY: Doubleday, 1911), 13972.

[87] Hale, "The Pension Carnival," 1911, quoted in Linker, *War's Waste*, 26.

The Spanish-American War was "a splendid little war" that lasted only a few months and resulted in relatively few casualties.[88] Only 385 American soldiers were killed in combat, another 1,662 were wounded, and 2,061 died from disease in just under four months of conflict.[89] Such low numbers made the notion of "waving the bloody shirt" on behalf of veterans—as had been done for decades to justify greater pension benefits to that point—seem preposterous. And the fact that Spanish-American War veterans were entitled to lifetime pensions for what amounted to, at most, a little over seven months' active duty highlighted the need to reform the pension system. Writing in *World's Work*, muckraking journalist Burton J. Hendrick framed the issue:

The young men who enlisted for the Spanish war were in many cases the sons of Civil War veterans; in any event they were familiar with our national pension habit; in their minds, serving one's country, even serving it bloodlessly, necessarily implied a pension. Only such a mental attitude can explain the eagerness with which these survivors began to attach themselves to the pension list.[90]

Indeed, most veterans of the Spanish-American War were drawing pensions in short order. By 1916, nearly 28,472 pension claims had been approved—an astonishing number considering that only about 30,000 soldiers served in the Cuban campaign—at a cost of more than $50 million to the Treasury, annually.[91] With the First World War raging in Europe and the likelihood of the United States being drawn into a conflict that would require millions to don the nation's uniform, officials in Washington began to take pension reform seriously.

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[88] This quote has erroneously been attributed to Theodore Roosevelt, but it was John Hay, Secretary of State in 1898 who wrote to Roosevelt, saying "It has been a splendid little war, begun with the highest motives… favored by that Fortune which loves the brave."

[89] U.S. Department of Veterans Affairs, Office of Public Affairs, "America's Wars: Factsheet," 2017.

[90] Burton J. Hendrick, "Pork-Barrel Pensions," *World's Work*, 30 (1915): 713-20.

[91] Report of the Commissioner of Pensions to the Secretary of the Interior for the Fiscal Year Ended June 30, 1915 (Washington: Government Printing Office, 1916)

Soon after the United States declared war on Germany in 1917, the Wilson Administration created the Section on Compensation for Soldiers and Sailors on the Council of National Defense's Advisory Committee on Labor, led by Judge Julian W. Mack and Children's Bureau Director Julia Lathrop—both good progressives—to develop a new system of veterans' benefits on the basis of workmen's compensation laws. It was indicative of the administration's desire and willingness to reform pensions that they turned to this new committee rather than to the established Pension Bureau in the Department of the Interior. Indeed, the goal was to reformulate veterans' benefits from the ground up, using workman's compensation insurance as a model. The Section on Compensation for Soldiers and Sailors recommended that veterans' benefits be moved to the Bureau of War Risk Insurance.[92]

Initially created in 1914 to subsidize American shipping against losses incurred due to German submarines, the Bureau of War Risk Insurance was primarily a maritime insurance operation supported by the U.S. Treasury. The recommendation to put veterans' benefits into its purview framed servicemembers and their families, essentially, as just another form of war materiel to be insured against potential loss. But this new framework—codified as it was in the War Risk Insurance Act of 1917—went further.

Proponents of the new legislation argued that the bill "not only protects the family of the man in service and compensates them should he die or be totally disabled, but protects the single man as well….It removes the necessity and should remove the possibility of both disability and service-pension legislation."[93] In essence, then, the idea was to replace pensions with a government-run insurance system in which servicemembers themselves would subsidize much of

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[92] Julia C. Lathrop, "The Military and Naval Insurance Act," *Nation* 106 (Feb. 1918): 157-58.

[93] Paul H. Douglas, "The War Risk Insurance Act," *Journal of Political Economy* 26, No. 5 (May 1918): 461-483.

the costs. And in the event of an incurred disability, the affected veteran would be afforded every opportunity to medically rehabilitate that disability as well as vocational training that would allow him to return to a productive, independent civilian life rather than become dependent on the government dole. The proposed legislation was so popular that Congress amended the War Risk Insurance Act or 1914 without dissent and President Wilson signed the new law on October 6, 1917.

The law passed so easily, in part, because it left in place the old pension system for veterans of earlier conflicts. Pension critics like Page praised the legislation, and Progressive Era reformers—concerned as they were with curbing corruption and improving government through expertise—touted its ostensibly objective, scientific basis. Rather than being redefined by Congress every few years, the WRI would rely on mathematical calculations and scientific principles to address social problems associated with warfare including disabled men, fatherless families, and a burdened treasury. As historian Beth Linker noted, the WRIA was "in short, a large-scale experiment in social engineering."[94] In theory, it would solve multiple problems. But putting the theory to practice proved remarkably difficult.

**Rehabilitating Disability…**

The War Risk Insurance Act of 1917 (WRIA) was an attempt to leverage modern medicine to rehabilitate disabled bodies and return them to productive, independent lives. This was possible because, by 1917, modern medicine was finally living up to its promise. X-rays allowed physicians to see inside the body. Aseptic techniques and anesthesia transformed surgery from a last resort of the desperate into an effective therapeutic intervention. And modern hospitals were no longer the

[94] Linker, *War's Waste*, 30.

disease-ridden almshouses of the early nineteenth century—they were clean, efficient sites of healing that were, for the first time, preferable to domestic care.

Progressive Era reformers sought to utilize modern science to improve society, and it appeared that modern medicine had the potential to not only designate the existence of a disability, but to rehabilitate it entirely—or at least limit its impairments. With the supervision of qualified physicians, disability could be diagnosed and treated, and when based on an insurance funding mechanism, the program held the potential to save the government a great deal of money in the bargain. But the legislation's authors recognized that it might be a hard sell to the veterans themselves. To get around this, they established mandates that required cooperation.

> *The injured person shall be furnished by the United States such reasonable governmental medical, surgical, and hospital services and with such supplies, including artificial limbs, trusses, and similar appliances, as the director may determine to be useful and reasonably necessary; Provided, That nothing in this Act shall be construed to affect the necessary military control over any member of the military or naval establishments before he shall have been discharged from the military or naval service.*[95]

This section essentially required any servicemember injured in the line of duty to remain in military service until they had completed medical rehabilitation. The idea being to ensure that only service-connected disabilities were treated and documented, to utilize military discipline to enforce this treatment, and to ensure that the servicemember retained a government income that would support them and their family during this process. With this requirement, it fell to the U.S. Army Medical Department to enact these provisions.

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[95] "An Act To amend an Act entitled 'An Act to authorize the establishment of a Bureau of War Risk Insurance in the Treasury Department,' approved September second, nineteen hundred and fourteen, and for other purposes," Sixty-Fifth Congress, Sess. I, Chs. 103-105, 1917, pp. 398-411. Hereafter referred to as the War Risk Insurance Act of 1917 or WRIA.

The Army Medical Department was aware of the new legislation pertaining to veterans and the military's role in that process. But it also had larger priorities—like establishing, provisioning, staffing, and training a medical apparatus that could support the largest war effort in the nation's history to that point. That effort involved developing plans to evacuate the wounded from the front line to a network of aid stations, field hospitals, and base hospitals in Europe. The most serious cases would return to the United States and be sent to facilities that specialized in certain injuries and ailments.[96] It was in this stateside layer of the system—the general hospital system—that the Army planned to establish the type of reconstruction hospitals that would uphold the military's obligation of the WRIA. As part of an unprecedented hospital construction effort, it took some time to implement.

Locations for hospital construction had to be scouted, the land procured, and the facilities constructed. Ideally, these hospitals were located near existing railroads or ports to allow for easy transport of the wounded, but they also had to be built in bucolic settings that would encourage patients' recovery.[97] Staffing, of course, was also a concern. These hospitals had to be staffed with everything required to run a modern hospital, from nurses, physicians, and orderlies to administrative staff, laboratory technicians, and maintenance personnel. And these facilities had to be inspected and certified before they could accept patients.[98] All of this took time. The first

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[96] Col. Joseph H. Ford, M.C., *The Medical Department of the United States Army in the World War* (Washington DC: Government Printing Office, 1927). https://achh.army.mil/history/book-wwi-adminamerexp-default

[97] The emphasis on environment and the bucolic setting demonstrates just how strong the principles Florence Nightingale laid out still were by 1917 in military medical circles. Even after the development of bacteriology and aseptic medicine, temporary field hospitals were still very much dependent on the principles of fresh air and sunshine, so these facilities were often located in remote, rural locations. An unfortunate side effect of this was that many soldier patients at these facilities got the impression that the Army was trying to hide them from public view—to store the invalids out of sight, as it were.

[98] U.S. Army Medical Department, "Chief Surgeon AEF Report," vol. 15, Ch. XV, "Hospital Construction; Procurement," https://achh.army.mil/history/book-wwi-adminamerexp-chapter15

hospitals started to become operational in May 1918, just as the first waves of troopships started bringing the wounded back home from across the Atlantic.

In Europe, the system was designed to get the wounded to competent medical care as quickly and efficiently as possible. Regimental aid stations near the front lines would do initial evaluations and provide basic dressings of wounds. Superficial cases would be treated and returned to the front line while serious cases would be stabilized for the trip to an evacuation hospital. These facilities were often hasty affairs consisting of an ad hoc surgical room or two and rows of cots tended by small teams of overworked surgeons and nurses. The seriously wounded might receive their first surgical interventions at this point before another evacuation to a base hospital established well behind the front lines.[99]

Some of the best medical talent available at the time could be found in the base hospitals. When the U.S. entered the war, the nation's best medical schools and institutions practically raced to organize medical units to support the war effort with entire cadres of physicians taking commissions as military officers. It was at the base hospitals that most of the wounded received their first serious and concerted medical care. Wounds would be cleaned, surgeries performed, and convalescence well supervised by professional staffs of nurses and orderlies. But the care received at the base hospitals was only one step in a larger process.[100] While a few base hospital patients were able to return to duty with their units—primarily those treated for contagious disease like influenza—the majority who suffered traumatic injuries were stabilized and sorted for transport back to the United States.

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[99] Ibid.

[100] Aaron Jackson, "Base Hospital No. 30, One Hundred Years Later – Part One: Organization, Mobilization, and Travel," *Brought to Light: Stories from UCSF Archives & Special Collections*. April 24, 2018. https://broughttolight.ucsf.edu/2018/04/24/base-hospital-no-30-one-hundred-years-later-part-one/

The Army Medical Department organized the general hospital system on best practices policies it was developing during the planning for the war, and the manner of this organization is telling. They established specialized hospitals dedicated to the treatment of three primary categories: tuberculosis, psychiatric disorders, and of course, general medical and surgical cases. For example, U.S. Army General Hospital No. 3 in Colonia, New Jersey, specialized in orthopedic and neurological surgical treatments. Its location close to the ports in New York City ensured that patients needing these treatments would get them quickly. General Hospital No. 21, on the other hand, specialized in the treatment of tuberculosis and was located in Aurora, Colorado because a dry, high altitude environment was considered beneficial for managing the disease.[101] Similarly, Medical Department planners studied the experiences of the British and French militaries to plan for a reconstruction hospital system that could handle the numbers of patients requiring rehabilitation.[102]

In August 1918, the Army issued a reconstruction plan that stipulated how the military would address their requirements of the WRIA while maintaining its primary mission of force sustainment. This plan prioritized three categories of patients: those who could be rehabilitated and returned to full duty, those who could become fit for limited or alternative service, and those eligible for discharge due to disability. In this memorandum, the surgeon general dictated that "no member of the military service disabled in the line of duty… will be discharged from service until he shall have attained complete recovery or as complete recovery as may be expected when the nature of his disability is considered."[103] Initially, fifteen hospitals were designated to this task,

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[101] Sheila Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (Baltimore and London: The Johns Hopkins University Press, 1994).

[102] Adler, *Burdens of War*, 40.

[103] "Memorandum for the Adjutant General Regarding Physical Reconstruction, from War Department Chief of Staff," Feb. 1918, CWCD.

with plans to adjust as necessary to casualty requirements and other anticipated factors, which likely did not include the end of the war.

The Armistice on November 11, 1918 dramatically shifted the nation's priorities. The enormous logistical machinery established so rapidly to support the war effort—and which had only truly gotten up to speed by mid-1918—was essentially thrown into reverse as the nation prioritized demobilization and a return to a peacetime footing as quickly as possible. Hospital construction projects were cancelled, and the Army Medical Department had to find ways to utilize existing hospitals to make up for this unanticipated shortfall.[104] This priority shift perpetuated the confusion that occurred as the Army attempted to meet its obligations established in the WRIA. Despite this confusion, however, contemporaries largely regarded the system as a success.

### … Requires (Re)Defining Disability

Determining success from failure in the medical rehabilitation effort centered primarily on two factors: the visibility of the disability in question and the capability of contemporary medicine to do anything about it.

As stated above, the government had a well-established tradition dating back to the Civil War of turning to medical expertise to determine the existence of a medical disability—generally considered to be the inability to earn a living through manual labor. That politicians liberalized pension benefits after the Civil War did not eliminate the principle of relying on medical experts to make disability determinations, and with the passage of the WRIA, Congress renewed this principle. It charged the Bureau of War Risk Insurance to create "a schedule of ratings of reductions in earning capacity from specific injuries or combinations of injuries of a permanent

[104] Frank W. Weed, *Military Hospitals in the United States*, vol. 5 of *Medical Department of the United States Army in the World War*, ed. M.W. Ireland (Washington, DC: Government Printing Office, 1923), 741-44.

nature."[105] Such a schedule would, in theory, eliminate much of the ambiguity in disability determination decisions.

The law attempted to further clarify the issue by noting that "the ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations and not upon the impairment in earning capacity in each individual case."[106] This both put all disabled veterans on a level—no more favoritism of white collar vets over blue collar—and reinforced the notion that compensation for disability should be based on working-class wages as industrial jobs were the only "civil occupations" likely to result in similar injuries. And to ensure that disability determinations were based on scientific evidence, the WRIA required compensation recipients to submit to medical examinations by government physicians—essentially resurrecting the process developed by the Pension Bureau roughly fifty years prior. Yet, this system had limitations. Specifically what medical science could both observe and measure.

Take tuberculosis, for example. Any well-trained physician at that time could recognize the obvious signs of the disease once it progressed to a certain point, and from that observation, they could determine whether or not the disease represented a significant impairment.[107] In such cases, the progression of the disease provided a scientific timeline for physicians to make the determination about whether the afflicted veteran contracted the disease in the service, which would be a compensable disability, or before, which would not.

Of course, there were a great number of wartime injuries and maladies that did not fit so neatly into medical categorization. Soldiers have experienced psychological traumas as a result of warfare for millennia. We call this posttraumatic stress disorder today, and it can be observed in

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[105] WRIA, Article III, Section 302(2).
[106] Ibid.
[107] Rothman, *Living in the Shadow of Death*.

texts dating back to ancient Egypt, more than 4,000 years ago. Homer intimately portrayed the condition through the experience of Achilles in *The Iliad*, and Herodotus wrote about it in his history of the Peloponnesian War.[108] So it stands to reason that it existed in the First World War. But how was such a thing to be measured and observed? This became especially problematic as the First World War enacted an unprecedented psychological toll.

Soldiers who experienced the terrible artillery barrages of the war often developed a neuropsychiatric syndrome commonly called "shell shock." They experienced similar symptoms: loss of hearing and sight, tremors, poor balance, nightmares, headache, and fatigue. But the medical community during the war was remarkably split regarding whether or not it qualified as an injury. Physically speaking, there was nothing visibly wrong with these men—at least nothing measurable. Some physicians speculated the cause to be tiny lesions in the brain due to proximity to high explosives, others that it was due to repressed memories of traumatic events. Many believed the soldiers to simply be malingering to get off the front lines.[109]

Modern research into chronic traumatic encephalopathy (CTE) seems to confirm the explosives hypothesis, but the issue remains speculative a century later because CTE can only be confirmed through postmortem examination.[110] Physicians in 1918 certainly had no way of confirming such a theory, let alone medically intervening to improve the condition. Despite the inability to scientifically measure the condition, the sheer numbers of shell shock victims and the relative uniformity of their symptoms encouraged medical consideration to classify the condition as eligible for treatment, if not for disability compensation.

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[108] Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York: Atheneum, 1994).

[109] Edgar Jones, "Shell Shocked," *Monitor on Psychology* 43, No. 6 (June 2012):18.

[110] Mayo Clinic, "Chronic Traumatic Encephalopathy," https://www.mayoclinic.org/diseases-conditions/chronic-traumatic-encephalopathy/symptoms-causes/syc-20370921

Purely psychological disorders were also recognized by the similarities of their presentations, but they similarly defied efforts of scientific measurement. Another disorder commonly associated with PTSD today was "soldier's heart." Patients demonstrated physical presentations like erratic heart palpitations, perspiration, difficulty breathing, and chest pain. But physicians could find no physiological basis for these symptoms and thus often assumed simple cowardice on the part of the patient.[111] Again, cowardice was not a universal medical opinion in these cases, but such views were prevalent enough to cause doubt.

The realities about the limitations of contemporary medicine offer an opportunity to reexamine the perceived successes of the reconstruction hospital system. General Hospital No. 3, for example, represented a microcosm of the wider system—at least the part that dealt with general medical and surgical treatment. Part of the network of temporary, specialized hospitals intended to rehabilitate the war's wounded and return them to independent civilian life, the Army kept meticulous records of the hospital to provide a measure of these efforts.

Built at a cost of $2.75 million on land leased to the Secretary of War for $1 a year, General Hospital No. 3 in Colonia, New Jersey, was designed on the standard 500-bed base hospital model—a variation of earlier pavilion hospital designs—but enlarged to accommodate the considerable number of surgical case anticipated by the surgeon general's office. No. 3 thus boasted 1,700 beds across 30 wards. The hospital cared for an average of 1,300 patients at a time with a peak patient load of 1,944 in December 1918. It included a dental clinic, bacteriological laboratory, x-ray department, specialized surgical wards, three recreational facilities, and an orthopedic workshop that created and fitted 843 artificial legs, 75 artificial arms, and 2,745 splints and braces. Between its opening in May 1918 and close in October 1919, surgeons performed

[111] Thomas Lewis, *The Soldier's Heart and the Effort Syndrome* (London: Shaw & Sons, 1918).

2,051 operations and the hospital treated 5,153 patients. Out of these cases, the hospital boasted of 4,571 successful cases—meaning the patients were either discharged after successful rehabilitation or transferred to other specialized hospitals for further treatment. The 582 unsuccessful cases included 15 desertions, 22 deaths, and 545 patients discharged for disabilities about which nothing could be done.[112]

These numbers tell the statistical success story of the reconstruction effort, or at least, they appear to do so. With only roughly 10.6% of the hospital's patients receiving disability discharges—and thus ending up on disability pension rolls—that meant that nearly nine out of ten patients who had been seriously wounded enough to warrant evacuation to a stateside hospital were successfully rehabilitated to the point that they could once again lead productive, independent lives. This was a remarkable success, considering that the vast majority of No. 3's patients would have previously been considered total disability cases in prior wars. But this portrayal leaves out the fact that of the three major categories of patient care in the general hospital system—general medical and surgical, neuropsychiatric, and tuberculosis—the general medical group had the smallest number of cases.[113] This meant that the outcomes of hospitals like No. 3 were not particularly representative of the reconstruction effort as a whole.

In a sense, then, the success story of General Hospital No. 3 and those like it is one that catered to the type of disability for which the system was preconfigured—readily apparent, physical conditions about which contemporary medicine could actually intervene. Disabilities that did not fit this pattern complicated the narrative. Hidden disabilities like psychiatric disorders and

[112] U.S. Army Medical Department, "Statistical data, United States Army General Hospital No. 3, Colonia, N.J., from May 1918 to October 15, 1919."
[113] Ibid.

chronic disabilities—those recognized by medical science but about which little could be done—failed to fit into the agenda of medical and vocational rehabilitation.

The fact that the reconstruction hospital system worked as well as it did for general medical cases ironically framed disability as not so much about whether or not a particular veteran could achieve independence but whether or not medical science had the ability to both diagnose and treat their particular disabilities in the first place. If scientific medicine and vocational training could do little about a given veteran's disability, it was either couched as beyond the current reach of medicine or found to be the fault of the veteran. This process was highly effective for cases that fit into contemporary social and cultural conceptions of disability—for amputees, the blind, and others—but it was less effective for the roughly two-thirds of disabled veterans with conditions about which contemporary medicine could do little. Psychiatric disabilities, in particular, were at least doubted by many medical professionals, which compounded already extant social and cultural stigmas that assumed such disorders were rooted in individual character flaws.[114]

Thus, the very foundations of the new, medicalized veterans' benefits system were built on limited or flawed contemporary notions. Without significant challenge, these notions persisted as the system developed, and the type of comprehensive reflection necessary to challenge these foundations was continuously deferred as the system shifted from crisis to crisis.

**Planning Failures: How (and Why) Long-Term Care for Veterans was Left Out**

Based on patterns of workmen's compensation laws, the War Risk Insurance Act provided stipulations that veterans be provided with hospital services by the federal government. But just as the law was ambiguous in defining how rehabilitation would take place, it was similarly vague

[114] MaryCatherine McDonald, et al., "From shell-shock to PTSD, a century of invisible war trauma," *Nation*, Nov 11, 2018.

about who would be responsible for the provision of such hospital services. It was up to several federal agencies and organizations to develop a solution that would conform with the law. One such organization was the Council of National Defense (CND).

Established in 1916 as part of the nation's shift toward wartime preparedness, the President charged the CND with coordination of industries and resources in the interests of national security. Consisting of experts appointed by the secretaries of agriculture, commerce, labor, the navy, and war, the CND primarily focused on industrial coordination to speed efforts to put the United States on a wartime footing.[115] But the CND was about medical affairs.

Chairing the CND's medical board was Dr. Franklin Martin—a personal friend of Surgeon General William Gorgas and a well-connected figure in professional medical circles. Dr. Martin was part of the generation of physicians that benefitted from the realization of decades of professional development after the Civil War. In 1905, Martin helped found and served as the editor for a medical journal associated with the American College of Surgeons, for whom Martin served as Director-General between 1913 and 1935.[116] With federal recognition of a civilian physician, his service on the CND board represented another opportunity to expand and promote the interests of the modern medical profession.

The CND's Medical Board had a hospital committee that studied the issue of how civilian institutions might be best utilized to support a war effort. This committee recommended that the CND be authorized to organize a network of special hospitals for the care of specific groups of cases—perhaps giving the Army Medical Department the idea to similarly triage the general hospital system—and this recommendation included facilities for long-term and aftercare, as

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[115] "President Names Defense Advisers," *The New York Times*, October 12, 1916, p. 10.

[116] John E. Jennings, "Memoir of Franklin H. Martin," *Annals of Surgery* 101, No. 4 (1935):979. Martin was a founding member of the American College of Surgeons and an active participant in contemporary medical journals.

needed. But as the hospital committee worked to study the issue, they decided the problem was too big to be handled well by various civilian institutions with their myriad organizational practices and instead suggested the problem be addressed by the Surgeon General's Office.[117] This created a conundrum.

On the one hand, the Army Medical Corps believed that keeping disabled soldiers under military discipline while there remained a chance for medical rehabilitation made sense. When British and French soldiers were presented the option between medical rehabilitation and pensions, too many took the latter option—so, keeping the men in the service during rehabilitation was essential. Moreover, military hospitals had uniform standards of care and reporting that would ease this phase. But the Army Medical Corps had no interest in providing long-term and aftercare.[118] If rehabilitation was not possible, the affected servicemember should be discharged, at which point, they were no longer a military concern.

Dr. Sigismund S. Goldwater, the New York City Commissioner of Health and Director of Mount Sinai Hospital in 1917, who also served on the hospital committee of the CND's medical board, agreed with this sentiment. Goldwater was an influential member of the American Hospital Association (AHA) and served on the editorial board of *Modern Hospital Magazine*. Like other medical organizations, the AHA was keenly interested in utilizing the opportunity of the war to expand the influence of their profession. In this case, that meant continuing to erode the reputation of hospitals as almshouses and to highlight modern hospitals as fundamental sites to the maintenance of good health. Given an opportunity to consult the CND, Dr. Goldwater argued that veterans should be able to utilize modern civilian hospitals and be treated among their fellow

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[117] Minutes, CND General Medical Board Meeting, May 13, 1917, RG 62, box 426, General Medical Board, Secretary's Office; Adler, *Burdens of War*, 24.

[118] Weed, *Military Hospitals in the United States.*

citizens. He noted that "the time of military officers would be wasted, if devoted to the care of physical wrecks returned from France, this being a job for a civilian." Instead, he proposed "the extension and development of existing civil hospitals and sanatoriums under government direction, in accordance with a Government program, and with the support of Government funds" as a better and more cost-effective option.[119] He noted that military hospitals constructed in remote locations would have difficulty retaining competent staffs after the war—a point that would prove to be prescient.

While officials recognized the merits of Goldwater's proposals—at least regarding long-term care—but the immediate needs to establish a rehabilitation plan and a system to support it quickly taxed the planning bandwidth. This was, of course, exacerbated by the all out effort to return to a peacetime footing as quickly as possible after the declaration of the armistice. So, in the event, while many acknowledged the need for long-term care, no one in the government directly addressed it in practical terms.

By 1920, as the reconstruction hospital system was completing its assigned task, many in the Army brass were eager to rid themselves of the responsibility of caring for disabled veterans. Major General Henry Jervey Jr., a career officer assigned to the War Department General Staff in 1918, reflected these views when he wrote a memorandum to the Army Chief of Staff stating that the Army "should free itself as soon as practicable of the prolonged care of disabled persons, turning them over to the agencies approved by Congress to provide for their care." After all, Jervey noted, "Congress has made no provision for the maintenance of the large medical establishment that would be necessary to continue the care and treatment of the large number of disabled persons

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[119] S.S. Goldwater, "Soldiers and the Civil Hospitals," *Modern Hospital Magazine* 10, no. 4 (1918); Adler, *Burdens of War*, 25.

resulting from the war."[120] Jervey and other Army officials noted that the Army hospital system was likely superior to federal civilian alternatives, but that seventeen months had passed since the war ended and continued care was no longer the Army's responsibility.

Veterans seeking hospital care after discharge could do so through an application to the Bureau of War Risk Insurance (BWRI), the federal agency created to administer insurance and compensation payments to First World War veterans. The BWRI would then examine the claim by coordinating with either the Department of the Army or Navy to corroborate the veteran's service and the characterization of discharge.[121] The Bureau might then order a medical exam to verify the existence and extent of disability. If both steps passed muster, the BWRI would refer the veteran for treatment at the Public Health Service (PHS). But neither the BWRI nor the PHS were historically focused or organized for the provision of medical care.

Established in 1914, the BWRI initially had a narrow focus: to oversee insurance policies that covered American shipping against war-related losses.[122] But with the passage of the WRIA in 1917, the agency's mandate expanded to include administering life and disability insurance for service members, distribution of family and survivor allotments, and the ambiguous provision of providing "reasonable governmental medical, surgical, and hospital services" to qualified disabled veterans.[123] It quickly became apparent that the agency was not prepared for its expanded scope.

As early as December 1918, the BWRI came under public and congressional scrutiny for inefficiencies in the disbursement of compensation payments, resulting in the resignation of its

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[120] Maj. Gen. Henry Jervey, General Staff, to Chief of Staff, memorandum, Apr. 23, 1920, CWCD, microfilm 1024, roll 346.

[121] WRIA, Sec. 308. "A dismissal or dishonorable or bad conduct discharge from the service shall bar and terminate all right to any compensation."

[122] An act to authorize the establishment of a Bureau of War Risk Insurance in the Treasury Department, Public Law 63-193, S. 6357, 38 Stat. 711 (Sept. 2, 1914).

[123] WRIA, Sec. 302(3).

first director. By 1919, its second director was forced to admit the system was on the verge of breaking down, and he too resigned.[124] At the same time—March 1919—the BWRI began to receive great numbers of new disability claims for soldiers, sailors, and Marines who had not gone through the reconstruction hospital system. Officials in the BWRI complained that the bureau "was suddenly confronted with the problem of caring for thousands of disabled ex-service men and women who were presenting their claims daily" when it had been assumed that all those discharged from the service would have undergone medical rehabilitation, first.[125] What's more, these officials complained that with the closure of the temporary Army reconstruction hospitals, the only "governmental" hospital services were those of the Public Health Service.

When the United States entered the war in 1917, the PHS administered a small network of 20 hospitals and 119 relief stations with a total bed capacity of 7,200. These facilities were located along the coasts, where these institutions offered care for federal maritime and immigration concerns. It was in no way prepared to provide care for the 204,000 U.S. soldiers classified as "wounded not mortally" in the First World War.[126]

Exacerbating matters, staffs at these two federal agencies were both inexperienced and inadequate. Claims processing proved to be slow and backlogs began to build up. By June 1919, the BWRI had received 233,000 claims—more than half of which were still pending review. Veterans found themselves caught in a bureaucratic nightmare. To seek compensation, they had to apply to the Bureau of War Risk Insurance, which then had to verify their status with the military services and schedule a medical examination. If approved, veterans then had to report to the Public

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[124] Adler, *Burdens of War*, 88.

[125] L.B. Rogers, "The War risk Act and the Medical Services Created under It," *JAMA* 26, no. 16 (Apr. 16, 1921).

[126] House Committee Print No. 69, 87th Congress, First Session, 1961.

Health Service for medical care, but the PHS would then have to verify the veteran's status with the BWRI. All of this government agency interaction and verification created opportunities for errors, and veterans were required to establish eligibility for services before anything could be done.

Recognizing the need for more facilities and staff, the Surgeon General of the Public Health Service requested $12 million from Congress for the construction of new hospitals. Congress balked at this request, noting that it had already authorized $99 million for the construction of military hospitals and wondering why those facilities could not be used. PHS responded that such facilities were constructed to be temporary and therefore unsuitable for long-term care. In response, Congress passed Public Law 326 on March 3, 1919, which transferred certain suitable military hospitals to the PHS, authorized the requested funds to expand the PHS hospital system, and fixed responsibility for hospitalization and related medical care firmly with PHS in the process.[127] And recognizing that it would take time to expand PHS capabilities, Congress authorized veterans to seek care at contracted civilian hospitals at government expense. In 1921, Congress appropriated another $18.6 million for additional PHS hospitals, bringing the total investment into the PHS system to more than $30 million since the end of the war—still only a fraction of the funds allocated to the construction of the military hospital system.[128]

Clearly, a significant consequence of the medicalization of veterans' benefits—the need for long-term care and hospitals—was an unwelcome reality to Congress, who proved only willing to act when the system was on the verge of collapse, and even then only so far as to get through

[127] Public Law 65-326, *An Act to authorize the Secretary of the Treasury to provide hospital and sanatorium facilities for discharged sick and disabled soldiers, sailors, and marines*. March 3, 1919.

[128] U.S. National Archives and Records Administration, Records of the Public Health Service [PHS].

the present crisis. This established a pattern for the provision of veterans' benefits that would be followed for the next century.

## Conclusions: Medicalizing Disability

The medicalization of veterans' benefits marked a significant shift away from the traditional pension models. Pensions had proven vulnerable to fraud and political exploitation, and they had been demonstrated to be enormously expensive. By firmly basing compensation on the ostensibly objective foundation of medical authority and by requiring veterans to undergo medical rehabilitation prior to discharge, officials hoped to clarify the ambiguity surrounding many disabilities, to rehabilitate or at least reduce the impairment of these disabilities, and to incentivize veterans to continue to pursue productive independence after their service. Thus, in theory, the War Risk Insurance Act of 1917 framed an effective solution.

But while the theory seemed sound, putting that theory into practice required overcoming significant obstacles—some foreseen, many unforeseen. The former included selling the idea to the public, politicians, and veterans. Advocates for reform accomplished this through effective propaganda campaigns that highlighted the ills of the pension system, played on contemporary notions of masculinity, and appealed to notions of civic duty and faith in progressive reforms through science. The apparent success of these efforts seemed to prove that disabled veterans were not generally looking for a hand out; rather, they sought a helping hand to get them back to being able to return to civilian life—ironically undermining the very characterizations of veterans being lazy grifters that motivated reform of the pension system in the first place. With the advancements of modern medicine, disability was seen as something that could, in many cases, be cured or at least diminished. And the reports of the Army Medical Department's successes in this area reinforced this notion.

This, of course, was only possible through an effort to define or redefine the boundaries of disability itself. Multiple actors exerted agency in this process. Obvious physical disabilities played an outsized role in the minds of legislators, who therefore designed a system that catered primarily to amputees and other physical ailments. The fact that contemporary medical intervention had the capability to intervene in these cases through surgical reconstruction, physical rehabilitation, and the fitting of modern prostheses only reinforced the conception of disability as something modern medical practice could improve. Thus, even though general medical cases represented less than one-third of all disabilities that warranted discharge, the Army Medical Corps' reconstruction effort appeared to be an enormous success.

And indeed, regardless of its success, the military reconstruction hospital system was unprecedented. The notion that the military bore at least a portion of responsibility for returning veterans to productive civil lives was a novel idea. But the military took only so much responsibility, here—insisting that its primary role was the fight and win wars and that maintaining the long term health of veterans was a purely civilian affair. Unfortunately for these veterans, the pressing concerns of the war and then efforts to demobilize after the armistice pushed planning for a long-term federal medical system off the priorities list until well after the war ended.

And while Congress authorized the Bureau of War Risk Insurance and the Public Health Service to implement long-term medical care established in the War Risk Insurance Act of 1917, neither agency was prepared to support or implement the type of medical system needed to care for more than 200,000 casualties of the First World War. Congress was thus forced to make emergency provisions for the expansion of the PHS hospital system and complained that the expensive military system established during the war was not a permanent solution. This

established a pattern in which legislators who were happy to pay for a war were later reluctant to pay the entirety of its costs.

But, of all these steps, it is perhaps the unintentional framing of disability that had the most significant and lasting steps on the impact of veterans' healthcare. The medical framing of disability, based as it is in the Clinical Gaze, prioritized observable physical ailments in the classification of disability. This was exacerbated by notions of contemporary medicine's ability to intervene. An amputated limb could be surgically repaired and fitted with a prosthesis, lessening the effect of an otherwise debilitating impairment. But contemporary medicine could do little about psychoneurotic conditions like shell shock. As a result, such hidden disabilities were subjected to contemporary stigmas that permeated the ostensibly objective medical lens. Combined with officials' failures to properly provision long-term care systems because they rested their hopes in the rehabilitative abilities of the temporary reconstruction hospital system and it is not surprising that many First World War veterans experienced frustration in receiving their earned benefits.

The result was the nascent incarnation of what would eventually become the largest healthcare system in the United States. As such, it is worthy of historical examination from an institutional standpoint. It was created to serve specific notions of disability inherited from earlier systems—notions that went without significant challenge—but it was nonetheless innovative. Understanding these foundational frameworks and their persistent influences as the system developed and adapted to challenges is therefore crucial for understanding the history of veterans' health care delivery and potential for further reforms.

The next chapter examines how the healthcare system evolved from an institutional standpoint—how it expanded from an ad hoc system administered by multiple federal agencies into a single government agency dedicated to the provision of veterans' benefits, including health

care. It explores the continued relationship between notions of disability, the establishment of the nation's largest hospital network, and the influence of contemporary medical institutions. And finally, it demonstrates how the system adjusted to external pressures, most notably to the Second World War, and came to resemble the familiar VA healthcare system in place today.

## 2) INSTITUTIONALIZING VETERANS' HEALTHCARE

### "Broken"

January 2020 - Vet Center, California

"Do you know what brought this on?" the counselor asked.

I had an idea, but I was ashamed to admit it. I thought that something as simple as reading a newspaper article shouldn't have caused a mental collapse. But every time I thought about it, there it was. It was the only thing that made sense at the time. The article may not have been the sole cause—I think I was struggling before I read it—but it was certainly the catalyst. Or maybe just one catalyst. It was hard to tell. I was very much in the grip of conflicting and confusing emotions, many of which had to do with the fact that I didn't know how any of this was supposed to work. At the same time, I was beating myself up. I was supposed to be tougher than this, right? After everything I had faced and overcome, to fall apart now? Could an article cause that? Maybe. The counselor waited patiently for my reply. I nodded and shrugged and tried to express what caused all this, but to do that, I had to provide some back story.

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July 2002 - Fort Benning, Georgia

My introduction to the institutions of the military began when I arrived at Fort Benning, Georgia—home of the United States Infantry. It was a rather cliche experiences, to be honest. I stepped off the bus and was immediately beset by a yelling, gesticulating drill sergeant. He told me where to go, where to stand, how to stand, and where to look, all while screaming directly into my ear and standing far too close for comfort. Of course, that was the point.

It was a test of sorts. How do you handle pressure? It was more than that, too. Drill sergeants were charged with turning us—the latest motley batch of raw recruits—into soldiers.

And that meant they had to get to know us. All the yelling and screaming and standing too close was one of the ways they figured us out. Who would fall in without question, who was confused, who might be a problem, and so on. They had their work cut out for them, but they also had tried-and-true patterns to follow. More than two centuries after Baron Friedrich Wilhelm von Steuben taught the men at Valley Forge how to drill as a professional army, the United States Army has honed those skills to an artform.[129]

That's one of the truisms that allows a generalization to be made about veterans: they tend to be strong people—or, at least, able to put up with a lot of bullshit. We aren't exceptional in this regard, to be honest. I have seen plenty of folks who never wore the uniform exhibit remarkable strength, resilience, and discipline. But I do know that one of the common traits of every veteran is that we have been tried and tested in ways that most civilians simply aren't.

The drill sergeants yelled at us, every day, all day, for weeks. They subjected us to surprise inspections and cussed us out at every opportunity—providing useful linguistics lessons and the nuances of cussing in the process. They utilized pain and shame the way a blacksmith uses a hammer and anvil to forge metal into a more desirable shape. The worst part was the collective punishment. If one of your fellow recruits screwed up—fell asleep on watch or ran their mouth in a way that could be perceived as disrespectful—everyone paid that mistake. There was a lesson in that too: take care of your buddies, and that means making sure they're doing the right thing. We weren't simply being exposed to training, we were being culturally conditioned. I may not have appreciated all of this at the time, but in hindsight, there is a genius to this approach.

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[129] Friedrich Wilhelm von Steuben spent 17 years in the Prussian army, fighting against Austria and Russia before attending Prussia's elite staff school for officers. It's a fascinating story. Paul Lockhart, *The Drillmaster of Valley Forge: The Baron de Steuben and the Making of the American Army* (New York: Harper Perennial, 2008).

It made us police each other, which not only made the drill sergeant's job that much easier, it instilled in us a constant vigilance of our peers and our environment. It made us pay attention, and not just for things that were going wrong, either. When one of us succeeded in overcoming an obstacle, the others learned how he did it. Before long, we came to trust each other, even if we didn't like each other. We know where everyone was supposed to be, and we knew what our jobs were at all times. These are the essential elements of a good soldier.

We developed trust in the institutions of our training. Know your job, do it well, help your buddy, and the big picture will take care of itself. Pretty soon, all of that yelling and stress had the desired effect. In a matter of just over a dozen weeks, we weren't getting yelled at so much. We were "squared away" or at least getting there. And it all came down to trust.

Trust your equipment and your training, both will save your life. Drill your training until it become muscle memory because, when things go wrong, you don't always have the luxury of enough time to think through a problem—you simply have to act and trust your training. Doubt could be deadly.

My first serious experience of this occurred at Airborne School—a three-week course that trains soldiers how to not only jump out of a perfectly good airplane but also how to deal with any of the literally dozens of potential malfunctions that can occur between the moment they jump and when they hit the ground. How well these soldiers paid attention to their training determines how hard they hit the ground. Obviously, you don't want to hit the ground too hard. And the U.S. Army Airborne School has been giving out good advice for over eighty years.

The Sergeant Airbornes—Airborne School's version of drill sergeants—begin by trying to weed out those who can't take the stress by reverting to the yelling and all the rest. Again, it's not perfect, but it is effective at sorting those who are serious about subjecting themselves to the

demands of the school from those who aren't. Those who make the cut are then taught to trust their equipment and the training through endless drills, all day, every day, for more than two weeks. Those who are a danger to themselves or others are either recycled (sent back to the beginning with another cadre) or washed out to the needs of the Army or to return to their unit, having to explain why they failed to complete the course. Those who make it through to "Jump Week" get to put their new skills to the test by conducting five real jumps.

My first three jumps were out of a C-141 Starlifter. It's a jet, and as such, it pretty much swims through the air. Jumping out of jets is easy. I had spent the previous two weeks practicing a "strong exit jump" because the Sergeant Airbornes said it was vital. We would spend ours lining up in a metal tube that simulated an aircraft, doing mock jumps out of the door. If you didn't jump hard enough—if your boots didn't hit the far side of the well-worn dirt pad below the door—you could be assured the Sergeant Airborne would give you an earful and make you do it again.

But as I said, the first time I jumped from a C-141, which is easy. I found that all I had to do was stick the toe of my boot out the door. The air would catch it and—whoosh!—I'd be out of the aircraft without any effort at all. Easy as pie. It honestly felt like going down a water slide as a kid. I'd assume a good body position (chin on chest, legs straight, bent at the hips so your body looked like an L, and elbows in) and counted to four, waiting for my static line to play out. That was always the scariest part. If you got past four, you knew you were already in trouble.

The static line is a cord that you hook onto a big cable in the airplane. When you jump out, the line plays out until it runs out of slack, at which point it pulls open your main parachute. That process takes (or at least took, back when I was in) about four seconds. If you get past four and didn't feel a tug, you could assume that something went wrong and you better start preparing to pull your reserve parachute.

I always felt the tug right when I was supposed to. But I was always afraid I wouldn't. I trusted my equipment and training, but that didn't mean I wasn't afraid. Still, my first three jumps had me doubting my training a little bit. Why did they make us practice a strong exit jump so much? That was easy!

My fourth jump was out of a C-130 Hercules. It has props. It doesn't "swim" through the air so much as it furiously doggy-paddles its way forward, leaving the air behind it a choppy mess. This was also my first combat load jump, meaning I had about fifty pounds of extra kit attached to me. *No big deal*, I thought. *Just stick my foot out the door and the wind will do the rest*. So, when it came time for me to jump, that's exactly what I did. I stuck my boot out the door.

Nothing happened.

Confused, I looked at the Jumpmaster—in this case a Sergeant Airborne who was responsible for ensuring we all exited the airplane safely. He angrily shouted, "Jump!" So, I jumped. Awkwardly.

With one boot already out the door, I could only "jump" off one foot. And with the extra kit attached to me, it wasn't much of a jump. My butt hit the floor of the aircraft and I tumbled forward, out the door into that choppy air. I could tell I was spinning like crazy—I probably looked like a ball of yarn dropped down the stairs.

I counted to four and felt the familiar, welcome tug. *Good*, I thought, going through the checklist in my head. *Next step: check canopy and gain canopy control*. I tried to raise my head to get a look at my chute, hoping to see a nice familiar hemisphere of silk catching plenty of air. But I couldn't move my head straight back. Something was in the way. So, I tilted my head to the side and looked up.

*Oh, shit!* I thought. This was bad.

My risers—the lines that connect my harness to my canopy by a network of dozens of nylon cords—were twisted up like a twisty-tie, all the way to the base of the canopy. Instead of looking like an upside-down bowl, my parachute looked like a balloon on a string, which isn't nearly as effective at slowing you down.

My training kicked in. Twisted risers need to be untwisted. Grab your lines, pull outward as hard as you can, and kick your feet like you're riding a bike—this will untwist your risers. I started pulling and kicking, my mental checklist automatically shifting to cover the contingency of this situation. Check rate of descent with fellow jumpers.

I was second-to-last to jump out of the plane, so I looked around and slightly below me for the rest of the group. There they were, right where they should be. My pulling and kicking started a spin as my chute untwisted, so I lost sight of them. I turned around once, and they were gone.

*What the fuck? Where'd they go?* I thought. Then I looked up and saw them, well above me. I was falling faster than they were. A lot faster. *Oh, shit! Oh shit oh shit oh shit!*

I had a good spin going now. My risers were unravelling and the chute was catching more air, but I didn't know if it was enough. I heard someone—a Sergeant Airborne watching from the ground below—yell through a bullhorn: "Pull your reserve!"

*That's a good idea*, I thought. Every paratrooper, at least in Airborne School, has a reserve chute attached to their harness that can be manually released. I moved my hand down and grasped the release handle, preparing to deploy my reserve. But then I remembered another part of my training: the rare occasions where you don't want to pull your reserve. This was one of those.

If I pulled my reserve while spinning like this, there was a good chance the reserve chute would wrap around my main. Both chutes would get tangled and neither would be useful. It was a

dilemma, and I only had a few seconds to make a decision. If I made the wrong call, I would burn in, doing the human impression of a lawn dart.

I didn't want to lawn dart, so I trusted the training and kept kicking my legs. A few hundred feet above the ground, my chute opened all the way up and caught air. I hit the ground, hard enough to knock the wind out of me. It hurt, but nothing felt broken. I found I could wiggle my fingers and toes and stand up. And before long, I could breathe again. I had survived!

Later that night, I jumped out of a C-130 again. This time, I jumped harder and had a good experience all around. And with that fifth jump, I qualified for my Airborne Wings. I was a paratrooper.

Yeah, I had a scary experience. It was stressful and could have gone so very, very wrong. But I trusted my equipment and training and was able to walk away. And in the process I learned the very important lesson that if they train you to do something, it's for a good reason—even if your experience isn't always what they say it will be.

Trust the system. Do your part right, take care of your buddies, and the rest will take care of itself.

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December 2003 - Outskirts of a village in Khowst Province, Afghanistan

We had been in-country for a little over two months and found ourselves patrolling routes near the border with Pakistan, looking for insurgent supply routes. This day, my gun truck—a Humvee with a heavy machinegun in the turret, thus the name—was posted on the perimeter of a village while one of the line companies searched homes for contraband, high value targets, and intel. We just had to pull security, which was boring. We already knew this was a "good" village

because the kids came out to look at the Americans, like we were the circus come to town or something. If the villagers let their kids out to watch us, the village was generally safe.

It was also cold. Damn cold. My unit, the 1/501st ("first of the five-oh-first") was the nation's only Arctic Airborne unit at the time, and we prided ourselves on being able to endure the cold. Each of us trained in sub-zero weather. A lot of us were part of the 50-below club, meaning we had spent a night outside in temperatures below -50 degrees. But, of course, we came to Afghanistan expecting it to be hot, so we didn't bring our cold weather gear, and that meant we shivered while watching the snow-covered mountains and roads surrounding this village.

But we did have a little entertainment. I had just received a care package from home—an early Christmas package full of goodies from my mom. She packed chocolates, hot cocoa packets, a few recent editions of my hometown newspaper, a few disposable cameras so I could take pictures and send them back to get developed, and an orange. We always had oranges in our stockings at Christmas when I was a kid. And, of course, I shared the wealth. Mackall (my gunner) and I were keeping our hands warm, sipping on hot chocolate out of our metal canteen cups while we pulled security. Sergeant Walker (the truck commander) was making another batch of hot cocoa with a camp stove set up on the hood of the truck. And "Doc" Guzman (the platoon medic) was reading one of the newspapers. He'd never been to my hometown, but it was news and entertainment all the same, and those were in short supply.

Other than the cold, it was a pretty good day, I thought.

It got even better when a little girl came down the road to see us. This was a rare encounter. I mean, we saw little girls in the crowds of kids all the time, but they usually hung back in small groups behind the mass of boys who would pester us for pens, radios, and water. So, to have a solitary little girl come and check us out was neat.

She smiled and waved. She was dressed in a colorful, if threadbare, dress and scarf of vivid blues, reds, and oranges that made for a striking contrast with the white snow and bleak gray of everything else. I figured it was worth a picture, so I pointed to my disposable camera and then at her. She nodded, and I snapped a shot and waved in thanks.

She smiled again and made to run off back to the village, stepping in a small stream in the process. That's when I noticed her bare feet. Come to think of it, her dress wasn't much protection against the cold, either. Here we were, four tough paratroopers, shivering in the cold, and this little girl just stepped into a stream, barefoot. The simple thought of that made my toes hurt. I had to do something.

I called her back, handed her a piece of chocolate, and held up my hand for her to wait while I went back to my rucksack. I dug around inside, desperately hoping to find a pair of shoes that would fit a ten-year-old girl, but the best I could manage was my last clean pair of wool socks—men's size 11. It was better than nothing, I supposed.

I gave her the socks, a few more chocolates, and the orange—her eyes lit up at that part. I'm sure she was confused about the socks, but I didn't care. She said thanks in Pashtun and ran off at a full sprint. We could probably expect more kids to show up once she got back to the village with her armful of goodies.

"That was nice of you, Jack," said Sergeant Walker while he stirred the cocoa. Doc agreed.

"Yeah, well, we're supposed to be winning hearts and minds, right?" I replied, and I meant it. If we were going to root out the Taliban and al-Qaeda, we needed to have these people on our side. And besides, it felt good to do something positive. It went back to that old mantra—do the little things right and the big things would take care of themselves. We trusted our mission and the

institutions that put us there—the Army, the military, the government. Even the idea of American democracy. By doing our part, we supported those institutions.

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January 2020 - Vet Center, California

"I read a newspaper article recently," I replied. The counselor nodded for me to continue, which was a relief. I was afraid he'd laugh. "I think that started all this. It was from *The New York Times*, about how a U.S. drone killed a 25-year old woman in Khowst."

That article lifted the veil on more than fifteen years of self-imposed ignorance. You see, since I returned from Afghanistan in 2004, I kept tabs on the developments in the war, of course. I had a personal interest in the mission and a few of my buddies were still serving. But it was rare to see Khowst mentioned in the news. Khowst is a province in eastern Afghanistan, bordering with Pakistan. It's also the name of the largest town in said province, and one with which I was quite familiar. Khowst province made up most of my unit's area of operations, and we drove every road in that province probably a hundred times over, saw every village, and a lot of kids. Like I said, they'd come out to watch us like we were on parade. And somehow, in my mind, those kids remained kids all these years. That article made me do the math.

A woman named Malana, aged 25, had given birth to her second child at home. There were complications with the delivery and her family took her to the clinic in Khowst where they patched her up. On the way back home, a U.S. drone fired a missile at her car, killing Malana, three of her relatives, and the driver. The military confirmed the strike but claimed they had killed three Taliban fighters.[130]

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[130] Farooq Jan Mangal and Fahim Abed, "U.S. Drone Killed Afghan Civilians, Officials Say," *The New York Times*, December 1, 2019. https://www.nytimes.com/2019/12/01/world/asia/drone-civilians-afghanistan.html

If Malana was 25 in 2019, that meant she would have been about 9 in 2003—about the same age as the little girl with the socks. Hell, she could have *been* that little girl with the socks for all I knew.

Suddenly, sixteen years' worth of reality hit home. I didn't help make life better for the Afghanis. Even if that little girl wasn't the young mother killed by a drone strike, she grew up through sixteen years of continued and worsening war in which American soldiers like I had been transitioned from liberators to occupiers. And, at the least, Malana had been one of those kids that came out to see us. Had to be. And now, she was dead. Killed by someone who pushed a button miles away—destined to be classified as collateral damage in a flawed and failing campaign.

I came back from that war a changed person in many ways. But those who lived there had to keep dealing with it, day after day, year after year. So, while I had some experience of war—enough to know that the Taliban gaining ground was not a good thing and that the United States' continued support of a corrupt and ineffective Afghan government wasn't good, either. But those kids grew up experiencing that reality. Suddenly, for me, all those years in between became real, along with the realization that the institutions I trusted back then had failed.

Suddenly, I started questioning everything. The deaths of friends and soldiers I trained, the broken bodies of others, the months and years spent in service to a mission that now rang hollow. All of it. If these things were "sacrifices," as folks often frame them, then what was all that sacrifice for? We trusted the system—that if we did our part, the larger picture would sort itself out. But that didn't happen.

And because I couldn't trust the institutions, I felt like I couldn't trust myself. If my faith in those institutions had been so misplaced, what else did I get wrong? I was overwhelmed and ended up collapsing under the weight of it all. I was broken.

And yet, at that moment, I turned to another institution that I knew was best suited to help: the VA healthcare system.

## The Institutional Model of Care

What is an institution? It is a curious word—one of those that people seem to know, even if they can't concretely define it. Merriam-Webster defines the word as "an established organization or corporation (such as a bank or university) especially of a public character; a facility or establishment in which people (such as the sick or needy) live and receive care typically in a confined setting and often without individual consent; a significant practice, relationship, or organization in society or culture."[131] In this definition, it is correct to say that the Department of Veterans Affairs (VA) and the Veterans Health Administration (VHA) are both institutions. But so is the idea of providing care for veterans in the first place.

Academics have pondered the nature of institutions for some time. Eminent sociologist Emile Durkheim described the practice of sociology itself as the "science of institutions, their genesis and functioning."[132] Sociologist Wolfgang Streeck and political scientist Kathleen Thelen define institutions as "building blocks of social order [that] represent socially sanctioned [and] collectively enforced expectations with respect to their behavior."[133] So, in a sense, institutions are both the abstract ideas of social arrangements that govern matters of values, behavior, and trust, and they are also the concrete social structures that implement those expectations.

Concrete institutions—like government agencies, hospitals, healthcare systems, and the like—exist to serve community values reflected in abstract institutions. In this case, the VA and

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[131] "Institution," definition by *Merriam-Webster*, https://www.merriam-webster.com/dictionary/institution.
[132] Emile Durkheim, *Rules of Sociological Method* (New York: Free Press, 1964).
[133] Wolfgang Streeck and Kathleen Thelen, eds., *Beyond Continuity: Institutional Change in Advanced Political Economies* (Oxford: Oxford University Press, 2005).

VHA are concrete institutions that serve the abstracted notion of the nation providing for those disabled in its service. That notion exists independently of the existence of government agencies established to service it, of course. But it is through the material actions of the concrete institutions that they keep or break faith with the values of the underlying abstract notions. That means, of course, that trust is key.

In establishing a link between medical care and veterans' benefits, the government attempted to influence the abstract notion that nation should serve those disabled through its service, not by providing pensions, but by rehabilitating disabled bodies into productive bodies. This could only work if the established concrete institutions—in this case, veterans' hospitals and rehabilitations efforts—proved capable of keeping faith with the communities they served. These communities included the veterans, of course, but also the tax-paying public.

The veterans sought fair compensation for their disabilities—specifically the fulfillment of the promise of medical rehabilitation—and the public sought a system that would ensure disabled veterans did not become burdens while simultaneously restoring a sense of honesty to the effort. Both groups were interested in utilizing the promise of medicine to repair and rehabilitate disabled soldiers so that they could live up to contemporary masculine ideals.[134] This process began with the medicalization of veterans' benefits in the First World War, but it gained momentum in the interwar years with the improvement of medical technology. The theory seemed simple enough, but putting it into practice proved to be a complex effort with significant implications for determining who could—and who could not—expect to receive support at the government's expense as well as the definition of disability itself.

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[134] Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago: The University of Chicago Press, 2011).

## A Disjointed System

"No emergency of war itself is greater than is the emergency which confronts the Nation in its duty to care for those disabled in its service and now neglected."[135]

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The establishment of a new system of veterans' benefits based on medical rehabilitation was a revolution that reflected a wider societal pattern of public administration in the Progressive Era. Based on rational models of administration perhaps best described by sociologist of modernity, Max Weber, rational bureaucracy was intended to promote objective, scientific, efficient, and effective management of institutional operations in ways that eliminated traditional biases for the betterment of all.[136] This was essentially the basis for shifting away from traditional models of veterans' pension payments to a scientifically-managed system that would, in theory, be less prone to corruption while simultaneously improving outcomes for both veterans and taxpayers.

Theoretically, the proposed system was sound. In practice—given the government's hasty and vague implementation during the First World War, competing wartime priorities, and the postwar emphasis on a swift return to peacetime norms—by 1920, it was clear the government lacked the bureaucratic and medical infrastructure to live up to the new system's theoretical promise. In essence, the government risked breaking faith with the notion that the United States took care of those disabled in its service.

The ad hoc collection of federal agencies tasked with overseeing the new, medicalized system derived its legal basis from the War Risk Insurance Act of 1917, which vaguely stated that disabled

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[135] Dawes Committee Report to Congress, April 7, 1921.
[136] Max Weber, *Economy and Society* (Berkeley and Los Angeles: UC Press, 1978).

soldiers "shall be furnished by the United States such reasonable governmental medical, surgical, and hospital services" as necessary.[137] It did not state which agencies would be responsible for furnishing these services, and therein lay the problem. Veterans who bought into the new system in 1917 found themselves struggling with navigating multiple bureaucracies and often waiting years for access to promised benefits. That struggle and wait process started with filing claims.

The Bureau of War Risk Insurance (BWRI) was initially established in September 1914 to oversee a federally subsidized maritime insurance program to protect American shipping from wartime losses.[138] But by 1920, the BWRI was also responsible for administering the nation's largest life and disability insurance program as well as making eligibility determinations for veterans' benefits, including access to medical services.[139] The BWRI did not provide those services directly, however. Instead, it referred eligible veterans to the Public Health Service (PHS) or to civilian hospitals contracted by the government. Even so, processing disability determinations proved to be a monumental task.

In 1919, the BWRI employed 35 medical officers and 196 clerical staff and administrative personnel to process claims, and there were a lot of claims. In the annual report to the Secretary of the Treasury—the BWRI being part of the U.S. Department of the Treasury—the director of the BWRI noted that, at the beginning of the 1920 fiscal year, there were "approximately 39,000 cases awaiting action."[140] Each claim required a physical examination by a government approved and contracted physician, which was then reviewed by BWRI medical officers to ensure that the exam

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[137] WRIA.

[138] "An Act to authorize the establishment of a Bureau of War Risk Insurance in the Treasury Department," September 2, 1914, 38 Stat. 711 (Pub. Law 63-193).

[139] Secretary of the Treasury, Report on Finances for Fiscal Year Ending June 1920. https://www.va.gov/vetdata/docs/BWRIFY1920.pdf

[140] Ibid. 202.

met the standards of a qualifying disability and the extent of the disability in question. To address this backlog, the BWRI doubled its staff in 1920 and still had 4,444 cases remaining to be processed by the end of the year.[141] Catching up with the claims process was an improvement, but considering that many of these claims represented veterans seeking help for disabilities incurred as much as three years prior to the director's report, it's clear that claims processing by the BWRI was a significant obstacle in the process for many veterans. And that was only the beginning. Hospital space was a much bigger concern.

The provision of medical services fell primarily to two federal agencies: the Army Medical Corps and the U.S. Public Health Service (PHS), which were tasked with the medical rehabilitation of disabled veterans prior to discharge and the provision of long-term hospital care after discharge, respectively.[142] And while the Army's reconstruction efforts after the war appeared successful on paper, those successes, like the hospitals that provided them, proved to be remarkably temporary. The idea was that *all* veterans disabled in the war would go through the reconstruction hospital system prior to discharge. But by 1921, more than 300,000 veterans of the First World War who did not go through the reconstruction hospital system were seeking care.[143] And the PHS was wholly unprepared for such demand.

At the end of the First World War, the PHS administered a network of 20 small hospitals and 119 relief stations—all focused primarily on supporting federal maritime and immigration concerns.[144] Its 7,000 hospital beds and professional staff on hand were nowhere near sufficient to handle the needs of more than 200,000 wounded veterans of the First World War and the tens of

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[141] Ibid.

[142] Linker, *War's Waste*; and Jessica Adler, *Burdens of War: Creating the United States Veterans Health System* (Baltimore: Johns Hopkins University Press, 2017).

[143] Adkins, 104. Cited from "Public Health Reports," vol. 36, No. 21, May 27, 1921.

[144] State of the PHS hospital system in 1920—reference PHS reports to Congress. Adkins, 102.

thousands more that would seek care due to disabilities incurred during their service.[145] And while Congress authorized funding to expand the PHS hospital system in 1919, it would take years to build new hospitals and acquire additional staff. In the meantime, First World War vets complained about the lack of coordination between federal agencies that at best worked together awkwardly and with great difficulty and at worst resulted in "the runaround."[146]

PHS hospitals required proof of eligibility from the BWRI prior to admission. The BWRI, in turn, required proof of an approved disability and evidence that it was incurred as a result of the veteran's service and not from some other cause. This required coordination with the Departments of the Army and Navy to corroborate medical records. And even for those veterans lucky enough to have an easily-traced paper trail, the process could take weeks or months, and most cases were not so ideal. Each agency involved had its own filing and correspondence systems, none of the agencies saw veterans' healthcare as their primary mission, most records were hand-written, each case required extensive work and care to ensure accuracy, and all these records often had to be hand-copied and sent via mail across the country to related agencies.[147] All the while, the veteran seeking care would go without services.

Those able to successfully navigate these bureaucratic labyrinths often found that healthcare facilities were lacking in both quantity and quality. This was especially true for cases related to tuberculosis and mental health disorders—categories that made up more than two-thirds of all documented First World War disability cases.[148] As more and more veterans filed claims at

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[145] Adkins, 101.
[146] Adler, 123.
[147] Adkins, 103-104.
[148] Secretary of the Treasury, Report on Finances for Fiscal Year Ending June 1920, p. 202. https://www.va.gov/vetdata/docs/BWRIFY1920.pdf

rates faster than could be processed, officials recognized that the problems were only going to get worse.

In an internal memorandum for the Department of the Treasury in 1919, Dr. W. Charles Rucker—the Assistant Surgeon General of PHS and Chief Medical Adviser to the BWRI—noted that more than ten-thousand men were discharged from the Armed Forces with active cases of tuberculosis, overwhelming PHS sanitariums and contracted civilian hospitals alike.[149] Dr. Rucker requested an immediate increase of 30,000 hospital beds dedicated to the treatment of tuberculosis and noted that 25,000 more would be necessary by 1921. Veterans' complaints about the system amplified government officials' requests for more resources from Congress just as the nation entered an election year in 1920, with the conjunction creating the impetus for campaign promises.

**Promises Made, Promises Kept?**

In his acceptance speech for the Republican Party nomination for President of the United States, then Senator Warren G. Harding promised to improve the state of veterans' benefits:

I must speak of the service of the men and women who rallied to colors of the Republic in the World War. America realizes and appreciates the services rendered, the sacrifices made, and the sufferings endured. There shall be no distinction between those who knew the perils and glories of the battle-front or the dangers of the sea, and those who were compelled to serve behind the lines, or those who constituted the great reserve of a grand army, which awaited the call in camps at home.[150]

That Harding's promise applied to all veterans, regardless of service rendered, the nature of disability, or the circumstances under which it was incurred reflected the public's assumption

[149] W. Charles Rucker, Document No. 483, U.S. Department of the Treasury, December 1919.
[150] Warren G. Harding, Acceptance Speech at the Republican National Convention, 1920.

that service alone was all that was required to receive benefits. Obviously, given the struggles veterans faced in navigating the military, BWRI, and PHS systems, the reality of access to benefits was much more complicated. Still, after winning election, President Harding made good on his promise by appointing two committees to study the task: one to address bureaucratic obstacles and the other to make specific recommendations on the provision of medical care.[151]

The first committee was chaired by Charles G. Dawes, a successful businessman and politician who had a reputation for swift and decisive action in complicated matters—most notably at that time for his service as chairman of the Military Board of Allied Supply, which was the general purchasing agent for the American Expeditionary Forces during the First World War.[152] Dawes would later go on to become the architect of the Dawes Plan that linked the economies of Europe and the United States after the war and eventually to serve as Vice President of the United States. But on this committee, Dawes's task was to study veterans' benefits provisions and make recommendations to Congress to address any problems.[153] The resulting report placed the blame for difficulties squarely on divided government responsibilities resulting in confusion, duplication of work, inefficiencies, and red tape.[154] Dawes recommended that the government create a single federal agency to oversee benefits for First World War veterans, and on August 9, 1921, Congress created the Veterans' Bureau.[155]

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[151] Adkins, 109-112.

[152] Edward A. Goedeken, "Charles Dawes and the Military Board of Allied Supply," *Military Affairs* 50, No. 1 (Jan. 1986), 1-6.

[153] Amy W. Knight and Robert L. Worden for the Department of Veterans Affairs, *The Veterans Benefits Administration: An Organizational History, 1776-1994* (Washington, DC: Dept. of Veterans Affairs, 1995).

[154] Gustavus A. Weber and Laurence F. Schmeckebier, *The Veterans' Administration: Its History, Activities and Organization* (Washington, DC: The Brookings Institution, 1934), 217. Rosemary Stevens, *A Time of Scandal: Charles R. Forbes, Warren G. Harding and the Making of the Veterans Bureau* (Baltimore: Johns Hopkins University Press, 2016), 49.

[155] An ACT to establish a Veterans' Bureau and to improve the facilities and service of such bureau, and further to amend and modify the War Risk Insurance Act, 67th Congress, 1st Sess., August 9, 1921.

The new agency incorporated all those elements of the multiple federal agencies then administering benefits for First World War veterans. This included most of the Bureau of War Risk Insurance, those hospitals in the Public Health Service already tasked to providing care for veterans along with new construction projects, and several military hospitals that had been transferred to the PHS. Congress empowered the Director of the Veterans' Bureau, appointed by the President, with broad authority to organize and manage the new agency, but it left in place the statutes and schedules that governed benefits eligibility, meaning that disability claims still needed to be medically and bureaucratically verified.

The second committee was organized as a consultancy group of medical experts with experience areas of care particular to First World War veterans. Called the White Committee for its chairman, Dr. William c. White—then medical director of the Tuberculosis League Hospital—the committee's membership reflected the general division of disability claims made by veterans: surgical, tuberculosis, and psychoneurotic.[156] The committee's task was to study the state of healthcare provisions for veterans and make recommendations to meet demand, and the consultants were diligent in their studies. After two years of investigation, the committee delivered its report to the government.[157] The report was comprehensive and farsighted in its recommendations, covering everything from hospital locations and specializations to the affiliation of veterans' hospitals with medical schools. And it was delivered just as the Veterans' Bureau was facing its first significant crisis.

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[156] Adkins, 109-110. Committee members consisted of Dr. William C. White (tuberculosis), Dr. Frank Billings (surgery), Dr. John G. Bowman (surgery), and Dr. Pearce Bailey (mental hygiene).

[157] Report of the consultants on hospitalization, appointed by the Secretary of the Treasury, to provide additional hospital facilities under Public Act 384, approved Mar. 4, 1921. Report dated Feb. 28, 1923. (Washington, DC: Government Printing Office, 1923). Hereafter referred to as the White Committee Report.

## Scandal and Legacy

When he signed the law creating the Veterans' Bureau in 1921, President Harding appointed Charles R. Forbes to serve as its first director. It was an appointment that Harding would later regret.

Forbes was a veteran, businessman, politician, and most importantly, a close personal friend of President Harding. While his service in uniform fit the unspoken requirement that the Director of the Veterans' Bureau be a veteran, Forbes lacked the experience and capability required for such an appointment. His short tenure was marked with scandal, incompetence, corruption, and nepotism—all of which would have a significant and lasting influence in shaping how the government approached the provision of veterans' care and benefits.

Charles Forbes first served in the Marine Corps as a drummer boy before enlisting with the Army in 1900. Within months of his enlistment, he was charged with desertion. Found and returned to duty without trial, Forbes served eight years in the Army, including deployments to the Philippines, and was honorably discharged at the rank of Sergeant First Class in 1908. He then went into the construction business in Seattle before moving to Hawaii to work as an engineer at the Pearl Harbor Naval Station.[158] It was in Hawaii that Forbes began his career in politics and met and befriended then-Senator Harding, who was touring Honolulu as part of a congressional delegation.

During the First World War, Forbes accepted a commission in the Army Signal Officers' Reserve Corps and deployed to France with the 33rd Infantry Division, where he received the Distinguished Service Medal for "performing his duties with marked distinction, maintaining

[158] Morris R. Werner, *Privileged Characters* (New York: R.M. McBride & Co., 1935), 195.

communication at all times."[159] Essentially, Forbes received the Army's third-highest decoration—behind only the Medal of Honor and the Distinguished Service Cross and ahead of the Silver Star—for simply doing his job. He was again honorably discharged as a Lieutenant Colonel in 1919 and returned to the construction industry, working for the Hurley-Mason firm in Seattle, Washington.

Forbes's interest in politics continued after the war, and when he found out that his friend Senator Harding was interesting in running for President, Forbes traveled to the Republican National Convention in Chicago to lobby on Harding's behalf. In return, Forbes hoped to receive a potentially lucrative appointment to the U.S. Shipping Board. Instead, Harding nominated him to be Director of the Bureau of War Risk Insurance and then the first Director of the Veterans' Bureau.[160] Forbes was completely out of his depth.

From the moment of its inception, the Veterans' Bureau was larger in both budget and personnel than most cabinet-level federal agencies. It incorporated elements of at least three distinct federal agencies, each of which had its own bureaucratic systems that had to be adapted into a new, unified system. It had an annual budget of $500 million (roughly $7.6 billion, today), and it was responsible for the largest hospital construction and administration program in the history of the United States. Forbes, who had a reputation as a "dashing playboy" in Washington and who lacked experience managing large operations, delegated his authority liberally.[161]

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[159] Forbes's DSM citation. http://valor.militarytimes.com/hero/17542. It's worth noting that Forbes's military credentials that made him at least marginally acceptable for the post of Director of the Veterans' Bureau were largely due to circumstance. The President would not appoint a former sergeant first class to head the VB. A LTC who maintained a communications outfit for a single infantry division wasn't much better. But by calling Forbes "Colonel" there was an implication that Forbes was more experienced and qualified than he really was.

[160] Werner, *Privileged Characters*, 194.

[161] Rosemary Stevens, *A Time of Scandal: Charles R. Forbes, Warren G. Harding, and the Making of the Veterans' Bureau* (Baltimore: Johns Hopkins University Press, 2016).

While veterans' service organizations welcomed the creation of the Veterans' Bureau, believing it would help streamline the process of accessing benefits, most veterans were quickly disappointed on this front. To make the bureau appear economically responsible, Forbes established high thresholds for the determination and payout of disability insurance claims. More than 300,000 veterans filed such claims between 1921 and 1923, but only 47,000 were approved, with most denials later characterized as matters of "split hairs."[162] While the Senate and public largely attributed this frustration to Forbes's mishandling of the Bureau, the effects of this denial-first policy on the provision of veterans' benefits was not only tremendously detrimental to contemporary veterans, it also established bureaucratic patterns that had proven difficult to shake over the years since. By denying and limiting claims, the Bureau effectively put the onus on the veterans to prove their cases through appeals processes.

Another area where Forbes's policies conflicted with veterans' interests was in his relationship with the Bureau's medical experts. Forbes often argued with his medical advisors, mot notably Dr. Haven Emerson, who was the existing Medical Adviser to the Bureau of War Risk Insurance when Forbes became director of that agency in 1921 and who served in the same role with the Veterans' Bureau.

Dr. Emerson was a reputable public health physician who contributed significantly to developments in the fields of epidemiology and vital statistics thanks to his work during the First World War. His book, *Control of Communicable Diseases in Man*, first published in 1917, became a foundational work in the field. So, when Dr. Emerson complained about the poor state of medical affairs in the Bureau, it stood to reason that he knew what he was talking about. For instance, in September 1921, Emerson complained about the state of the Bureau's tuberculosis hospitals and

[162] U.S. Senate, Select Committee on the Investigation of the Veterans Bureau, March 2, 1923 to 1925.

how bureau policies encouraged veterans to fake illness to seek disability compensation.[163] But Forbes was more concerned about preventing any potentially negative news from reaching the President than he was in supporting his medical staff.

So, when Dr. Emerson took his complaints public—specifically complaints about Forbes's patterns of politics, corruption and incompetence—Forbes fired Dr. Emerson, claiming the good doctor was guilty of "managerial incompetence."[164] Forbes, like much of the Harding Administration, was enjoying a honeymoon of sorts with the press at the time, so Dr. Emerson's leaving the Bureau made few waves. To replace Emerson, Forbes selected Dr. Robert Patterson—a career Army officer who was less likely to question orders than a civilian doctor.

Forbes took a particular interest in the hospital construction program. He spent weeks at a time on inspection tours of proposed construction sites, often meeting with contractors interested in securing lucrative government construction projects. These tours, later described as "joy rides" in the press, would later come to define Forbes's tenure. He used the opportunities of these tours to solicit kickbacks and bribes to shift contracts to specific companies.[165] At about the same time, Forbes's lieutenants in the Bureau were making similarly corrupt deals. But with little direct oversight, Forbes was able to keep much of this under wraps, at least for a while.

In November 1922, President Harding was forced to cancel a contract made by the Bureau to affect the sale of hospital supplies from a depot in Perryville, Maryland after Dr. Charles E. Sawyer, the Presidential Physician and Chairman of the Federal Hospitalization Board received a complaint from the Surgeon General of the Public Health Service. The buyer, a company known

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[163] "Accuses Veterans of Faking Illness: Dr. Haven Emerson Tells Tuberculosis Conference They Handicap Physicians," *The New York Times*, September 13, 1921, p. 15.
[164] "Veterans' Bureau Doctor is Ousted," *Washington Post*, September 14, 1921, p. 1.
[165] "Mortimer Admits False Testimony," *The New York Times*, December 13, 1924, p. 17.

as Thompson & Kelly, Inc. of Boston, had purchased $3,000,000 worth of "surplus" supplies for only $600,000 through a no-bid contract arranged with Forbes and was subsequently selling these same supplies back to federal agencies like the Public Health Service at full market value.[166] Harding tried to get in front of the scandal by demanding and receiving Forbes's resignation, which the President announced on February 15, 1923, just before *The American Legion Weekly* published an article exposing some of the corrupt schemes taking place at the Veterans' Bureau.[167]

While Forbes was not a good candidate to head an agency like the Veterans' Bureau, he was an ideal scapegoat upon whom the government could pin the blame, which a Senate Committee established to investigate the Veterans' Bureau promptly did.[168] The investigation noted that some 200,000 pieces of mail from veterans seeking benefits had been found unopened, highlighted a few of the corrupt hospital contracts made with Forbes's authority, and culminated with the testimony of Elias H. Mortimer, a Chicago contractor who admitted paying Forbes a $5,000 bribe to shift contracts to his construction firm. Mortimer also claimed that Forbes had an affair with his wife, Katharine Mortimer, on an inspection tour that Mortimer described to the Senate as "one of the merriest, maddest junkets in the history of the Government."[169] Even in an era of speakeasies and rum runners, the Forbes scandal was salacious.

Yet, while it is important to note that Forbes was certainly corrupt and incompetent, he was not the only source of such problems at the Veterans' Bureau. Dr. Sawyer, for instance, was likely another source. The American Legion repeatedly tried to have Sawyer removed from his post on the Federal Hospitalization Board because they believed Sawyer was more interested in personal

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[166] "Harding Put a Stop to Bureau's Sales," *The New York Times*, November 7, 1923, p. 19.

[167] Marquis James, "What's Wrong in Washington? The latest Muddle in the United States Veterans' Bureau," *The American Legion Weekly* 5, no. 10 (March 9, 1923):11-20.

[168] U.S. Senate, Select Committee on the Investigation of the Veterans Bureau, March 2, 1923 to 1925

[169] "Wife of Chief Witness in Forbes Inquiry Charges Cruelty," *The New York Times*, June 16, 1925.

gain than in serving veterans' needs. Some believed that Sawyer was selling hospital blueprints to contractors—a practice that continued for months after Forbes's resignation.[170] But Forbes's name was already in the papers and it was easier for the Senate and administration to pin the blame solely on the disgraced former director. Forbes was convicted of conspiracy to defraud the government and sentenced to two years in prison and a $10,000 fine.

With his administration beset by this scandal and others, President Harding needed to restore faith in the Veterans' Bureau—to demonstrate that his administration took seriously the charge of caring for the nation's disabled veterans. For this task, he chose General Frank T. Hines.

**Back to Business**

To that point, Hines was best known for his command of the Embarkation Service in the First World War, where he oversaw shipping more than two million American soldiers and millions of tons of supplies to Europe over the course of eighteen months and bringing them all home again. This undertaking demonstrated his ability to successfully manage large and complicated systems. Combined with his business experience after the war, Hines represented a perfect replacement for Forbes in Harding's mind.[171]

Hines was reluctant to take the job. He claimed reservations about the political nature of the position and told the President, "I don't like politics and I don't know anything about politics." Harding replied that the general could run the Bureau as a business and leave the politics to the President.[172] On this condition, Hines consented to the appointment and took over as the new Director of the Veterans' Bureau. It was a position he would hold for more than twenty-two years.

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[170] Jesse T. Tarbert, "Scandal and Reform in Federal Veterans' Welfare Agencies: Building the Veterans' Administration, 1920-1932," Thesis. Case Western Reserve University. January, 2011.
[171] "General Hines Resigns," *The New York Times*, July 29, 1920, p. 7.
[172] Adkins, 126.

Hines's long tenure at the head of the Veterans' Bureau and Veterans' Administration had a profound influence on not only shaping the policies and operations of the government agency responsible for veterans' benefits and care during his administration, it helped establish patterns and cultures that still, in many ways, shape the processes that affect the provision of veterans' health care. As a businessman, Hines sought efficiencies in operations above all else. As a soldier, he preferred a rigid chain of command. And as a bureaucrat, his interactions with lawmakers and veterans' service organizations established patterns and expectations ab out how the head of the Veterans' Bureau and Administration should behave. Therefore, in the examination of the historical foundations of the institutions of veterans' care—both concrete and abstract—one must take a moment to examine the administration of Gen. Frank T. Hines.

If Hines was really as averse to politics as he claimed, he received an early education and learned quickly. He was the first witness called to testify in the Senate investigation and he took the opportunity to draw contrasts between himself and his predecessor. He enthusiastically outlined a list of abuses and inefficiencies discovered during the Forbes directorship, particularly noting the dramatic expansion of the Bureau's workforce—a move that, from the outside looking in, made it appear as if the Bureau was doing significant work. But Hines noted that Forbes had a poor handle of efficient bureaucratic administration, that many employed by the agency had little or nothing to do while others duplicated each other's efforts and gummed up the system.[173] This was especially true in claims processing.

Hines proposed a reorganization of the bureau that would eliminate inefficiencies, and he promised to promptly address any dishonesty discovered. He took a personal hand in these

[173] Report of the Select Committee on Investigation of the United States Veterans' Bureau, 68th Congress, 1st Session, 1924.

reforms, working on everything from the high-level reconfiguration of the Bureau's organization chart and the disposition of field offices to the smallest affairs of individual branch offices. On one occasion, concerned that mail was getting mixed up in the field offices, Hines directed that the mailboxes on every desk be clearly labeled to separate incoming and outgoing correspondence.[174] He reorganized the Bureau into six separate and insulated services: medical and rehabilitation, claims and insurance, finance, supply, planning, and control. This organization roughly emulated a military chain of command. The head of each service was responsible to the Director and, unless given prior authority, had no power to interact with other service heads. This allowed Hines to know precisely what was going on in the Bureau and to react accordingly. Efficiency was key with Hines, and he encouraged it in all areas of veterans' benefits and care, with some positive—albeit perhaps unintentional—benefits for veterans.

Regarding disability claims, Hines applied a multistep process for certain cases. Most claims were handled by one of fourteen regional offices, but in cases of permanent and total ratings, all such cases were "forwarded to the central office board of appeals for confirmation."[175] This ensured that decisions made by medical boards at the regional offices were not biased towards veterans and that strict compliance with the ratings schedule established as part of the War Risk Insurance Act of 1917 and amended by subsequent legislation was maintained in a uniform manner. This ensured that the Bureau applied as fair a standard as possible in all cases, and it led to an effort to undermine the efforts by some veterans to game the system.

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[174] Hines to Arnold, May 21, 1924, Box 220, Director's File, Records of the Veterans' Administration, Record Group 15, U.S. National Archives, Washington, D.C.

[175] *Annual Report of the Director, United States Veterans' Bureau, for the Fiscal year Ended June 30, 1924* (Washington, DC: Government Printing Office, 1924), 38.

Recall the complaints of Dr. Haven Emerson, the Bureau's Medical Adviser when it was created, and how he stated that the disability ratings system encouraged some veterans to seek unsupported ratings and the compensation that came with it. By requiring multiple independent reviews of such cases, Hines discouraged such gaming, but he also took it a step further. Hines noticed that much of the effort to increase ratings occurred in cases labeled as temporary partial disability, meaning that medical experts believed the disability could be cured or ameliorated in some way. By 1924, the data collected by the Bureau demonstrated that few of these temporary cases improved significantly enough to be dropped, that most cases degenerated, and that requiring veterans to subject themselves to subsequent exams created extra expense for the Bureau. As a practical measure, then, Hines adjusted policy to have these temporary cases designated as permanent partial disability.[176] Cases with permanent cases required less examinations, were easier to sort on the ratings schedule, and were less likely to inspire exaggerations of the type about which Dr. Emerson complained by ensuring a sense of security in disability ratings. Hines may have been concerned with ensuring an "economy in cost" in the administration of benefits, but it also resulted in more predictability for veterans and Bureau employees.

That's not to say that the process of rating disabilities became significantly easier. Hines often made such policy adjustments in order to free up administrative resources in conjunction with legislative changes. For instance, the policy change regarding partial disability designation occurred just as Congress amended the War Risk Insurance Act of 1917's rating schedule with the passage of the World War Veterans' Act of 1924.[177] This created a new disability compensation ratings schedule based on the a veteran's approximate earning capacity per their preservice

[176] Ibid., 39.
[177] World War Veterans' Act, 1924.

profession—the WRIA based compensation on an amalgamated average income. This required significant work by Bureau officials, both administrative and medical, to develop a schedule that not only took into account the existence and nature of a disability, but also the veteran's earning capabilities by profession.[178] The bandwidth required to generate this new rating schedule thus helped justify the Bureau adopting a policy that limited temporary partial disability ratings that ate up Bureau resources.

A similar process helped extend hospital care to more veterans. By 1923, the hospital construction program begun in 1919 was starting to catch up with demand in several parts of the country, creating surplus hospital beds in some facilities. At the same time, veterans with non-service-connected disabilities and aging veterans of other wars were being denied access to hospital care through the Veterans' Bureau—the establishment of service-connection being a prerequisite of such care at the time.[179] Believing as he did in bureaucratic efficiency, Hines hated to see government resources sitting idle. So, in December 1923, Hines began advocating for the authority to allow all veterans, regardless of service-connection status or war in which they served, to have the option of receiving care at veterans' hospitals.

In a letter to President Coolidge, Hines noted that "at present there are 9,500 vacant beds in Government hospitals. I recommend that all hospitals be authorized… to receive and care for, without hospital pay, the veterans of all wars needing such care, whenever there are vacant beds."[180] For Director Hines—and for most veterans—the only important qualification for access to hospital benefits was honorable service and need provided that such benefits were available.

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[178] American National Red Cross, Department of Civilian Relief, "Handbook of Information and Instructions for Home Service Workers; Post War Service, Service Claims and Information," 1921.

[179] WRIA, 405.

[180] World War Veterans' Act, pt. II, General Hines's letter to President Coolidge, December 19, 1923.

But, again, these views may have emerged from different motives. While veterans' service organization wanted to secure benefits for their members, Hines wanted to ensure that the type of idleness that characterized much of the Bureau under Forbes did not mark his own directorship, and Hines may have already had an eye towards expanding his influence in the relevant communities.

The World War Veterans Act of 1924 (WWVA) thus allowed veterans of all wars to seek medical care through the Bureau, with some stipulations. Service-connected cases from the First World War were given priority over others, and factors such as medical necessity, disability rating, and ability to pay were also considered in areas with limited resources. But as long as hospital beds were available, theoretically, any veteran with an honorable discharge could now secure care. This was a remarkable reform because, prior to this law, veterans' benefits were generally legislated separately according to the contemporary conflict. The Veterans' Bureau, for instance, administered care explicitly for First World War veterans prior to this point while the Pension Bureau in the Department of the Interior continued to administer benefits for veterans of earlier wars.[181] The WWVA retained established hierarchies of service-connection but allowed those with non-service-connected disabilities to seek care provided there was availability.

This move served at least two purposes. First, it allowed Hines and Congress to mollify veterans' service organizations that had been so stridently arguing for expanded benefits for First World War veterans, who no doubt recognized by then that veterans of earlier conflicts received much more generous compensation packages. Expanding access to care for disabled veterans regardless of the incurrence of their disabilities also fit with the notion of medical benefits allowing veterans to pursue independent, productive lives through medical support. And second, the move

[181] Adkins.

served as a prelude to Hines's efforts to consolidate all veterans' benefits under the administration of his bureau—not just those limited to veterans of the First World War.

Regarding the Medical Division of the Veterans' Bureau, Hines was as involved as elsewhere in the reorganization process, particularly in the early years of his administration, though his direct involvement here was not as beneficial. Hines sought to establish enduring policies that conformed to legislation, and he was keen to utilize expert advice in crafting such policies, but he retained the right to make final decisions. As a medical layman, Hines prioritized matters of administration over medicine, sometimes to the detriment of the latter.

Recall the work of the White Committee—the consultancy group established to study the veterans' hospital system and make recommendations. They completed their report in 1923, just after President Harding announced the resignation of Director Forbes and just before Hines assumed the directorship. Their in-depth report contained a wealth of information for Director Hines to create and manage the nation's largest modern hospital system.[182] The purpose of the report was to make recommendations on how best to enact legislation passed in 1921 to expand the veterans' hospital system through new construction.

It is important to note that, in the 1920s, the hospital was quickly becoming the locus of modern medicine—preferred over traditional in-home care models. For physicians, hospitals had been sites of medical practice and learning for centuries, but now the results of that learning were paying dividends to the point that hospitals became commodities in the medical economy—a consumer product in most ways superior to at-home alternatives.[183] Further, the hospital as a

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[182] Report of the consultants on hospitalization, appointed by the Secretary of Treasury, to provide additional hospital facilities under Public Act 384, approved March 4, 1921. (Washington, DC: Government Printing Office, 1928). Hereafter referred to as the White Committee Report.

[183] Rosenberg, *The Care of Strangers*. Stevens, *In Sickness and in Wealth.*

bureaucratic structure fit rather organically with the system Hines was developing for the Veterans' Bureau.

Hines appreciated the hospital as an organizational element that generated useful reports, summarized their needs, practices, and outcomes in ways that fit well with his concepts of nested, hierarchical management from above. If too few veterans had access to hospitals or to facilities specializing in a certain disease like tuberculosis—certainly the case when Hines took over in 1923—then it was a relatively simple matter of expanding said access by building more institutions patterned on established policies and procedures. In other words, Hines incorporated veterans' hospitals into his bureaucratic structure and utilized the numbers they generated—particularly bed capacity, admissions, and discharges—as a means to gauge the effectiveness of his administration. It was through this lens that Hines reviewed the recommendations produced by the White Committee, and perhaps why Hines refused to implement all of their expert recommendations.

During their examination of the veterans' healthcare system, the White Committee realized early on that they needed further consultation to best understand veterans' healthcare needs. They formed a consultancy group that included Dr. T. W. Salmon, representing the National Committee for Mental Hygiene; Dr. Haven Emerson, the renowned epidemiologist who clashed with Director Forbes; and members of the National Tuberculosis Association, the U.S. Public Health Service, and the National Homes for Disabled Volunteer Soldiers.[184] With these consultants, the committee diligently studied the issue of veterans' hospitalization, paying attention to both contemporary needs and likely future concerns.

Director Hines adopted most of the White Committee's recommendations, particularly those regarding the best locations for veterans' hospitals and the notion that veterans' care be

[184] Adkins, 115.

confined to government facilities to ensure matters of control, quality, and price were more predictable and manageable while access remained as equitable as possible.[185] The recommendations fit well with Hines's administrative preferences, and in that regard, the White Committee report set policy in the Veterans' Bureau and Veterans' Administration that would last through the Second World War.

But Hines did not adopt all of the committee's recommendations. Most notably, he rejected notions of affiliating veterans' hospitals with the nation's leading academic medical institutions.[186] The physicians on the committee viewed such affiliation as holding the potential to not only improve the quality of veterans' care but also the quality of medical education. This was, in effect, an expansion of the clinical model of medical education. But for a medical layman like Hines, it sounded like veterans would be subjected to medical experimentation and substandard care by medical students while simultaneously complicating matters of government control. With this in mind, Hines consistently resisted overtures for academic affiliation throughout his tenure.[187]

Regardless, Hines used the White Committee's report to expand access to hospital care for veterans suffering from tuberculosis and mental health disorders. The Bureau prioritized new hospital projects geographically to favor large veteran populations above other concerns, and it emulated the committee's use of expert medical consulting by forming a Medical Council to advise the Director and Medical Director on all matters of procedure and practice in the provision of health care and in specific medical specialties.[188]

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[185] Equitability of access in this case has two significant exceptions. Neither female nor Black veterans received the same considerations as the white, male majority of the population—a topic covered in more detail in Chapter 4.

[186] White Committee Report.

[187] Adkins, 117.

[188] Annual Report of the Director, United States Veterans' Bureau, for the Fiscal year Ended June 30, 1925 (Washington: Government Printing Office, 1925), 38.

The Medical Council, meeting every three months, primarily paid attention to studies involving the standardization and improvement of outpatient treatment, social service, and domiciliary care—work that helped define the parameters of the Veterans' Bureau's disability rating schedule. In 1925, they worked with the American College of Surgeons to survey and accredit all 50 veterans' hospitals in operation at the time.[189] And they urged that the Bureau prioritize medical research and continued to stress the potential benefits of academic affiliation "so that the clinical load of the hospitals could aid in advancing medical knowledge."[190] Hines did authorize the creation of an internal, government controlled research section to study difficult medical cases affecting veterans, but such efforts were generally small, poorly funded, and explicitly banned from cooperating with entities outside the government scope. Given Hines's resistance to even the implication that veterans might become subjects of medical experimentation, the mere existence of any research division was a relative plus. Meanwhile, Hines translated his administrative success into expanding his influence.

**Consolidation**

Throughout the 1920s, Hines's reputation continued to benefit from the contrast with Forbes's scandal-ridden tenure. Hines's standing was only boosted by the apparent success of his reorganization and administrative efforts. The Veterans' Bureau, by all official accounts, appeared relatively effective in processing claims, providing benefits, ensuring efficiency and economy, and most of all, being trustworthy. By ensuring a standardized rating schedule based on medical expertise and by making temporary disability designations permanent, Hines was able to not only

[189] Adkins, 138. Of the 50 veterans hospitals, 45 were fully approved after the first survey. Two (including the hospital at Tuskegee) were conditionally approved and the remaining three were approved after completing requirements.

[190] Ibid.

cut back on falsified claims, he was able to expand access to veterans' hospitals to non-service-connected cases and to vets of older conflicts. And while Hines may have initially claimed an aversion to politics, by the end of the decade, he was navigating Washington and the halls of Congress as well as any other official in the Capital and better than most. Further, he gained significant influence and support among the various veterans' service organizations. Hines was able to leverage all of this to expand his authority.

By February 1927, Congress was seriously contemplating the consolidation of veterans' service agencies within the Veterans' Bureau—most notably the Pension Bureau in the Department of the Interior and the National Home for Disabled Volunteer Soldiers in the War Department. Both were legacies of the Civil War. Part of this congressional contemplation was spurred by the efforts of the newer veterans' service organizations like the American Legion, Veterans of Foreign Wars, and Disabled American Veterans, who believed that the Bureau would better serve all veterans.[191] Ostensibly in response to this pressure, Hines outlined his support for such a merger in the Bureau's 1928 annual report to Congress, noting that he:

> *... will vigorously support any legislation that has for its object this unified plan of control. In the opinion of the director, the main advantage of such consolidation would be in bringing together in one definite agency under the President matters which are so closely related at this time as to make it essential for those charged with the administrative duties to be familiar with all phases of the problem.*[192]

Using the Bureau's annual report to promote what was, at the time, a political proposal was essentially a reflection of support among several of the interested communities. The newer VSOs represented the majority of American veterans and a significant voting bloc, which translated into

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[191] "Heads of the 5 Great Veterans' Groups Ask Preparedness," *Washington Post*, February 19, 1927.

[192] Annual Report of the Director, United States Veterans' Bureau, for the Fiscal Year Ended June 30, 1928 (Washington DC: Government Printing Office, 1928), 2.

support for the plan in Congress. Majorities in both chambers, along with officials in the Coolidge administration, supported the notion of consolidation. But support for the plan was not universal.

The heads of the other agencies in question stood to lose a measure of power and influence, and members of older VSOs like the Grand Army of the Republic and Spanish-American War Veterans feared that consolidation in the Veterans' Bureau could result in cuts to their benefits. And these groups had a curious ally in their opposition: the American Medical Association (AMA), which was the largest and most influential medical organization at the time.

The AMA's objection had to do with the organization's concerns that consolidation of veterans' agencies and the provision of medical care was a slippery slope towards a nationalized healthcare system.[193] Such a system threatened to undermine physicians' ability to set fees for their services and control business elements of their practices, so the AMA was significantly interested in undermining anything that could potentially affect that autonomy. But despite the AMA's self-interested objection and the concerns of older veterans' groups, the proposal only gained steam.

By 1929, Director Hines asked newly-elected President Herbert Hoover to name a committee to study the issue. The President complied, and by 1930, Hines was offering testimony before Congress.[194] Hines framed the issue as one in which veterans had to deal with multiple agencies, leading to inefficiencies and drawing a parallel to the disastrous pre-Bureau efforts to administer benefits for First World War veterans. This was not a wholly accurate comparison—extremely few veterans had to navigate between the various agencies and there was little need for those agencies to interact with each other—but it was effective. On July 3, 1930, President Hoover

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[193] 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):281-305.

[194] House Committee on Expenditures in the Executive Departments, *Consolidation of Veterans' Activities: Hearings on H.R. 6141,* 71st Congress, 1st Sess., 1930.

signed Public Law 536 of the 71st Congress into law, authorizing the consolidation of the various veterans' agencies into a new Veterans' Administration (VA) with Gen. Frank T. Hines as its first Administrator.

Hines set about incorporating these agencies into the VA as diligently and methodically as he optimized the Veterans' Bureau in the previous decade. These efforts were complicated by Congress increasing pension payments and creating a disability allowance—both moves aimed at garnering support in a midterm election year and both welcomed by veterans' service organizations.[195]

The disability allowances included in the World War Veterans' Act of 1930, in particular, complicated the rating schedule.[196] These allowances differed from standard compensation payments in that the allowances were intended to make up for potential loss in earnings and, to its critics, smacked of the type of corruption that so plagued the old pension system. Indeed, President Hoover vetoed the bill on the basis that it "would give war disability benefits to from 75,000 to 100,000 men who were not disabled as a result of the war."[197] Hoover's primary complaint with the World War Veterans Act was that it seemed to undermine service-connection requirements by creating presumptive classifications of compensable disabilities, potentially allowing men disabled in civilian life after the war to be put on a level with those wounded in battle. This had the potential to massively expand veterans' benefits, which is why it was so popular with veterans' organizations and members of Congress.

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[195] "Veterans Ask Senate to Pass Pension Over Veto," *New York Times*, June 2, 1930, p. 13.

[196] Stephen R. Oritz, *Beyond the Bonus March and the GI Bill: How Veteran Politics Shaped the New Deal Era* (New York: New York University Press, 2012).

[197] Herbert Hoover, Veto of the World War Veterans' Bill. Online by Gerhard Peters and John T. Woolley, *The American Presidency Project*. https://www.presidency.ucsb.edu/node/210897.

Congress passed the law over Hoover's veto and within a year, the VA received 541,943 applications for this benefit that had to be adjudicated.[198] At the same time, the consolidation of all veterans' benefits in the VA enabled hospitalization benefits to all veterans with service-connected disabilities, creating significant demand for VA hospital services. But by the end of 1931, Hines's consolidation efforts were complete and Hines settled into a routine of continually tweaking operations to achieve maximum efficiency in compliance with Congressional mandates, just as economic disaster struck.

## The Economy Act and National Priorities

If the World War Veterans' Act of 1930 and Hines's consolidation of federal veterans' programs in the VA opened the door to more disability claims in the interests of economic efficiency, other developments threatened to shut them down. The Great Depression significantly affected the veterans' healthcare system in multiple ways. Many veterans found themselves on the receiving end of skyrocketing unemployment and turned to the VA for assistance, even as the administration of newly-elected President Franklin D. Roosevelt made a concerted effort to cut federal expenditures, including veterans' benefits, which constituted one quarter of the federal budget at the time.[199] The law revoked veterans' benefits by erasing all laws pertaining to medical and hospital treatment, domiciliary care, compensation, and pensions and allowing the President to establish new systems through executive order.[200] FDR thus instituted restrictive provisions including limiting care for non-service-connected cases to those of total disability.[201] This resulted in a significant drop in veterans' hospital utilization.

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[198] Adkins, 145. Also Annual Report for FY 1930.

[199] David M. Kennedy, *Freedom from Fear: The American People in Depression and War, 1929-1945* (New York: Oxford University Press, 2007).

[200] Economy Act of March 20, 1933, Sec. 17.

[201] Adkins, 154.

In his annual report for 1933, Administrator Hines noted that the hospital load at VA facilities had dropped by nearly a quarter from the previous year. He attributed this decrease to the Economy Act "and the regulations issued thereunder, which denied the benefit of hospitalization to many veterans who had been eligible under prior laws."[202] Curiously, despite this practically unprecedented restriction in eligibility, the VA experienced an increase in hospitalizations for a specific type of disability: psychoneurosis.

Psychoneurosis was a contemporary catch-all category for a variety of mental disorders that have since received better diagnostic definitions. These disorders ran the gamut from generalized depression and anxiety to what contemporaries called "shell shock" or what would today be diagnosed as posttraumatic stress disorder. Most of the admissions to the VA hospital system in 1933, fell into this category.[203] Some VA officials attributed this increase to the hard economic times. Robinson Adkins, assistant to Administrator Hines, framed this position well, noting "those were the days of the great depression, and students of mass psychology pondered the possibility of a connection between hard times and illness…. Do joblessness and attendant worry escalate the incidence of mental illness?"[204] Adkins might have been pleased to note that students of mass psychology are still asking this question.[205] The dramatic increase in service-connected hospitalizations—because non-service-connected cases were barred benefits by the Economy Act—for psychoneurosis certainly lends weight to this theory.

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[202] Annual Report of the Administrator of Veterans' Affairs for the Fiscal Year ended June 30, 1933 (Washington, DC: Government Printing Office, 1933), 11.

[203] Ibid. There were 71,139 first-time admissions (52% of the total) in 1933, 60% of whom reported neuropsychiatric distress.

[204] Adkins, 146.

[205] Arthur Goldsmith and Timothy Diette, "Exploring the link between unemployment and mental health outcomes," American Psychological Association, The SES Indicator (April 2012), https://www.apa.org/pi/ses/resources/indicator/2012/04/unemployment.

Another possibility was that many First World War veterans were experiencing mental health breakdowns associated with what would today be classified as chronic posttraumatic stress. For nearly fifteen years, these veterans carried with them the scars of their wartime experiences without treatment, and after those burdens became too great to bear, they sought hospitalization benefits to which they were entitled. In other words, increases in mental health hospitalizations during the 1930s may have been caused or exacerbated by the Great Depression, but they may also have other origins. Regardless, it is clear that the Great Depression had a severe impact on veterans' benefits—even to the point of threatening the abstract institution that veterans deserved access to care regardless of the genesis of their disabilities.[206]

Under the new provisions established after the passage of the Economy Act, pensions for non-service-connected disabilities were limited to total disability, capped at $20 per month, and limited to veterans with incomes less than $1,000 if single or $2,500 if married.[207] These conditions effectively stripped all pensions for veterans with non-service-connected disabilities. Total disability designations for such cases were rare, and the means testing requirement put the onus on the veteran to prove financial need for a maximum potential benefit of $240 per year. Similar orders restricted eligibility to receive medical and domiciliary benefits to only service-connected cases.[208] As a result, while certain cases like psychoneurotic claims increased, overall VA hospital utilization dropped by 23 percent from the preceding year. It's important to note that this decrease was due entirely to the erection of bureaucratic barriers—not to any decrease in medical need. Veterans and veterans' service organizations began to protest the situation.

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[206] Marc-Antoine Crocq and Louis Crocq, "From Shell Shock and War Neurosis to Posttraumatic Stress Disorder: A History of Psychotraumatology," *Dialogues in Clinical Neuroscience*, vol. 2, no. 1 (March 2000).

[207] Executive Order 6093, March 31, 1933.

[208] Executive Order 6094, March 31, 1933, and Executive Order 6095, March 31, 1933.

It is perhaps an irony of circumstance that a veterans' protest helped put Franklin Delano Roosevelt in office in the first place. Desiring Congress to authorize the early payment of their adjusted compensation certificates, many unemployed veterans of the First World War formed what came to be called the Bonus Expeditionary Force (BEF or Bonus Army) in 1932 to march on Washington and make their voices heard. In the event, the BEF failed to sway Congress, but many decided to continue their protest by occupying vacant federal buildings and public parks in Washington, DC.[209] Concerned that the Bonus Army's continued presence would hurt his re-election chances, then-President Hoover ordered their evacuation.[210] Army Chief of Staff Douglas MacArthur mobilized infantry, cavalry, and even tanks to the effort. Members of the BEF initially cheered, believing the Army troops to be in support of their cause, but then MacArthur's men charged, fired tear gas into the crowds of First World War veterans, and set fire to their encampments. The scandal of the event helped Franklin Delano Roosevelt defeat Hoover in a landslide. But by 1933, it was FDR's administration that was cutting benefits in the interests of economic savings.

Veterans activists mounted two more Bonus Army protests of the Economy Act. In contrast to their violent reception by President Hoover, however, President Roosevelt set up a camp for the marchers at nearby Fort Hunt, Virginia complete with field kitchens providing three meals a day, bus transportation to and from the city, and entertainment from military bands. Further, First Lady

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[209] "Bonus Expeditionary Forces March on Washington," Anacostia Park, National Park Service; Alice Kamps, "The 1932 Bonus Army: Black and White Americans Unite in March on Washington," *Pieces of History*, National Archives blog (July 15, 2020).

[210] "B.E.F. Chief Agrees to Quit Buildings as President Acts," *The New York Times*, July 28, 1932, p. 1; Terence McArdle, "The Veterans were Desperate. Gen. MacArthur Ordered U.S. Troops to Attack Them," *The Washington Post*, July 28, 2017; "Heroes: Battle of Washington," *Time,* August 8, 1932; "Hoover Orders Eviction," *The New York Times*, July 29, 1932, 1-2.

Eleanor Roosevelt visited the veterans to hear their grievances, prompting one veteran to remark that "Hoover sent the Army, Roosevelt sent his wife."[211]

Eleanor Roosevelt described the veterans in glowing terms that undercut narratives of the marchers as communists and criminals. But the best the Roosevelt administration could offer most veterans was the promise of positions in the newly-created Civilian Conservation Corps (CCC)--a promise the President kept with an executive order exempting veterans from the age requirements of the CCC.[212] This was a clever appeal to veteran's sense of continuing service to the nation in line with the effort to reform veterans' benefits from pensions to medical care and the promise of a return to productive independence. Working for the CCC ensured veterans received an income, lodging, and food, while they continued to serve the nation.

The response was remarkably popular. About 225,000 veterans enrolled in the CCC's veterans' contingent and received benefits for the program. This had the effect of essentially shifting the burden of indigent veterans into a work-for-welfare program, albeit one complicated by the fact that many of the participants were disabled. In a sense, then, Roosevelt was trying to reform veterans' benefits once again—this time by removing veterans' privileged status in one way and transforming it to privileges in programs accessible to wider segments of American society.[213] But by 1934, Congress had changed its mind about the Economy Act.

That year was a midterm election year, and Congress took the opportunity to reassert its legislative control of veterans' affairs by passing the Independent Offices Appropriation Bill, restoring full funding to the Veterans' Administration and allowing the VA to resume providing

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[211] "Bonus Army Row Finally Adjusted," *The New York Times*, May 15, 1933; Paul Dickson and Thomas B. Allen, "Marching on History," *Smithsonian Magazine*, February 2003.

[212] H. W. Brands, *Traitor to His Class: The Privileged Life and Radical Presidency of Franklin Delano Roosevelt* (New York: Random House, 2009), 391.

[213] Brands, 150.

benefits as it did before the Economy Act.[214] Veterans with non-service-connected disabilities could once again utilize hospitals and compensation payments returned to the previous schedule. Roosevelt, of course, attempted to veto the law.

FDR noted that the new bill added $228 million to the budget without providing revenue streams to cover the amount, expressed his willingness to act through executive authority to restore veterans' benefits—essentially arguing that such authority should be retained by the President instead of Congress—and restated his opposition to "presumptive" disability status that entitled veterans to benefits. Roosevelt said that "disability was a question of act rather than a question of law… that the 'presumptive' cases which Congress now seeks to return to the compensation rolls should be treated on individual merit… [that] there was no justification for 'legislative dicta which, contrary to fact, provide that thousands of individual cases of sickness which commenced four, five or six years after the termination of the war are caused by war service."[215] Roosevelt's reasoning for medical determination of disability served his political priorities, but also raised an interesting point: was disability to be determined through legislation and policy or through medical expertise? In the VA in 1934, it was a mix of both.

Congress passed the bill over FDR's veto, and they expanded veterans' benefits further in 1936—another election year and again over another presidential veto. With the support of veterans' service organizations, Congress passed the "baby bond" bonus bill, authorizing veterans to exchange their compensation certificates for interest-bearing treasury bonds and giving them the option to keep the bonds until they matured in 1945 or to cash them in immediately.[216] This

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[214] Independent Offices Appropriations Act of 1934.

[215] "House, 310 to 70, Overrides Roosevelt's Veteran Veto; Close Senate Vote Likely," *The New York Times*, March 28, 1934, 1.

[216] "Bonus Bill Becomes Law; Repassed in Senate, 76-19; Payment will be Speeded," *The New York Times*, January 28, 1936.

was, essentially, precisely what the Bonus Army demanded in 1932, and it demonstrated that Congress, regardless of party affiliation, was back in its traditional benefit of expanding benefits. While somewhat tangential to the big picture of the development of disability determinations in the VA, given its relatively short timeframe, the passage and repeal of the Economy Act had a remarkable influence on the shape of the VA system. It reinforced the notion that not only had veterans come to accept the VA's medicalized benefits but to also see them as an essential support system. Perhaps just as important, the reintroduction and reinforcement of presumptive conditions—those that do not require direct evidence of service-connection to qualify for coverage—was an important development in reinforcing the way that disability works as an administrative category. Thus, the events of the 1930s reinforced the foundations of the medicalized benefit system established in the 1920s.

With the repeal of the Economy Act, hospital utilization once again stressed the veterans' hospital system's capacity, requiring the government to contract with civilian hospitals in some cases—a point Hines stressed in his annual reports to Congress. What's more, the case load breakdown by disabilities had changed significantly since 1923, when Hines's tenure began. He noted that when he started overseeing the veterans' hospital system, "41 percent of the patients were classed as tubercular, 39 percent as neuropsychiatric, and 20 percent as general."[217] By 1937, those numbers had shifted to 10 percent for tuberculosis, 57 percent for neuropsychiatric disabilities, and 33 percent for general—reflecting changes in the types of disabilities experienced by an aging veteran population. This was a problem that Hines anticipated would only grow as the veteran population got older.

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[217] Annual Report of the Administrator of Veterans' Affairs for the Fiscal Year ended June 30, 1937 (Washington, DC: Government Printing Office, 1937), 6.

In response to Hines's concerns, Congress passed laws authorizing further expansion of veterans' hospital capacity in 1937 and again in 1940. The latter effort included a ten-year plan to gradually expand capacity according to institutional needs on an annual basis to a maximum of 100,000 hospital beds of all types.[218] The Federal Hospitalization Board estimated that number to be capable of meeting the anticipated peak load of hospital utilization. But this plan failed to account for the possibility of the United States entering the Second World War, which was by then already raging.

That is not to say that the VA did not make plans to expand its role in the lead up to American involvement in the war—quite the contrary. Rather, it is to say that the government, as it did in preparing for involvement in the First World War, neglected to account for the potential long-term effects of war on the horizon. So, while the VA recognized that national defense preparedness policies enacted in 1940 would likely result in increases in training accidents and deaths, it failed to anticipate the medical necessities required during a war and its aftermath.[219] But, to be fair, the VA was not alone in this lack of long-term planning.

## A New War and the State of Modern Medicine

Lessons learned from the experience of the First World War meant that the United States was generally better prepared for the outbreak of the Second, but only barely. Medically, the war had a profound impact on the development of medical research, affirming the quality of American medicine, and whetting the nation's appetite for more doctors and medical care.[220] And this,

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[218] Adkins, 157.

[219] Annual Report of the Administrator of Veterans' Affairs for the Fiscal Year ended June 30, 1940 (Washington, DC: Government Printing Office, 1940), 12.

[220] Kenneth Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (Oxford: Oxford University Press, 2005), loc. 2019 of 8023, digital version.

combined with the record number of veterans created by the Second World War, had a profound impact on the development of veterans' healthcare.

The passage of the Selective Service Act in 1940 made every American male between the ages of 21 and 36 eligible for potential military service, with 900,000 men drafted in the nation's first-ever peacetime draft.[221] This was significant to the VA because this single draft represented an eventual increase in the veteran population of nearly 20% with the potential to add approximately 18 million to the veteran rolls in the event that all eligible men were drafted. At the same time, Congress created a vast new system of servicemen's and veterans' insurance programs with the passage of the National Service Life Insurance Act of 1940—a benefit system administered by the VA but separate from the system developed for First world War veterans. Hines followed his usual pattern of dedicating the majority of his time to the new duties assigned by Congress—in this case, the administration of the new insurance programs—trusting in his established policies to manage the rest of the VA. But regarding the medical care of veterans, this turned out to be a mistake.

By 1941, the VA—along with every other medical institution across the country—was beginning to experience the difficulties of maintaining services and keeping facilities properly staffed while sacrificing personnel to the needs of the military.[222] At the outset of the war, the VA employed 45,000 personnel who oversaw everything from the administration of benefits to medical care. The VA had 91 hospitals at the time, with a capacity of 62,000 beds—18,000 of which were set aside to provide domiciliary care for older veterans, leaving a potential capacity of

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[221] Public Law 76-783, "An Act to provide for the common defense by increasing the personnel of the armed forces of the United States and providing for its training," September 16, 1940.

[222] V. T. Grando, "Making do with fewer nurses in the United States, 1945-1965," *Image: Journal of Nursing School* vol. 30, no. 2 (1998): 147-9; Eli Ginzberg, "The Impact of World War II on U.S. Medicine," *The American Journal of the Medical Sciences* 304, no. 4 (October 1992):268-71.

only 44,000 beds for other types of care, but even this was a misleading number.[223] The administration's ability to fully staff these beds was hampered by the appointment of many VA physicians to other government duties—primarily to conduct induction screening of potential draftees and volunteers.[224] And when the war broke out in full measure on December 7, 1941, these difficulties only grew worse, creating significant distractions that would prove instrumental in spurring reforms in the VA healthcare system.

The VA's efforts to support induction screening was seen not only as the VA supporting war preparedness, but also influencing the pool of potential veterans. Officials placed significant faith in the value of qualified and thorough examination of draftees suspected of neuropsychiatric vulnerabilities.[225] In the 1930s, VA psychiatrists and physicians gained significant experience treating mentally ill First World War veterans, and the prevailing notion was that many of those men who broke down on the battlefields of Europe or later as a result of their service only did so because they were predisposed towards mental illness before their service—that more rigorous induction screening would have prevented their illness and saved the VA from responsibility for their care. Developments in the Second World War would undermine this notion, but in the event, much of the VA's staff was dedicated to the induction screening process. More staff shortages would soon follow.

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[223] Annual Report of the Administrator of Veterans' Affairs for the Fiscal Year Ended June 30, 1941 (Washington, DC: Government Printing Office, 1942), 7.

[224] Ibid., 3. Adkins, 161.

[225] Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (Hove, UK: Psychology Press, 2015), 104. Such screening was supported by notable psychiatrist Harry Stack Sullivan (1892-1949) and some 12% of potential inductees were eliminated from consideration for military service through this screening.

Despite the VA's preferred status as a defense agency, it lost some 7,000 employees to the war effort in 1942, alone.[226] Exacerbating this issue, Administrator Hines refused to ask for deferments to maintain staffing—seeing supporting the military effort as a higher priority—which created particular shortages in hospital personnel. Nurses and doctors were in critical supply, but so were hospital attendants and other personnel necessary for the efficient and orderly operation of hospitals. And by 1943, Second World War veterans began to appear in VA hospitals in numbers that would have stressed the system's capacity in normal times, and these times were far from ideal. To address these personnel shortages, the VA was forced to make concessions and adjustments to meet the demand.

One such adjustment was to clear some of the bureaucratic hurdles surrounding the determination of a service-connected disability. Under normal circumstances, the VA would go to great lengths to corroborate a veteran's claim, including a medical examination to determine the existence of a disability and coordination with the War and Navy Departments to secure copies of medical records, establish service-connection to the disability, and to verify the nature of discharge. But in the effort to support the war effort, Director Hines volunteered VA hospitals for the treatment of Second World War veterans discharged on account of disability. This—along with the shortage of available personnel to conduct regular verification—resulted in the VA adopting the policy of being as liberal as possible with disability determinations by accepting sworn statements regarding the circumstances of an injury.[227] Essentially then, the war itself became a de

[226]Administrator of Veterans' Affairs, Annual Report for the Fiscal Year Ended June 30, 1943 (Washington, DC: Government Printing Office, 1943), 43.

[227] Adkins, 168; Annual Report of the Administrator of Veterans' Affairs for the Fiscal Year Ended June 30, 1944 (Washington, DC: Government Printing Office, 1944), 14.

facto presumptive cause of disability for veterans arriving at VA hospitals and benefits claims were adjudicated accordingly.

It is clear that Director Hines tried to adjust the VA systems to accommodate the stresses of the Second World War. He even took the unprecedented (for him) step of decentralizing the administration in certain areas to speed up claims processing—primarily to death benefit adjudication.[228] In all his long tenure, Hines consistently resisted ceding authority to his subordinates, so this move reflects the type of stress under which the VA was operating. And by 1945, those stresses created cracks in the system that spurred the most significant reform of the VA since Hines took over in 1923.

## A Medical Renaissance

On January 7, 1945, journalist Albert Deutsch published the first of a series of articles dedicated to the provision of medical care in the Veterans' Administration. Deutsch was best known for his writing on the treatment of mental illness in the United States. In the 1940s, Deutsch wrote for the *New York Post* on social aspects of health care, and so his series on the VA's medical treatment of veterans in the newspaper *PM* was generally well regarded. That he had been able to secure interviews with top officials, including Administrator Hines, only reinforced Deutsch's credibility. But it was the revelations of abuse of Second World War veterans and his characterizations of VA hospitals as "medical backwaters" that gained national attention.

Deutsch's first article laid out the problems as he saw them. They included fiscally-responsible but otherwise incompetent VA executives, a colossal and slow-moving bureaucracy that would only get worse with the expansion of veterans' benefits through the 1944 GI Bill, and

[228] VA Annual Report 1944, p. 4.

an isolationist attitude within the administration. But perhaps worst of all was a "medieval attitude toward medicine which discourages good doctors from going into Veterans Administration facilities, accepts new creative drugs and devices belatedly and reluctantly, puts a damper on medical research that keeps a medical staff alert and advanced, and checks mutually helpful cooperation with medical groups and facilities outside the veteran field."[229] Recall that under Hines, the VA catered to the concerns of Congress and the veterans' service organizations, which primarily revolved around the efficient and budget-conscious management of expanded benefits. As long as Hines kept these two constituencies happy, he faced scant critique or oversight. Deutch's series thus represented the first significant public review of the VA since the scandalous stories of the Forbes years, some two decades prior.

In his second piece, Deutsch provided a profile of Administrator Hines that was honest, but less than flattering. And it contrasted directly with the reputation Hines had spent so long curating as a capable, politically disinterested public servant. Deutch noted that "nobody doubts Hines's extraordinary skill as a politician who has consolidated and expanded his power under Republican and Democratic regimes alike…. It is said that whenever a Congressman phones the VA for information, Hines insists on handling the call personally. He always lends a sympathetic ear to… requests for jobs on behalf of constituents."[230] The implication being that Hines's interests in direct communication with lawmakers had less to do with courtesy and more to do with prevalent notions of patronage. Deutsch also noted that Hines held similar relationships with veterans' service organizations and that much of Hines's positive reputation stemmed from continued contrasts with Forbes.

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[229] Albert Deutch, "Vet's Setup Needs Revamping Now to Avert Scandal," *PM*, January 7, 1945, 9.
[230] Deutch, "Hines: Darling of the Economy-Minded Conservative," *PM*, January 8, 1945.

Worse, from Hines's perspective, Deutsch implied that the operation of veterans' laws under the VA breeds a particular type of disability—Deutsch called it "pensionitis" or "pension neurosis." This framing was both a reflection of arguments Progressive Era reformers made against the old pension system and the employment of "neurosis" as a word that carried with it significant contemporary stigma—with both meanings reflected in the ostensible objectivity of medical science.[231] Deutsch was essentially arguing, then, that the cycle of ever-increasing bureaucracy, politics, and paternalism in the Hines Administration had brought the issue of veterans' benefits full circle back to the troubling days of the General Law pension system. Medical expertise, Deutsch argued, had been buried by legislation and bureaucratic policy to the point that the system "pays a man to be sick, and pays him more to get sicker… [making] social wrecks of potentially useful citizens."[232] This, of course, was precisely what a benefits system based in medical science and medical diagnosis of disability was supposed to avoid.

Unlike his Progressive Era predecessors, Deutsch did not center his criticisms on the existence of pensions or frame them as a social evil. Rather, he argued that if anything, pensions should be more generous for deserving veterans while criticizing the way the VA administered benefits through a system that encouraged veterans who were capable of medical rehabilitation to instead seek further disability designations because doing so was administratively more efficient. To highlight this process, Deutsch examined cases labeled as psychoneurosis—a sort of catch all for emotional and behavioral disorders that did not meet the standards of a serious psychosis like

[231] J. L. Henderson and Merrill Moore, "The Psychoneuroses of War," *New England Journal of Medicine* 230, no. 10 (March 9, 1944): 273-278.

[232] Deutsch, "How Operation of Vet Laws Breeds 'Pension Neurosis,'" *PM*, January 12, 1945.

schizophrenia but which were nevertheless similarly stigmatized.[233] By designating thousands of veterans with this disability, and by not undermining the social stigma associated with it, Deutsch argued that the VA effectively made gainful employment more difficult for these veterans. And in this regard, the United States Army seemed to agree—at least initially.

## Mental Health and Rehabilitation

There were several notable technological developments in medicine made during the Second World War. One was the adoption of films to expand and improve medical training throughout the armed services. The Professional Medical Film (PMF) series was a collection of motion pictures produced by the U.S. Army to cover contemporary medical training, policy, and other health topics with the intent of improving medical training and practice. One topic covered by the PMF series was the classification and treatment of psychoneuroses.

While the Army Medical Corps was no longer legally required to ensure that every disabled soldier receive medical rehabilitation to the extent possible prior to discharge, it still made attempts to achieve this, particularly regarding mental health. Army officials recognized the existence of stigmas associated with mental health and how poorly it would reflect on the Army if it simply discharged these soldiers into the civilian world. So, the Army decided that a PMF series film could potentially serve as a public relations effort to educate civilians about the steps taken to address neuroses in the Army and that such men were rehabilitated and as capable of employment

[233] Roy R. Grinker and John P. Spiegel, *War Neuroses* (Philadelphia: The Blakiston Company, 1945). Contemporary works like that of Grinker and Spiegel note the significant stigmas associated with neuroses despite distinct medical designations.

as anyone.[234] The Signal Corps tapped Major John Huston to make a film tentatively entitled "The Returning Psychoneurotics" in June 1945.

John Huston was already an accomplished Hollywood director of *Maltese Falcon* fame when the war broke out. Like some of his colleagues, he enlisted and ended up working in the Army Signal Corps, producing feature films, propaganda films, and documentaries for the military. His popularity with general audiences, it was hoped, would ensure that as many Americans as possible viewed this new documentary on the effective treatment of neuropsychoses.

Huston was given free rein to research and explore Army medical facilities for his documentary. He selected Mason General Hospital on Long Island because it was the largest military psychiatric institution on the East Coast, because the doctors and staff at the hospital were sympathetic to the cause of the film, and because it was conveniently located to Huston's studios in New York City. Huston decided that the best way to document the efforts at Mason General would be to follow a cohort of patients through their entire rehabilitation process, from admittance to discharge.[235]

As documentary techniques go, Huston's approach was well ahead of its time. His crew set up cameras in the receiving room and started filming as soon as patients filed in. The hospital's receiving officer told the men they were being filmed, that it was part of their treatment—and it was, as the psychiatrists were curious about the effect the filming would have on that treatment—and that the cameras would follow them the whole time. Huston set up two cameras for each individual interview. One camera on the patient, the other on the physician. In this way, Huston

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[234] Gary Edgerton, "Revisiting the Recordings of Wars Past: Remembering the Documentary Trilogy of John Huston," in Gaylyn Studlar, David Desser, and John Huston, *Reflections in a Male Eye: John Huston and the American Experience* (Washington, DC: Smithsonian Institution Press, 1993).

[235] Scott Simmon, "*Let There Be Light* (1946) and Its Restoration," National Film Preservation, 2012.

captured genuine and candid presentations of psychiatric disorders, the behaviors of attending physicians, and reactions to therapy.[236] The result was a documentary that featured real patients in a real hospital with honest portrayals of war-induced psychiatric trauma and the Army's efforts to therapeutically rehabilitate the same.

For Huston, the project was an enlightening experience bordering on the religious. Suffering from what he called "a mild form of anxiety neurosis" after having spent months filming the fighting in Italy, Huston found he could relate to the traumatized men being treated at Mason General. And he was encouraged by the care and professionalism of the staff. This inspired Huston to rename the film *Let There Be Light*—a reference to Genesis 1:3 and an allusion to the effect of revealing truths previously considered too frightening or shameful to acknowledge.[237] It thus appeared to Huston, the physicians at Mason General, and the patients—who all signed off on their inclusion in the film—that the presentation would have the desired effect in undermining some of the stigmas surrounding mental health disability.

Unfortunately, Huston's film was censored by the Army in 1947. It was never publicly screened. Army officials were apparently concerned that acknowledging that one in five combat veterans of the Second World War suffered mental trauma of some form could potentially hinder recruitment efforts just as it looked like the nation might be on the verge of war with the Soviet Union.[238] Ironically, this reasoning only reinforced the very stigmas the film set out to undermine. Regardless, when the Army tasked Huston with making the film in 1945, the military was—or at

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[236] Gary Edgerton, "Revisiting the Recordings of Wars Past: Remembering the Documentary Trilogy of John Huston," in Gaylyn Studlar, David Desser, and John Huston, *Reflections in a Male Eye: John Huston and the American Experience* (Washington: Smithsonian Institution Press, 1993).

[237] Studlar, Desser, and Huston, *Reflections in a Male Eye*.

[238] Aaron Jackson, "Making a Mythos: Treating Neuroses in Army Medicine after World War II," conference presentation, Society for Military History, April 2022.

least important elements of it were—every bit as concerned about the treatment and perception of veterans suffering mental health disabilities as Albert Deutsch.

Deutsch's reporting in *PM* inspired similar investigations from journalists and magazines with larger national audiences. Albert Q. Maisel—a prolific author known in particular for covering the social aspects of medicine—wrote critiques of the VA system for both *Cosmopolitan* and *Reader's Digest*.[239] With this kind of exposure raising citizens' concerns about the treatment of Second World War veterans, Administrator Hines felt compelled to defend himself and the VA. On March 21, 1945, Hines wrote the editor of *Cosmopolitan*, contesting the portrayal of VA care and wondering if the "desired end to be attained" by the criticism "would justify the worry, apprehension, and lack of confidence that it has caused thousands of relatives of veterans, the veterans themselves, and others interested in [their] medical treatment."[240] Beyond the concern these articles caused, Hines argued that any such cases were anecdotal, and that the official record was a testament to the VA's care of veterans.

Taking these arguments a step further, Hines requested Congress perform its own investigation of the VA, confident that he and his administration would be vindicated. In that investigation, some of the more scandalous accusations were dismantled by VA officials, but others were confirmed.[241] And given the public's veneration of veterans at the time, any such scandal was too much.

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[239] Albert Q. Maisel, "Third-Rate Medicine for First-Rate Men," *Cosmopolitan*, March and May 1945.
[240] Frank T. Hines, Letter to the Editor, *Cosmopolitan*, March 21, 1945.
[241] Investigation of the Veterans' Administration with a Particular View to Determining the Efficiency of the Administration and Operation of Veterans' Administration Facilities: Hearings Before the Committee on World War Veterans' Legislation, House of Representatives, Seventy-ninth Congress, First Session, Pursuant to H. Res. 192 (79th Congress, 1st Session) a Resolution to Direct the Committee on World War Veterans' Legislation to Investigate the Veterans' Administration (Washington, DC: Government Printing Office, 1945). https://www.google.com/books/edition/Investigation_of_the_Veterans_Administra/7vtLjgEACAAJ?hl=en&gbpv=1

In his last article about the VA, Albert Deutsch interviewed one Robert Hegler, a conscientious objector during the war who was assigned to be an attendant at the veterans' hospital in Lyons after refusing service in the armed forces. This was a fairly common practice with conscientious objectors who were drafted.[242] They were often tasked to other areas of critical need so that the government could make some use of them and potentially free up someone else for military service. Mr. Hegler kept a diary of events at Lyons, noting several disturbing incidents:

The second day I worked on the wards at Lyons, I was assigned to the disturbed ward. The most conspicuous patient on the ward was a young fellow, a veteran of this war, who was tied to a chair with a sheet. He was loud and abusive in his language, and cursed the attendants in wholesale fashion. One of the attendants told him to shut up. When the patient refused, the attendant threw several vigorous body punches into him. Five other attendants, including a head attendant, looked on without comment…. Later, I saw a hyperactive but non-resistant patient slugged in the face by an attendant immediately after the patient had been tied to chair with a leather strap. I protested mildly and was angrily ordered to leave. Two days later, the chief nurse called me into her office and transferred me to another ward, while the attendant who had hit the patient stayed on.[243]

Deutsch noted that Hegler's diary contained at least fifty similar instances of abuse at the Lyons facility and that, while Helger's report of these abuses spurred the VA to announce an investigation in November 1944, more than two months had passed without a report from the administration—a delay that reinforced Deutsch's earlier critiques about a ponderously slow bureaucracy. And as if to cut off the anticipated response, Deutsch noted that nothing would be

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[242] Kali Martin, "Alternative Service: Conscientious Objectors and Civilian Public Service in World War II," The National WWII Museum, *The War* (October 16, 2020). https://www.nationalww2museum.org/war/articles/conscientious-objectors-civilian-public-service.

[243] Robert Hegler, quoted in Albert Deutsch, "Report Still Awaited on Probe at VA Hospital," *PM*, January 19, 1945.

accomplished by firing a few individual attendants. Rather, he said, problems like the abuses reported by Hegler were systematic, even cultural, and could only be addressed with proper training in the treatment of mental health patients.[244] Deutsch's points resonated with the public. And despite Hines's best efforts to stay in front of the story, the uproar only grew until by April, it caught the attention of President Truman.

Truman, having been recently elevated to the presidency with the passing of FDR, was almost instantly beset with questions from the press about whether he had any plans to "shake up" the VA in response to the reporting. Truman replied that he had no such plans but promised that "the VA will be modernized."[245] And on June 7, 1945, the President shocked the press by announcing that he was accepting the resignation of Administrator Hines and naming General Omar Bradley as the new head of the agency.[246] Bradley was an inspired choice to head the VA to restore confidence in the administration, but his appointment also presented an opportunity for significant reforms in veterans' healthcare.

## Opportunity and Reform

As one of the chief military commanders of the Second World War, Bradley had celebrity status with the American public, who knew him to be a capable, successful commander who emphasized good manners and a calm demeanor in his leadership. All of which made him, in President Truman's mind, a perfect fit for the VA position. The only problem was that Bradley didn't want it.

Bradley experienced a meteoric rise in his military career between 1942, when he commanded a single infantry division, and 1945, when he commanded the 12th Army Group,

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[244] Deutsch, "Report Still Awaited."
[245] "Veterans Bureau Will Expand; Hines to Stay, Truman Declare," *New York Times*, May 16, 1945, pg. 36.
[246] "Bradley to Succeed Hines As Veterans' Agency Head," *New York Times,* June 8, 1945, pg. 1.

consisting of 43 divisions and more than 1.3 million men—the largest collection of American troops ever assembled under a single field commander. Bradley reported only to General Dwight D. Eisenhower, the Supreme Allied Commander, General George C. Marshall, the Army Chief of Staff, and the President of the United States. Shortly after the surrender of Nazi Germany, Bradley expected a reassignment, but he was not expecting it to be to the Veterans' Administration.

In his memoirs, Bradley admitted that, at the time, he "knew nothing about the Veterans' Administration" and that he was "reluctant to go to any desk job in Washington before the war with Japan was over, especially one outside the Army and one that seemed on first blush so inconsequential and demeaning…. The only job I wanted was Chief of Staff of the Army."[247] But, he noted, he could not refuse the assignment. A request from the Commander in Chief was tantamount to an order, and Bradley was a good soldier.

That Bradley was popular and capable made him a good fit to restore public trust. That he demonstrated remarkable capability to adapt to and manage complex organizations meant he was well-suited to tackle an organization like the VA. But perhaps most importantly, the fact that his professional ambitions lay elsewhere—and even his ignorance of the VA to that point—meant that Bradley was well situated to make effective changes at the VA. Unlike Hines, Bradley did not have decades of connection to Congress, to the existing bureaucracy, or to the veterans' service organizations. He was a trusted, capable, and disinterested professional, but he had his work cut out for him.

Bradley approached the problem as he approached planning for a military operation—studying the situation, listing objectives, identifying obstacles, and setting priorities. The challenges were manifold. In addition to the pressures of the war—primarily personnel and other

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[247] Omar Bradley and Clay Blair, *A General's Life* (New York: Simon & Schuster, 1983), 439.

resource shortages—the passage of the G.I. Bill of 1944 complicated matters. With the passage of that law, the VA had become "the world's largest social welfare agency, the biggest life insurance agency, the biggest dispenser of pensions, the biggest medical agency, and a huge bank, guaranteeing loans to veterans for homes, businesses and farms and providing funds for rehabilitation and education."[248] This, of course, made the VA the focus of intense and often competing political pressures. And then there was the issue of demobilization.

The war with Japan ended far sooner than most believed possible, and just like after the First World War, significant pressure built up to "bring the boys home" as quickly as possible. Bradley was familiar with the Pentagon's carefully crafted plans to gradually demobilize over a period of three years to mitigate and hopefully prevent the very type of chaos that so troubled the nation after the First World War, but he fully expected those plans to be scrapped under the pressure, and so they were.[249] Wholesale demobilization commenced in October 1945, and by 1946, nearly thirteen million newly minted veterans returned to civilian life. The primary effect of this, for the VA, was that the population of potential VA beneficiaries had exploded from about 5 million in August 1945 to nearly 17 million by June 1946.[250] Applications for benefits soon piled up, and the VA's existing bureaucracy didn't have the bandwidth to handle it.

Hines's administrative preferences for running almost everything through the central office in Washington, D.C. may have been effective in turning the mess that was Forbes's Veterans' Bureau into a functional and efficient administration in 1923, but these same policies created enormous obstacles in 1946. The central office could process, at most, about 75,000 pieces of

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[248] Bradley, *A General's Life*, 447.

[249] Tyler Bamford, "The Points Were All That Mattered: The US Army's Demobilization After World War II," *The War*, The National WWII Museum, August 27, 2020.

[250] Administrator of Veterans Affairs, Annual Report for Fiscal Year Ending June 30, 1946 (Washington, DC: Government Printing Office, 1947), 1.

correspondence a day. It was receiving letters at a rate of 300,000 per day.[251] Much of this mail had to do with compensation claims. Many service members were being encouraged by fellow soldiers, family members, and veterans' service organizations to file compensation claims with the VA "whether they believed they had any justification for it or not."[252] Even with the liberalized policy of accepting sworn statements as the basis for service-connection of a disability still in place, the adjudication process for these claims required the VA to engage additional medical rating boards to establish the existence of a compensable disability in each case.[253]

To address this, Bradley enacted a large-scale reorganization effort that delegated central office authority to regional offices in the nation's largest cities—with each effectively becoming a small-scale VA in its own right and each supervised by a deputy administrator authorized to make decisions. In turn, each branch was divided into regional offices in smaller towns and cities, and these branches were authorized to hire staff at the local level, provided they emphasized hiring veterans.[254] This allowed the VA to dramatically expand its workforce from 65,000 to over 200,000 personnel in just two years while simultaneously ensuring that the majority of new VA employees were also veterans capable of relating—and sympathetic—to veterans' needs. This handled the administrative bandwidth. To address the medical part of claims adjudication, rather than a hindrance, demobilization proved to be a benefit.

While the war required medical personnel to be pulled away from their civilian occupations, demobilization provided an opportunity for the VA to temporarily expand the

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[251] Bradley, *A General's Life*, 449.

[252] Adkins, 196.

[253] Ibid. This was different from the cases that were being admitted to VA hospitals during the war, who were almost exclusively medical discharge cases wherein the existence of a disability was self-evident. A claim made as a service member was being discharged still needed medical authorities to validate the existence of a disability.

[254] Administrator of Veterans Affairs, Annual Report for Fiscal Year Ending June 30, 1946 (Washington, DC: Government Printing Office, 1947), 2.

workforce of medical staff to process claims without competition from the military branches or other concerns. This expansion of the medical boards allowed the VA to put itself on pace to address the entire backlog of Second World War claims by June 1946.[255] But adjudicating claims was only the tip of the iceberg with relation to providing medical benefits to veterans.

Medical care proved to be a particular challenge—one that Bradley recalled as the most significant he experienced in his tenure with the VA. Albert Deutsch was not far off the mark when he described VA hospitals as "backwaters of American medicine." This was due primarily to Hines's persistent reticence to adjust the VA's Medical Division to keep pace with contemporary medical developments. Recall that the White Committee recommended academic affiliation in 1923—an arrangement that would allow the VA to benefit from the nation's leading medical schools and allow those schools the benefit of access to VA hospital patient populations. Hines refused to take this step because, as a medical layman, he feared it would result in veterans being the subjects of medical experimentation and receiving subpar care.[256] By refusing this recommendation, and by restricting medical research in the VA to the VA alone, Hines effectively isolated VA medicine and allowed it to stagnate. While VA hospitals were on par with their civilian counterparts in 1923, by 1945, they had fallen well behind the curve. Bradley recognized this, but he also recognized that he had no experience in healthcare systems. So, he turned to Major General Paul R. Hawley, who had been the Chief Surgeon for the European Theater in the Second World War, to serve as the VA's new Medical Director.

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[255] Ibid., 12-13. Also, "another material advance toward equalizing benefits for veterans was achieved by the enactment of Public Law 458, Seventy-eighth Congress, approved 27 June 1946. This act provided a single effective date, 1 April 1946, for all increased rates under a revised Schedule for Rating Disabilities which VA had prepared and published in the fall of 1945."

[256] See pg. 78.

Paul Hawley was a career military medical officer with extensive experience, but he had little experience running civilian institutions like the VA with one exception: his supervision of some of the greatest medical talent the United States had to offer during the Second World War. As in the First World War, doctors, nurses, and other healthcare professionals from the nation's top medical institutions answered their nation's call in the Second World War. That meant Hawley ended up supervising some of the most talented medical outfits available while serving in Europe. He recognized their talent and capability and wanted to bring that with him to the VA. To do that, he had to overcome one significant obstacle: the United States Civil Service Commission.

The most pressing issue in VA medicine was the need for quality physicians. In 1945, the VA only had 2,300 full-time physicians on staff, but 1,800 of those were "borrowed" from the military.[257] When their service contracts expired, the VA would only have a little over 500 physicians to fill an immediate need of 3,500 and a potential need of as many as 7,000.[258] Complicating these staffing concerns, the VA was then obligated to go through the Civil Service Commission to hire new staff. Civil Service had its own elaborate bureaucracy, providing federal agencies with lists of eligible hires. Of the 80 or so doctors listed by the Civil Service as eligible for VA appointments in 1945, Hawley noted that more than half were of retirement age and most had not kept up with contemporary medical practices.[259] Even worse, the types of physicians Hawley wanted to bring to the VA—the young, professional, well-educated doctors he served with in Europe—were generally turned off from Civil Service work because it offered poor pay, a

[257] Administrator of Veterans Affairs, Annual Report for Fiscal Year Ending June 30, 1946 (Washington, DC: Government Printing Office, 1947), 70.

[258] Adkins, 192.

[259] Hearings Before the Committee on World War Veterans' Legislation, House of Representatives, Seventy-ninth Congress, First Session on H.R. 4225, "A Bill to Establish a Department of Medicine and Surgery in the Veterans' Administration" (Washington, DC: Government Printing Office, 1945), 39.

stagnant seniority system, and a prolific red tape. With Bradley's support, Hawley helped craft a bill that would exempt VA from Civil Service hiring requirements for certain types of employees—notably physicians. Congress passed this law and the President signed it in January 1946, but direct hiring of physicians only alleviated the immediate concern. Hawley was more interested in reforming the entire VA healthcare system to better serve veterans and provide "medical care second to none."[260] This required not only providing top notch medical services but also promoting medical research and education as well.

To achieve this, Hawley partnered with Dr. Paul B. Magnuson—an eminent orthopedic surgeon and prominent figure in academic medicine at the time. Dr. Magnuson, like many of his colleagues, was intrigued by the possibilities of academic affiliation between the VA and the nation's leading medical institutions. Through such partnerships, the VA could assist in training new healthcare professionals and support medical research that would not only help veterans but all Americans.[261] This was essentially the same recommendation made by the White Committee back in 1923.

Hawley and Magnuson presented a three-point program to Administrator Bradley consisting of reforms in medical care, research, and education—noting that each was integral to the capability of the other two. Their proposal became official with the issuance of VA Policy Memorandum No. 2 on January 30, 1946, which framed the relationship between the VA and academic medical institutions.[262] The VA would retain responsibility for the care of patients while the partnered medical school accepted responsibility for all graduate education and training.

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[260] Adkins, 220.
[261] Adkins, 209.
[262] Department of Veterans Affairs, "Policy Memorandum No. 2," January 30, 1946. https://www.va.gov/oaa/Archive/PolicyMemo2.pdf

Affiliated schools would work closely with associated hospital managers to establish programs that benefited both institutions. And from these programs, the VA would assemble a Special Medical Advisory Group (SMAG) that could be consulted for all medical matters from the direction of medical education to the provision of care for veterans to determinations of disability.[263] By 1946, then, academic institutions became a foundational partner in the provision of veterans' benefits and even the very definition of what it meant to be a disabled veteran.

The influence of such affiliation on the development of the modern veterans' healthcare system simply cannot be overstated. It resulted in a mutually-beneficial partnership that increased the VA's access to physicians in both quantity and quality, it provided medical institutions access to a significant patient population that proved invaluable to medical research and education, and it resulted in advancements in care that made the whole system more efficient.

Take the development of outpatient care for tuberculosis, for example. TB still represented a significant portion of disability cases in VA hospitals in the 1940s. In fact, in 1947, it was the largest cause of hospitalizations among veterans of the Second World War, with each patient occupying a VA hospital bed for an average of 150 days.[264] That same year, the VA began implementing outpatient TB treatments developed through the Cooperative Studies Program—a joint research venture between the VA and affiliated medical schools—with the result of freeing up many thousands of hospital beds for other patients. By 1951, the average tuberculosis patient in VA hospitals was occupying a hospital bed for only about 90 days.[265] Like other reform efforts

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[263] The SMAG was formally adopted as policy with the passage of Public Law 79-293, "An Act to establish a Department of Medicine and Surgery in the Veterans' Administration," (Washington DC: Library of Congress, 1946).

[264] Administrator of Veterans Affairs, Annual Report for Fiscal Year Ending June 30, 1947 (Washington, DC: Government Printing Office, 1948), 3-4.

[265] Administrator of Veterans Affairs, Annual Report for Fiscal Year Ending June 30, 1952 (Washington, DC: Government Printing Office, 1953), 21.

during and in the years immediately succeeding the Bradley Administration, these reforms were often predicated by an immediate, pragmatic need—in this case, the need for more hospital beds. But also like many of those reforms, the solutions proposed by officials Bradley brought on board—like Hawley and Magnuson—served both the immediate and long-term necessities of the VA healthcare system.

Bradley, Hawley, and Magnuson were thus able to capitalize on the opportunities presented by these pressures to reform and improve the concrete institutions of the VA to better serve the abstract institution of providing care for veterans. In less than two years, they could boast that the VA provided "medical care, second to none." And the policy of academic affiliation in particular ensured that VA medicine would continue to remain among the best in the nation. Writing for *Look* magazine in 1947, Albert Deutsch pronounced that VA medicine had undergone a revolution that "infused the whole hospital program with the spirit of modern, scientific medicine."[266]

With these changes complete, both Bradley and Hawley left the VA in 1947. The dust was still settling from their reforms and the new bureaucratic infrastructure was finding its place. But in their short tenure, Bradley and Hawley managed to restore public faith in the institution of the Veterans' Administration and establish a partnership with academic medicine that would guide future development to the benefit of veterans and contemporary medicine alike. But for at least one class of disabled veterans, contextual shifts would not be so fruitful.

**Shades of Gray - Shifting Values in a New Context**

By 1948, the efforts to modernize the VA had borne fruit. The combination of affiliation with academic medical centers, bypassing Civil Service hiring requirements, and the establishment

[266] Albert Deutch, *Look*, 1947. Specific article title and date still needs to be determined. The LOC has a *Look* archive.

of cooperative research programs ensured that not only was the VA flush with medical expertise and delivering quality care, its close association with scientific medicine ensured that it would continue to keep pace with developments in the field. The VA had 125 hospitals in operation, all fully staffed, and plans to build as many as 90 more to meet the needs of the nation's 20 million veterans as they aged.[267] These results were due to significant institutional shifts in priorities and culture made possible by the pressures exerted by the Second World War, and the administrative team of Bradley, Hawley, and Magnuson took advantage of the opportunity to institute lasting reforms in their short tenure with the VA. But the context that made that opportunity possible was temporary, and priorities quickly shifted from crisis management back to peacetime standards of achieving economic and bureaucratic efficiency.

An example of this contextual shift can be seen with the way the military addressed the public portrayal of psychiatric casualties. Recall John Huston's film *Let There Be Light*, which was commissioned in 1945 to educate the public about the efficacy of the Army's mental health treatment program and to undermine stigmas associated with psychiatric disorders. News of the film and its contents had started to spread, raising excitement among contemporary psychiatric professionals about the film's potential.[268] But by the time the film was ready for screening, the cultural and political contexts had shifted considerably.

Huston screened the film for Army approval in February 1946. He asked for and received permission from the Army Public Relations office to give a screening at the Museum of Modern Art in New York, but minutes before the film started rolling, military police arrived and confiscated Huston's personal print. The Army had censored the film—ostensibly for violating

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[267] Administrator of Veterans Affairs, Annual Report for Fiscal Year Ending June 30, 1948 (Washington, DC: Government Printing Office, 1949), 5-6.

[268] "Stress Psychiatric Films by H'wood as Aid to Rehabilitation of War Vets," *Variety* (Feb. 27, 1946).

patient privacy—and it remained classified and hidden from public view until 1981. Apparently, by 1946, the Army had bigger concerns than convincing the public of the efficacy of its mental health treatment programs.

The passage of the G.I. Bill and a booming postwar economy meant that, unlike previous wars, veterans of the Second World War had relatively little difficulty obtaining employment. This undermined any potential economic motive for Huston's film. More pressing, however, was the context of the emerging Cold War. Many military leaders fully expected a war to break out between the United States and the Soviet Union, and under such circumstances, they were keenly sensitive to anything that might affect recruiting or imply American weakness.[269] Huston's film opened with the relatively shocking—but completely accurate—statistic that "20% of all battle casualties of the American Army during World War II were of a neuropsychiatric nature."[270] That alone might have qualified the film for censorship, but other factors played a significant role as well. One significant factor was the state of contemporary psychiatry.

Prior to the war, military psychiatrists supported the theory that thorough induction screening could reduce and possibly eliminate battlefield neuroses by "weeding out" soldiers with weak mental constitutions. This theory was based on the hereditarian framework developed from Sigmund Freud's early theories.[271] Indeed, some 12% of potential draftees were eliminated through induction screening for this purpose. But the theory did not hold up to reality.

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[269] Bradley, *A General's Life*, 478-483. In 1948, Bradley became Army Chief of Staff following his tenure as VA Administrator, and he noted that the U.S. Army was in such a state that it could "barely fight its way out of a wet paper bag," let alone hold up to the Red Army, but he saved such public commentary for his memoir for obvious reasons.

[270] Huston, *Let There Be Light*, 1946. Film. Opening scene (00:33). Any assumptions about the Army's motives for censorship, unfortunately, remain assumptions as the Army is not releasing its reasons for initial censorship.

[271] Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (Hove, UK: Psychology Press, 2015), 104. It's worth noting that Freud himself, after 1918, argued that this theory was flawed.

The sheer number of psychiatric casualties suffered by U.S. forces obviously undermined its logic, and by 1944, the military abolished psychiatric induction screening.[272] But during the war, military psychiatry was full of some of the best minds in the field—men who left academia and private practice to support the war effort. This cohort of psychiatrists rejected hereditarian frameworks and stressed who psychiatrically-impaired soldiers experienced normal reactions to abnormal environments.[273] But with the end of the war, most of these doctors returned to civilian careers and control of military psychiatry reverted to career military physicians who remained entrenched in hereditarian explanations of disease.

The Army replaced Huston's film in the PMF series with one that better suited the new context. Directed by Joseph Henabery, PMF 5047 was initially titled *The Neuro-Psychiatric Problem in the Army*, but—perhaps again highlighting the Army's concerns about appearances—the title was changed to *Shades of Gray* when the film was released in 1948.

Henabery clearly attempted to emulate Huston's work. He used the same camera angles, covered the same types of neuroses and treatments, and shared the same statistics—though Henabery buried these in the middle of his film rather than bring attention to them at the beginning.[274] But it is the differences between the two films that speak volumes.

First, while Huston documented real patients with genuine presentations of disease, Henabery utilized actors to imitate patient behaviors. Ostensibly, this protected patient privacy, but in practice, the actors and staged scenarios in *Shades of Gray* simply reflected contemporary stigmas and assumptions about mental health disorders. In *Let There Be Light*, patient responses

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[272] Carol Schultz Vento, "World War II Psychiatric Wounds of War," *Defense Media Network*, April 25, 2022.
[273] Allan V. Horwitz, *PTSD: A Short History* (Baltimore: Johns Hopkins University Press, 2018), 71.
[274] Scott Simmon, "*Let There Be Light* (1946) and Its Restoration," National Film Preservation Foundation, 2012.

and presentations are genuine. In *Shades of Gray*, the actors mope, whine, talk softly and cry because they either assume that's what they're supposed to do or because they have been directed to do so.

Second, the audiences of the two films are notable. Huston's was intended to educate the general public, but Henabery's was intended for a much more select group of newly-inducted and contracted military psychiatrists and physicians, whose responsibilities would, once again, include induction screening.[275]

And perhaps most importantly, while Huston's film reflected contemporary psychiatry's view that anyone could fall victim to combat neuroses under the right circumstances, Henabery's film shifted blame from military service, pinning it on society in general and overanxious mothers in particular—and it does so with all the grace of a rampaging bull in a China shop. *Shades of Gray* opens with a literal bang as a soldier experiences an anxiety attack at the grenade range, putting himself and others in danger. The montage continues with examples of soldiers overcome with emotions, constantly visiting sick call for maladies about which doctors can find nothing physician wrong, and expressing "jittery" behavior after spending days under enemy fire. The narrator helpfully explains that these problems are not due to military service; rather, he explains that "the foundations of… mental health are laid in infancy."[276] The scene shifts to that of a young mother raising her son. By ensuring a sense of security through constant attentiveness in a nuclear family environment—meaning the father is almost never around—and by allowing the baby to experience

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[275] Robert A. Cardona and Elspeth C. Ritchie, "U.S. Military Enlisted Accession Mental Health Screening: History and Current Practice," *Military Medicine* 172, no. 1 (Jan. 2007):31-35. World War 2 accession standards were viewed as "excessive" so the mental health criteria was reevaluated with an emphasis placed on morale, leadership, and secondary screening.

[276] United States Army, Joseph A. Henabery, director, *Shades of Gray*, film, 1948, 07:16.

and overcome difficulties on his own as he grows up, the mother is helping him develop "a sound foundation of emotional and mental health."

The implications that alterations to such a healthy foundation could result in harm is clear, but Henabery goes on to make the point explicit through another example. A second child "has a mother who is overanxious, afraid to let him expose himself to the smallest danger. As a result, instead of getting over his earlier fears, he tends to hold on to them and exaggerate them."[277] The child in this second example grows up to become the soldier who freezes at the grenade range in the opening scene.

Essentially, then, *Shades of Gray* depicts mental health disorders as social problems inherited by the Army—problems apparently rooted in poor mothering techniques—making the film an apologetic that excuses military service from any responsibility for psychiatric casualties. According to the film, all Americans have some level of mental health disorder—some "shade of gray," with darker shades indicating proclivity for psychiatric trauma. Military service thus does not cause such disorders, it merely exacerbates what is already there.

To drive the point home, Henabery highlights what his target audience—again, newly-inducted and contracted military healthcare workers—can do about the issue. The film notes that rigorous induction screening can "eliminate… those who have little chance of withstanding the strains of Army life," and subsequent treatments per Army standards can "salvage" a little more than half of all psychiatric casualties incurred.[278] By insisting on these goals, the film better fit the

[277] Ibid., 10:35-13:21.

[278] Ibid., 16:51-17:44 for induction screening; 50:49 for salvaging psychiatric casualties. The film notes that 40% of psychiatric casualties in the combat area in WW2 were returned to full duty after processing at division clearing stations, another 20% were able to be "salvaged" to noncombat roles.

Army's pragmatic concerns about protecting and preserving its combat effectiveness and utilizing preventative measures to limit the incidence of such casualties—such weakness.

By framing mental health disorders so, *Shades of Gray* not only reflected contemporary stigmas, it amplified them. By 1948, the film was being widely distributed throughout the Army to train new generations of military physicians and healthcare workers, while *Let There Be Light* gathered dust in a secure storage facility for classified material.

That shift had significant implications for veterans suffering mental health disorders. It meant that several subsequent generations of veterans experienced something remarkably similar to those filmed by John Huston in 1945: a feeling of hopelessness and isolation.[279] That is not to say that the Army or VA would have necessarily been any better prepared to help such veterans had Huston's film not been censored. But considering the alternative was a film that—intentionally or not—made a mockery of mental health disabilities, attributed their causes to childhood and poor mothering, and classified them as things that needed to be eliminated by the very authorities that were supposed to be helping certainly begs the question: did these subsequent generations of veterans feel more helpless and isolated because prevailing stigmas were not undermined earlier? Was this an instance of an opportunity lost?

## Conclusions: Institutional Influences

Institutions come in two general types: the abstract and the concrete. Abstract institutions reflect communal values and concrete institutions serve the interests of those values. We have hospitals to care for the sick, a military to defend the people, and so on. And when concrete

[279] U.S. Army, John Huston, director, *Let There Be Light*, film, 1946, 03:52.

institutions fail to properly support their abstract foundations, the concrete can crack and shift, creating opportunities to reinforce or even rebuild structures to better fit the ideal.

Regarding veterans and the nation's obligations to them, this process has gone through several iterations. The late-nineteenth century gave rise to the provision of pensions that grew ever more generous—to the point of testing the limits of the nation's obligations to its veterans. Critics attacked the system and reformers made plans to overhaul it entirely, resulting in the incorporation of modern scientific medicine as an improvement that would ostensibly avoid the pitfalls of the pension programs. What's more, modern medicine appeared to hold the promise of rehabilitating disability entirely—or as entirely as possible given the limits of contemporary medical science. That tantalizing promise is still there, today.

But it soon became obvious that putting the promise of medical rehabilitation into practice required a specialized, concrete institution to administer these newly-conceived benefits. And so the Veterans' Bureau was established. And when scandals of corruption and malfeasance under Director Charles R. Forbes threatened to cause a public outcry, the Veterans' Bureau experienced its first significant fissure and opportunity for reform. The old structures were torn down, the leadership replaced, and new foundations were developed under the watchful eyes of Gen. Frank T. Hines. His long tenure gave the impression of a successful institution, but his reluctance to keep up with developments in contemporary medical practice set the stage for the institution's second fracture point. Under the stresses of the Second World War, the foundations cracked again as the public learned of the Veterans' Administration's poor treatment of at least some veterans of the Second World War and came to realize the poor state of medical practice in VA hospitals. The new leadership of Gen. Omar Bradley, Gen. Paul Hawley, and Dr. Paul Magnuson developed plans to modernize VA medicine and largely succeeded in their endeavor despite a short and tumultuous

tenure. VA hospitals—finally partnered with the nation's leading academic medical institutions—could by 1948 boast of providing care "second to none," and the new foundations of veterans' medicine ensured such quality care would continue in the future.

That was not the last fracture point in the history of the VA, and there will likely be more in the future. The cycle of construction, fracture, and reconstruction is a necessity for concrete institutions as they react to shifts in the abstract notions they serve. Each phase of fracture and reconstruction shapes possibilities of subsequent development.

But these moments of change tend to be reactive rather than proactive. Each shift sought to address an immediate concern—the difficulty of applying for benefits in the 1920s, the incompetence and corruption of Forbes and his lieutenants, and the lumbering and calcified bureaucracy established in Hines's long tenure. And despite significant changes, each shift also witnessed significant continuities. Service-connected designations of disabilities, for instance, have been a constant throughout the history of the provision of veterans' benefits with relatively little criticism or analysis. This is, in part, because the notion of service-connected disabilities receiving priority over non-service-connected cases fits the underlying notion of veterans' part of the bargain. The American people owe veterans care for disabilities incurred *during* service, not necessarily otherwise, and therein lie the seeds of subsequent—and potentially future—fractures in the system's foundations.

In the next chapter, I will examine how veterans as patients experienced and navigated the hospital-centered veterans' healthcare system that emerged after the Second World War, where they found fault with the institutions and cracks in its foundations, and how they exercised their agency to reform the system from within.

## 3) THE PTSD PIVOT: PATIENT ADVOCACY, AGENCY, AND AUTHORITY

### "Prom Dresses and Survivor's Guilt"

July 2022, Veterans' Center, California

I pulled into the parking lot of an old bank for a weekly meeting with a group of fellow combat veterans. I had been coming here for nearly a year and a half and it still seemed a bit of an odd place. It was obvious the building hadn't been a bank in a while, but it still looked like one. The old drive-thru stalls were being used for parking, now. The only thing that marked this as a government building was the sign on the door that declared it to be a Vet Center. Back in the 1980s, these facilities started popping up in working-class neighborhoods and suburbs across the United States, but I didn't know about their existence until I needed one. Despite its seemingly odd location, I have no doubt this place saved my life, and I think plenty of others would say the same—including some of the veterans I was meeting.

I parked the car, grabbed my folding chair out of the back, and trekked across the lot to a shady spot where five older men and a VA counselor were already sitting in a circle and talking. The old men were all Vietnam veterans. Most served in the Army like I did. Most were drafted for the war. All of them had seen combat. Buck—the self-styled "shot to shit Marine" who survived four bullet wounds in Vietnam—waived at me and pointed to a box of donuts in the middle of the circle.[280] That was part of the ritual of these meetings. Buck brought the donuts and insisted we all have one. Thankfully, he has fine taste in donuts. I took a chocolate bar and settled in.

The conversation had been going for a bit by the time I arrived, so I was thankful that eating my donut allowed the opportunity to catch up. Today's topic: prom dresses. I have to say, I never

[280] While everyone in this group gave me permission to recount this story, I have changed the names out of an abundance of concern for privacy.

would have expected to have a conversation about prom dresses with other combat vets before joining this group, but after attending these meetings for a while, it wasn't really the strangest topic of discussion.

There's always small talk at these gatherings, and these older guys have all lived long lives full of experiences outside the military. One was in law enforcement, another was a defense attorney. One ran a newspaper for a while, another spent a career on the railroad, and yet another used to own his own auto repair shop. They all had families—wives, kids, ex-wives, and lots of grandkids these days—and talking about family was usually the subject of the small talk. I figured that's how the conversation turned to prom dresses.

Several of the guys had daughters and granddaughters and they were taking the opportunity to communally air their grievances about the expense and hassle of the whole prom thing. This segued into recounting tales of giving "the talk" to young men who came to take their daughters to the dance. Apparently, the cliche about frightening young boys with implications of violence should any harm come to one's daughter held up with this group.

My donut finished, it was time for me to join the conversation—another part of the ritual. Everyone participates. Everyone checks in. I didn't have a prom story—the closest I could come to anything like it was the day I met my in-laws. Bailey and I had been dating only a few weeks at the time. I was still in the Army and nervous as hell because her dad is a retired lieutenant colonel. I was just a corporal. Corporals don't talk to colonels if it can be avoided. Turns out, I had nothing to fear. I got on great with Bailey's folks and always have. Her mother was certainly concerned about my plans to get out of the military, though. She kept asking for confirmation: "You're getting out, though, right?" Yes, ma'am.

And so I did. I left the Army in January 2006, but it wasn't exactly an easy decision. I mean, I certainly liked Bailey a lot more than I liked the Army, but I had reservations about getting out, too. See, my unit—the 1/501st (first of the five-oh-first)—was just a little over a year back from Afghanistan back then, and we were busy training to go back to war. We didn't know where or precisely when, but we knew it would happen, and my company leadership wanted to keep me around. The First Sergeant (aka "Top") was trying the stick approach—withholding an earned promotion until I agreed to re-enlist. The Captain tried the carrot.

"The same thing happened to me," said Adam—one of the other veterans. He had been an infantry company's radio telephone operator back in Vietnam. He was one of those guys who knew his draft number was coming up and decided to get it over with by enlisting, first. Apparently, the Army took that as a sign of potential career material. "They offered me officer's candidate school if I stayed in," he continued before grinning. "I told them, uh, how about NO!" We all chuckled. My decision wasn't quite so easy as Adam's, though there were similarities. If I re-enlisted, the Captain promised not only would I get that promotion that Top had been blocking, he'd get me orders for officer's candidate school when we got back from the next deployment. In the meantime, he'd send me back to my old platoon. That was the real temptation.

I had been pulled from my platoon and stuck in the training room—a largely administrative job—because the previous company commander wanted someone who could type in that position. I was good at the job, but it chafed to be away from my guys to push paperwork while they were training for war. More important, though, was the fact that my best friend was still in that platoon. Wright and I had been together since our first day in the Army. We were assigned to the same platoon in Basic Training and again in both Airborne School and the Ranger Indoctrination Program. We both received orders for the 501st and figured we'd finally be split up once we got

to the unit, only to have the streak continue as we both ended up assigned to the anti-tank platoon. That kind of thing just doesn't happen in the Army. The only difference was that, while Wright signed up for six years, my contract was up in four. But, if I re-enlisted and went back to my old platoon, the streak could continue a while longer. We could keep watching each other's backs, just like we had since the first day in the Army. That was tempting.

So, I talked about the Captain's offer with Wright. He didn't hesitate for a second before telling me to turn it down and get out—that I had done my bit. It felt like he was letting me off the hook, and maybe he was. He knew me like a brother and understood that I was on the fence about letting him and the rest go back to war without me. So, he may have chosen to make the decision easy for me. "Get out. Go live a soft civilian life with Bailey. You've earned it," he said. So, that's what I did. A few weeks after that conversation, I was a civilian again.

Bailey and I moved in together, and I worked odd jobs to support us while she finished school. We got engaged on Veterans' Day 2006—my first as an official veteran. And the next year, Wright and the 501st deployed to Iraq while Bailey and I moved to Colorado. I kept up with the guys, of course. I sent them care packages and letters because I remembered how important those things were when we deployed to Afghanistan. It was a strange experience to be on the other side of a deployment—to be worried about your buddies and know you couldn't do anything about it. But I dealt with that by doing what I could. I kept up with their families, made sure they were good and shared news. It made me feel at least somewhat connected to what was going on "over there." So, when I got a call from Wright's wife, it didn't trigger any alarms. I answered the phone.

"You weren't there," she said, sobbing.

A giant pit opened up in my gut—not just in the event, but again in retelling the story for the other vets at the Vet Center. They all groaned at this part of the story. They understood just

how devastating it is to hear those words, and the implications of what that did to me inside. I appreciated that, but at that particular moment, I was more concerned about the fact that I was re-experiencing the emotions from the day I got that call as if no time had passed at all. Tears welled in my eyes, my chest felt tight, and I was suddenly mad as hell at myself.

I took a few slow breaths to calm down and get some distance from the well of emotion. That was one of the techniques I learned at the Vet Center—to recognize anger as a reaction to something deeper, to step back form it and examine it without shutting it down, and to figure out the message under the reaction. Sometimes that process is easy. Most of the time, it's hard as hell. That's what makes groups like this one so important: we can help each other when the emotions are too strong or confusing. It takes trust, of course, but that's easier to establish with folks who have gone through similar experiences. I trusted these guys, and they were there to support me, to hear my story, and to help carry its burden. I swallowed and continued, hoping that the next part of the story would help. I needed them to know the whole thing so they could help me sort it all out.

While on patrol in Iraq, Wright's truck had been hit by a new type of improvised explosive device called an explosively-formed penetrator (EFP). The Iranians designed these things to penetrate armored vehicles and gave them to militias in Iraq, who used them against American troops.[281] They were damn effective, and a whole array of these things exploded by Wright's truck. He should have died.

That he survived was an enormous relief, of course. Some of the tension left my body just saying it out loud. But I was still mad and said so. Someone asked why I was mad. "Because she was right," I said. "I wasn't there."

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[281] Andrew Tilghman, "DoD discloses data on Iraq War deaths linked to Iran," *Military Times*, Sept. 16, 2015.

Adam leaned forward in his chair, a very serious look on his face. “What the fuck makes you think anything would have been different?” He could be blunt, but he was always genuine and definitely cared about the rest of the group. “Don’t do that! Don’t tell yourself that you could have changed anything. You don’t know! Hell, it could have been worse!” The rest of the group agreed with Adam. So did I. I understood that beating myself up about it was irrational—I’d been telling myself that for fifteen years. But it was different hearing it from these guys. It was validating.

Buck spoke up and everyone grew quiet. “Aaron,” he said, “what you’re describing is a classic case of survivor guilt. It’s tough, I know. After my first battle, I always wondered if I could have done anything to save my buddies. I couldn’t, but I beat myself up about it for years and nothing good came from that. It’s okay to feel that way, but you need to process all that shit. Forgive yourself. And the sooner, the better.” Buck could be blunt, too. “I think all of us who experienced combat experienced something like that. We all come away changed.”

Most of the group agreed again, but this time Dave interjected. He’d been a helicopter pilot back in Vietnam, and an officer. “That’s what bothers me,” he said. “We agree that combat changes *everyone*, but why is it *us* who are here, in this group right now? Where’s everyone else? What’s wrong with *us*?”

No one else in the group had a good answer to that one. I know that I had wondered that same thing about myself since experiencing my mental collapse and having to call the Veterans’ Crisis Line. What was wrong with me? The shared silence told me I wasn’t alone in that thought.

At this point, the counselor stepped in. There’s always a trained VA counselor at these group sessions to make sure the conversation stays safe and to intervene when necessary. Usually, these counselors are veterans themselves. It helps clients know that the counselors understand the contexts and experiences of being a veteran.

“That’s just it,” said the counselor. “There isn’t anything wrong with you guys in this group. As we always say, these are normal reactions to abnormal circumstances. Survivor’s guilt, PTSD, all of it. The fact that you’re here working on it doesn’t mean you’re worse off or different than other combat vets—there’s nothing wrong with you. It just means that doing this is what is helping you. Everyone has a different path to walk. In fact, you being here means you’re probably better off, because you’re finding ways to deal with these experiences that aren’t harmful.”

That made sense to me, and the nods and grunts of the other guys told me they agreed. We had all experienced the other ways of dealing with this stuff: the muscling through, ignoring it when you could, self-medicating when you couldn’t. It never got better that way. But coming to the Vet Center was different. Whether it was for individual counseling or to meet in a group like this, it was helping. It was certainly hard—harder than opening a bottle and having another bender, that’s for sure—but unlike those efforts at self-medication, this was actually working. And I was so thankful for that.

When I was offered that impossible choice at the VA Medical Center—to admit myself to the emergency department or to go and get a disability rating—I was able to get help here because the Vet Center didn’t have the same care access requirements. These facilities were designed on a care-first, paperwork second model. And during my crisis, being able to talk to a counselor, sort out my emotions, and talk to others going through he same things, all on my terms, oddly enough gave me hope again. And this particular meeting reinforced by appreciation of this place.

I hadn’t talked about the incident of getting that phone call with this group before. I had no plans to talk about it at all and may not have even thought about it if not for the odd direction of the conversation winding from prom dresses to survivor’s guilt. Not all of these group meetings end up with a big emotional revelation like that, of course. But when they do, it’s good to be able

to share it with folks who understand. The pit in my stomach didn't entirely go away, but it felt smaller. And now that I knew it was still there, I could work on it. We could work on it together. And that's huge—knowing someone who understands is there to watch your back and counting on you to watch yours. It helps.

**Homecoming: Readjustment Counseling Services**

In 2016, journalist and author Sebastian Junger published the book *Tribe: On Homecoming and Belonging* to explain why American society is particularly difficult on combat veterans' ability to readjust to civilian life. A few of my Army buddies recommended I read it, but at the time I was up to my eyeballs in my Master's program studies. The copy I purchased sat on my bookshelf for years. After my mental health collapse, when I was trying to make sense of why it happened, the counselor at the Vet Center recommended I finally read it.

Junger's argument is essentially that modern American society ironically undermines the systems to which humans have evolved over thousands of years to find connection and meaning within their communities. The resulting disconnect is particularly acute—or perhaps just particularly visible—in combat veterans. These evolutionary social structures are hardwired into our neurology. They're what make our species so successful at survival. We have built-in reward and punishment systems that dictate social behavior, but it only really works at small scales like extended family units or tribes—groups about the size of an infantry platoon, which is essentially a surrogate family. But with its size, complexity, and relative anonymity, modern American society undermines these evolutionary structures, which in turn exacerbates the already difficult experience of social reintegration after exposure to trauma, like combat.[282] Junger points out that

[282] Sebastian Junger, *Tribe: On Homecoming and Belonging* (New York: Twelve, 2016), 55, 124-125.

"given the profound alienation of modern society, when combat vets say they miss the war, they might be having an entirely healthy response to life back home."[283] That resonates with me.

Part of the reason I became interested in the history of veterans' status in society was due to my interactions with civilians and other veterans shortly after coming back from the war. I found that conversations about my service with civilians were often difficult, frustrating, and potentially perilous—even with folks I knew particularly well, like friends and family. It was as if I suddenly spoke a new language but couldn't figure out how to translate certain expressions or phrases so they could understand. And the frustration of that resonated with my personal fears. Will they understand what I mean? Will they think I'm a monster? Or, perhaps worse, will they call me a hero and thank me for my service without knowing what any of that entailed?

In contrast, conversations with veterans—even perfect strangers—were remarkably easy. It was as if the translation barriers fell away and the relief of that burden was palpable for both parties. I looked forward to talking to other veterans regardless of their service while I worried about conversations with civilians.

Navigating the perils of civilian interactions—those moments when someone realizes you are a veteran—can be difficult enough at the best of times. But when you're experiencing an acute mental crisis brought about by chronic conditions, wracked with self-doubt, paranoia, and suspicion, it can be impossible hard. Many veterans worry about being stereotyped.[284] Others worry that civilian healthcare professionals—even those who work for the VA—will not be able to relate to or understand their issues. To be fair, this is a concern shared by many caregivers.[285]

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[283] Junger, *Tribe*, 78.

[284] Office of the Chairman of the Joint Chiefs of Staff, "Veteran Stereotypes: A Closer Look," White Paper, October 2014. https://www.jcs.mil/Portals/36/Documents/CORe/141024_veteran_stereotypes.pdf.

[285] American Osteopathic Association, "Civilian physicians feel underprepared to treat veterans, survey finds," *Science Dailey*, 2015. https://www.sciencedaily.com/releases/2015/06/150611122542.htm.

Establishing trust is a key element to healthcare, after all. That's part of the reason why being able to go to a Vet Center was such a big deal for me and hundreds of thousands of veterans like me over the years. Unfortunately, not many veterans know about Vet Centers or what they do.

The Veterans Administration officially began the Vet Center program in 1979 with the recognition that significant numbers of Vietnam era veterans were experiencing persistent difficulties transitioning back to civilian life.[286] These community-based counseling centers, staffed primarily by veterans located in innocuous neighborhood settings like strip malls and old banks, build upon experiences and contexts endemic to veteran cultures to establish trust, ease the transition process, provide counseling, organize peer support, and help with referral and other services in a non-institutional setting. These are not hospitals full of well-meaning but inexperienced experts. They're more like outpatient clinics that provide qualifying veterans, servicemembers, and their families a measure of flexibility in their treatment options while simultaneously relieving pressure on the VA hospital system.

Today, Readjustment Counseling Services (RCS—the official name for the Vet Center program) includes more than 400 facilities across the nation, including Mobile Vet Centers to extend their outreach and accessibility even further. They provide a broad range of mental health centered services including individual, group, and family therapy, military sexual trauma (MST) counseling, employment assessment, housing assistance, substance abuse treatment referrals and more. In 2021 alone, RCS provided services to 216,809 unique clients, supported 32,415 outreach

[286] "Veterans' Health Care Amendments of 1979, S. 7," U.S. Senate, Hearing before the Committee on Veterans' Affairs (1979). The initial law provided readjustment counseling for "any veteran who served on active duty during the Vietnam era who requests such counseling within two years from discharge or within two years after the date of enactment of this Act."

events, and supported the VA's natural disaster response efforts.[287] RCS receives only a minute fraction of the VA's annual budget, but its utility serves as a force multiplier for the wider veterans' healthcare system. And for the vets involved, Vet Centers represent an alternative model of care access—one that doesn't require the standard administrative disability designations and instead relies on an ever-expanding list of other qualifying conditions.

As an alternative to the standard, disability-based VA care model, Vet Centers provide a point of comparison with the wider veterans' healthcare system and its priorities. And the history of the development of the RCS program demonstrates how patient veterans exercised agency in shaping the veterans' healthcare system and access to care.

The timing of the RCS program was not spontaneous. In 1974, the United States pulled the last American forces out of the conflict in Vietnam. Veterans of that war made up a significant portion of the total veteran population at the time, but not a majority—a distinction from pervious conflicts as veterans of both World Wars immediately outnumbered their predecessors at the end of those wars.[288] This meant that the veterans' healthcare system at the time emphasized addressing the needs of an aging Second World War and Korean War veteran population. Combined with congressional priorities on achieving fiscal efficiency in the VA since 1947, Vietnam veterans found themselves in a strange competition with older vets for ever more limited resources. It was a competition in which they were at a disadvantage because their older peers, by dint of their greater numbers, held more sway with established power structures in the veterans' service organizations and lawmakers. While national commitment to the idea of supporting veterans

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[287] Department of Veterans Affairs, *FY 2023 Budget Submission*, "Medical Programs and Information Technology Programs," Volume 2 of 4, March 2022, 213-214.

[288] VA Annual Report, FY 1979, ps. 2. Korean War veterans shared this experience, but enough of the Korean War veteran population overlapped with the Second World War population that, by and large but with notable exceptions, the two groups were essentially lumped together.

remained strong in general, Vietnam era vets had to make do as second-class members of an unspoken hierarchy, undermining the then-young veterans' already shaky trust in institutional medicine and the quality of care provided.

This coincided with ongoing reverberations of the Civil Rights Movements that were so active in the sixties and seventies. As the nation struggled to come to grips with civil rights, it was simultaneously struggling with its passionate ambivalence regarding the Vietnam War and those who fought it. Combined with new deployment methods that replaced the movement of entire units with individual replacement, many veterans felt particularly isolated upon returning home. Their buddies were often still overseas, the war was ongoing, there were no victory parades or commemorations to mark their return, and it was up to them to find ways to engage with society and the VA without any guidance. Exacerbating this still further, growing public hostility to the war and policy spilled over into the public perception of those who fought it, resulting in a strange mix of sympathy, pity, disappointment, fear, and even hostility directed at Vietnam veterans.[289]

At the same time, contemporary psychiatry was finally developing the definition of post-traumatic stress disorder (PTSD)—the culmination of work that began in the First World War. The inclusion of PTSD in the third edition of the *Diagnostic and Statistical Manual*—the authoritative guide to the diagnosis of mental disorders—paved the way for a new classification of veterans' disabilities, but also one that carried significant social stigmas. Veterans had to find ways to seek care for this condition while undermining the associated stigma.

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[289] Jerry Lembcke, *The Spitting Image: Myth, Memory, and the Legacy of Vietnam* (New York: New York University Press, 1998).

All of these factors conjoined to create particularly difficult circumstances for Vietnam era veterans. This situation is perhaps best represented in popular memory by Oliver Stone's 1989 film *Born on the Fourth of July*.

**Advocacy: Born on the Fourth of July**

Based on the autobiography of Ron Kovic, a Marine Corps veteran, activist, and author, the film *Born on the Fourth of July* received rave reviews in the popular press. Writing for *The New York Times*, film critic Vincent Canby said the film was "the most ambitious nondocumentary film yet made about the entire Vietnam experience."[290] the film received eight nondocumentary Academy Award nominations and won two, including Oliver Stone's second award for Best Director, and it held the number one position at the box office for three weeks straight.[291] The popularity of the film may not reflect a serious desire on the part of the American people to understand the Vietnam War, but it certainly reflected and shaped public perceptions of the war.

Ron Kovic was born on July 4, 1946. As part of the Baby Boomer generation, he grew up doing what many boys his age did by idolizing and romanticizing the wartime service of his father's generation. He bought into the traditional patriotic themes—the flag waving, barbecues, parades, and most importantly, the promotion of American values and exceptionalism. A devout Catholic, Kovic was strongly influenced by President John F. Kennedy's call to service in his inaugural address: "Ask not what your country can do for you; ask what you can do for your

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[290] Vincent Canby, "How an All-American Boy Went to War and Lost His Faith," *The New York Times*, Dec. 20, 1989, pg. 66-67.

[291] Oliver Stone's first award for Best Director was for *Platoon* in 1987, which was a semi-autobiographical account of Stone's experiences in Vietnam. That Stone was himself a veteran, interested in speaking out against the war, explains why he wanted to direct *Born on the Fourth of July* and tell Ron Kovic's story. Box office results courtesy of Box Office Mojo, "Born on the Fourth of July (1989)," IMDb.

country."[292] Kovic felt he was answering that call when he enlisted with the Marine Corps in 1964 and volunteered for service in Vietnam.

Kovic experienced several traumatic situations in Vietnam, including the accidental killing of a fellow Marine and firing on civilians including children before ultimately being shot himself while on patrol in the Demilitarized Zone in January 1968. One of the bullets that hit Kovic ripped through his spine, leaving him paralyzed from the chest down.[293] the fact that Kovic was wounded just before the Tet Offensive in 1968 makes his personal story align rather well with the generalized American experience of Vietnam. Before his injury, Kovic, like America, was generally optimistic about the war and believed in the cause. It was his injury that forced him to reckon with the nature of the war, just as it was the Tet Offensive that forced the American public to do the same. American support for the war was never universal, but the general trend began a serious decline in 1968.

Evacuated to the United States, Kovic recuperated at the Bronx VA Hospital near his family home. The hospital itself was a former Catholic orphan asylum acquired by the federal government in 1922 to serve as a veterans' hospital.[294] By 1970, the facility was in such a state of neglect that the conditions attracted the attention of journalist Charles Childs, who wrote an Albert Deutsch style expose for *Life* magazine about it.[295] The report, of course, didn't help Kovic, who described the Bronx VA as having slum-like conditions with overcrowded, filthy, rodent-infested

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[292] Ron Kovic, *Born on the Fourth of July* (New York: McGraw-Hill, 1976); Ron Kovic, "Anti-war & Veterans Rights Activist," *Americans Who Tell the Truth*, https://americanswhotellthetruth.org/portraits/ron-kovic.

[293] Kovic, *Born on the Fourth July*.

[294] "Veterans Hospital Opens in the Bronx," *The New York Times,* April 16, 1922.

[295] Charles Childs, "From Vietnam to a VA Hospital: Assignment to Neglect," *Life* 68, no. 19 (May 22, 1970): 24-33.

wards. This was a long way from the "medical care second to none" that Hawley and Bradley fought so hard to achieve in 1946.

It's important to note that the Bronx VA hospital was likely an outlier in the VA hospital system, but perhaps not by much. As early as 1948, Congress began pressuring the VA to economize its budget, and this pressure gradually and incrementally built over the decades until, by the late 1960s, many VA hospitals were underfunded and understaffed, and the oldest—like the Bronx VA—were literally falling apart.[296] When Kovic decided to move to California, he hoped conditions on the West Coast would be better, but found that the state of the Long Beach VA Hospital's spinal cord injury (SCI) wards were just as bad, if not worse.[297]

SCI wards treat some of the most severely-injured veterans, and the poor state of the wards added insult to injury for the veterans who relied on them. They were often ignored by staff, left to sit in their own filth for hours, and stuffed into overcrowded wards riddled with pests.[298] For vets who already sacrificed their bodies for their nation, such neglect not only violated their honor as veterans but also their basic dignity as human beings. Some, like Kovic, decided to speak out and protest this treatment.

While Oliver Stone's film summarizes Kovic's activism with groups like Vietnam Veterans Against the War (VVAW), it skips over an important part of Kovic's story that highlights the impetus for the Vet Center Program and the evolution of veterans' healthcare in the 1970s. In

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[296] The number of VA hospitals between 1946 and 1980 peaked in 1955 at 172. Providing an analysis of how much money was spent per hospital and how well each was maintained would be difficult. In 1952, the VA changed its accounting categories in its annual reports, and again in 1955, 1961, and so on. One would have to examine individual hospitals' records for an accurate account.

[297] Ron Kovic and Robert Scheer, "Ron Kovic and the Continuing Struggle for Veterans," *Scheer Intelligence*, KCRW, Feb. 19, 2016.

[298] Childs, "From Vietnam to a VA Hospital," *Life*.

1974, Kovic and fellow plegic veterans and allies decided to occupy portions of the Federal Office Building in Westwood, California to bring attention to their plight.

While living in Los Angeles in 1973, Kovic once spent 93 days in the SCI ward at the Long Beach VA while healing a bed sore—a common and potentially life-threatening complication for those with paralysis. During his stay, Kovic realized that several of the other veterans were as fed up with the state of their care as he was, and he began organizing them using methods he learned at VVAW with the goal of gaining public attention and pressuring the government to enact reforms.[299] Due to his earlier experiences with VVAW, Kovic believed that organization's limited membership similarly limited its political impact. The solution, he thought, was to broaden the scope. So, he created the American Veterans' Movement (AVM) with the goal of including veterans from other wars, and Kovic believed the best place to start this new movement was with his fellow SCI ward veterans.[300]

On February 12, 1974, Kovic managed to convince several other paralyzed veterans to go with him to the Federal Office Building in Westwood for what he told them was an arranged meeting with Senator Alan Cranston, member of the Senate Committee on Veterans Affairs, to air their grievances.[301] Soon, a veritable convoy of wheelchair bound veterans was crossing Los Angeles to advocate their cause.

When the veterans arrived at the Senator's offices on the 13th floor of the Federal Office Building, Kovic, Bill Unger, John Adams, and several others decided to organize an impromptu

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[299] It's worth noting that VVAW emulated organization and activism techniques of more established Civil Rights groups including the NAACP, SNCC, and the Black Panther Party.

[300] Gerald Nicosia, *Home to War: A History of the Vietnam Veterans' Movement* (New York: Carroll & Graf, 2004), 308.

[301] Ibid. Kovic knew that Senator Cranston was in Washington D.C. at the time and admitted that he lied to his fellow vets to get them to come with him, but many of the veterans decided to stay anyway, and this lie was effective in getting the VA staff to allow the large group of veterans out of the SCI wards for the trip.

sit-in hunger strike by taking over one of the rooms in the office and barricading themselves inside. They styled themselves as the beginning of the American Veterans' Movement (AVM) and demanded to speak with both Senator Cranston and Donald E. Johnson, Administrator of the Veterans Administration.[302] Cranston, whose offices were directly impacted, was amenable to a meeting and sympathetic to the veterans' plight. Administrator Johnson, on the other hand, was less inclined.

Donald Johnson was a former agricultural businessman, a veteran of the Second World War, and former head of the American Legion who received President Richard Nixon's appointment to head the Veterans Administration in 1969. Like many other Nixon officials, Johnson was sensitive to perceived criticism of his administration from "leftists," which included organizations like the Vietnam Veterans Against the War and Kovic's offshoot AVM. Johnson prided himself on the VA's accomplishments expanding home loan and educational benefits in his tenure—both of which were at record highs.[303] But his record regarding the provision of medical care was not so well polished, so he felt personally attacked by any criticisms in that department and for good reason.

Johnson's policies in the medical care of veterans had pushed the system to the brink in his efforts to save money. He was already facing significant criticisms from members of Congress like Senator Cranston and Representative Olin "Tiger" Teague, a World War II vet and Medal of Honor recipient who accused Johnson of malfeasance in the administration of the VA.[304] Believing AVM to be a splinter of the "militant" VVAW, and seeing nothing but an opportunity to garner more

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[302] Nicosia, *Home to War*, 325.

[303] VA Annual Report FY 1973, pg. 3-6. Johnson was particularly proud that VA educational benefits increased veterans' median incomes by more than $3,000 per year.

[304] Nicosia, *Home to War*, 308.

congressional criticism by acceding to AVM's demands, Johnson initially refused to meet with the veterans occupying Senator Cranston's offices in Westwood.[305] That changed on February 25—thirteen days into AVM's hunger strike—when independent White House correspondent Sarah McClendon confronted President Nixon about the strike directly.[306] Johnson was thus forced to meet with the group or confirm criticisms that he and the President were inconsiderate of veterans' issues.

Administrator Johnson flew from Washington, D.C. to Los Angeles on Thursday, February 28. Once there, he insisted that he could only meet with the AVM veterans on VA property, demanding that AVM's representatives meet him in the VA offices on the 7th floor of the federal building. AVM responded that they were weak from their hunger strike and noted that the Administrator had already traveled all the way across the country for this meeting—what was the difference of six more floors? Johnson refused to budge, left the building, and flew back to D.C., resulting in a public relations nightmare for the Nixon administration.[307]

Johnson's demands of the veterans, flippant attitude to their condition, and refusal to travel six more floors after having crossed the entire country certainly seemed to confirm AVM's and others' accusations that VA management was insensitive to the needs and grievances of Vietnam veterans. Almost as soon as he got back to D.C., Johnson flew back to Los Angeles and met with AVM members and the press in Senator Cranston's office on March 3, 1974.[308] Reporters noted that Johnson brought two VA security guards to the meeting, implicating that the Administrator feared violence from paralyzed veterans.

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[305] Jon Nordheimer, "Veterans' Group Ends 19-Day Sit-In," *The New York Times*, March 3, 1974, pg. 21.
[306] "Miss McClendon Tells Nixon He's Misinformed on G.I. Aid," *The New York Times*, February 26, 1974, pg. 23.
[307] Nicosia, *Home to War*, 331.
[308] Jon Norheimer, "Veterans in Sit-In Meet Head of V.A.," *The New York Times*, March 3, 1974.

At the meeting, John Adams—a severe, thin, red-headed veteran—leaned forward in his wheelchair and demanded more funding for veterans, noting that "if the Government can allocate $85 billion for bombs, why can't it allocate more than $2.5 billion for men's bodies busted up by bombs?"[309] Johnson objected to Adams's figures on the VA budget only to be interrupted by Kovic.

"John didn't have time, like a lot of us, to go to college and learn all about statistics," Kovic said. "He was too busy fighting the war. But he knows when he is mistreated. He knows when he is being abused and made distraught in your hospitals."[310] After that, Johnson remained relatively quiet while the veterans aired their grievances and proposed reforms, which included quality control committees to inspect VA facilities, the creation of a hotline staffed by qualified VA employees to provide vets with referral services and to report complaints, and outpatient centers to meet the special needs of combat veterans—the last demand being very similar to what would become the Readjustment Counseling Services program. Johnson promised to take AVM's concerns under advisement and follow up with another meeting in a few weeks.

The strike was over, and it seemed that AVM had achieved a victory. Their activism garnered the support of powerful figures like Senator Cranston and Representative Teague in Congress. It gained the attention of the press, who in turn educated the public about the state of VA hospitals. The resulting public and political pressure forced the administration to listen to their demands. But achieving reform was not quite so simple.

Administrator Johnson met with AVM again on March 25 at the Wadsworth VA Hospital, a few blocks away from the Westwood Federal Building. The meeting was less than productive.

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[309] Nordheimer, "Veterans' Group," 21.
[310] Ibid.

Johnson came to the meeting armed with reports that highlighted the achievements of his administration; the AVM provided witness testimony from paralyzed veterans who claimed abuse in VA hospitals. In response to this testimony, Johnson attacked the character of the veteran witnesses, noting that two of those giving testimony had not been paralyzed during the war—a point that smacked of the VA's hierarchical preference of service-connected disabilities. This, of course, outraged members of the AVM, who demanded Johnson's resignation, at which point the Administrator left the room.[311]

The American Veterans Movement fell apart after trying and filing to replicate the Bonus March of 1932 for their cause, and Administrator Johnson resigned his post without implementing any of AVM's demanded reforms. But AVM's hunger strike was not the entirety of veterans' efforts to enact agency in pushing for reforms—it was just a relatively visible example and one likely necessary to demonstrate the resolve of affected veterans. Other efforts proved more successful in achieving the types of policy reforms that ensured veterans' access to quality care on more liberal terms.

## Agency: Taking Care Into Their Own Hands

Vietnam era veterans had good cause to advocate for better care and facilities. The veterans' hospital system of the 1960s and the early 1970s was dramatically different than the one reformed by Omar Bradley and Paul Hawley in the 1940s. The VA was still affiliated with the nation's leading medical schools—indeed, the residency programs were remarkably successful—meaning access to the best medical minds was not a problem. Indeed, the VA healthcare system continued to operate under the advisory guidance of the Special Medical Advisory Group

[311] Nicosia, *Home to War*, 332.

(SMAG), which consisted of some of the best medical minds in the country. But the SMAG's role was purely advisory. It was up to VA officials, and ultimately Congress, to provide the VA with the resources it needed. And between 1947 and 1974, there was a consistent pressure on the VA to eliminate inefficiencies and improve the bottom line. Combined with the fact that Second World War veterans continued to make up the majority of the nation's veteran population and membership in veterans' service organizations with their lobbying power, this meant that younger veterans often found their needs falling lower on the priority list than their predecessors'.

For instance, when the arrival of 3,500 Marines in Vietnam marked the beginning of the American ground war in 1965, the VA was operating 168 hospitals with a total bed capacity of 120,509 to serve a total veteran population of 21.7 million. By 1968, when American troops levels in Vietnam peaked at more than half a million, the VA was down to 166 hospitals and 115,108 operational beds. This despite the fact that the total veteran population grew to 23.1 million.[312] That same year, VA Administrator William Driver noted in a SMAG meeting that the VA could expect to see the veteran population grow by as much as 70,000 each month for the duration of the conflict in Vietnam.[313] Yet, the SMAG's physicians noted that Congress only seemed interested in veterans' care for the wounded and the elderly, essentially neglecting to plan or provide for those making the transition from one category to the other.

Vietnam veterans and healthcare professionals noticed this neglect as well. Without the overwhelming numerical support that the Second World War generation enjoyed, they were forced to turn to other avenues for redress. Thankfully, the wider Civil Rights Movement provided

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[312] Data collated from VA annual reports, FY 1947-1974, with particular emphasis on FY 1965 and 1968.

[313] "Veterans Administration Minutes of the Semi-Annual Meeting of the Special Medical Advisory Group" (December 9, 1968), 8, Record Group 15, Records of the Department of Veterans Affairs, Department of Medicine and Surgery, Records of Advisory Committees, box 19, National Archives and Records Administration, Washington, D.C.

examples of the types of activism and organization that could generate traction while filling the voids in institutional care through grassroots social service efforts.

In 1967, many Americans believed the United States was winning the war in Vietnam and that the cause against the spread of communism was just. Most were content to follow the President's guidance as long as nothing seemed unduly alarming.[314] But not all Americans were so complacent, including a handful of Vietnam veterans who joined a massive crowd of protesters at the "Spring Mobilization to End the War" demonstration in New York City on April 15. One of them, Jan Barry, recalled being against the war but also nervous about the "crazy stuff that was 'the peace movement.'"[315] Initially overwhelmed by the crowd size—some 400,000 strong—Barry soon realized that Vietnam veterans like him had important roles to play in the protests when someone called for veterans to go to the front of the march.[316]

Carrying a giant banner that read "Vietnam Veterans Against the War!" Barry and his fellow veteran protesters noted that the pro-war demonstrators who hurled invectives at the dignitaries and celebrities leading the march grew conspicuously quiet when they realized that veterans were among the anti-war marchers. The mere presence of veterans like himself made the pro-war demonstrators question their position on the war. After the march, Barry decided to start organizing like-minded veterans with the goal of telling their experiences of the war and shaking up American complacency about it. Thus, Vietnam Veterans Against the War (VVAW) was founded as an anti-war organization based on the credibility of direct experience.

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[314] William L. Lunch and Peter W. Sperlich, "American Public Opinion and the War in Vietnam," *The Western Political Quarterly* 32, No. 1 (March 1979): 22.

[315] Andrew E. Hunt, *The Turning: A History of the Vietnam Veterans Against the War* (New York and London: New York University Press, 1999), 10-11.

[316] Hunt, *The Turning*, 11.

Initially, VVAW's members presented a conventional, clean-cut and respectable appearance. They wore suits and crew cuts, participated in debates, and volunteered for political campaigns, reflecting the organization's early emphasis on top-down political reform. Much of their efforts hinged on the election of an antiwar presidential candidate like Eugene McCarthy.[317] But when McCarthy lost the nomination in 1968, VVAW's politically-minded leadership grew cynical and retreated, exhausted after a long and tumultuous campaign season and a year full of bad news coming out of Vietnam. This made space for new leaders and tactics emphasizing change and intervention at the grassroots level and creating opportunities for intersectional activism.

At about the same time that VVAW was coming together, a variety of medical activists were working to address shortfalls in community support and healthcare systems. Physician H. Jack Geiger and the Medical Committee for Human Rights (MHCR) worked in 1964 to support the Freedom Summer efforts in Mississippi and address the inherent health issues of poor, rural, primarily Black communities by creating health centers organized and operated by the communities themselves.[318] Geiger was able to parlay early philanthropic efforts into support from the federal Office of Economic Opportunity to establish community health centers that so impressed congressional leaders like Ted Kennedy that the Senator was able to successfully appropriate more than $51 million to expand the community health center program in partnership with academic expertise.[319]

Meanwhile, prominent mental health professionals argued that community-based clinics could provide services more efficiently and effectively than the then-predominant and problematic

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[317] Hunt, *The Turning*, 32.

[318] H. J. Geiger, "The First Community Health Center in Mississippi: Communities Empowering Themselves," *American Journal of Public Health* 106, no. 10 (October 2016): 1738-40.

[319] John Dittmer, "The Medical Committee for Human Rights," *Virtual Mentor* 16, no. 9 (2014): 745-48.

asylums—the idea being that smaller, more responsive clinics combined with psychotropic therapies would enable patients to "more readily adapt to their environments" and therefore decrease patient loads on large institutions.[320] These medical developments conjoined with an expansion of the new veterans' activism in the 1970s to create opportunities for veterans to exercise agency in establishing alternative care systems.

By the early 1970s, VVAW experienced exponential membership growth due to several factors. First, members of the growing G.I. Movement—a generally unorganized resistance against military institutions and the war by active duty servicemembers—became veterans and joined VVAW in this new role.[321] Then, the Nixon administration's decision to expand the war into Cambodia along with the Kent State shootings and Hugh Heffner's donation of a full-page advertisement for VVAW in *Playboy Magazine* resulted in tens of thousands of veterans becoming dues-paying members of VVAW.[322]

This was no longer the small organization of politically active, clean-cut vets working out of a small office in New York City. The new VVAW was more grassroots, more confrontational with their activism, even as they retained a basis in peaceful nonviolence. The new members wore their hair long and substituted suits and ties for fatigues and combat boots. Many were drawn to activism by experiencing poor conditions in VA hospitals.[323] While retaining elements of political activism, VVAW's members were interested in helping their fellow veterans get through problems

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[320] Jessica Adler, "Help Without Hassles, Instituting Community-Based Care for U.S. Veterans after the War in Vietnam," *Bulletin of the History of Medicine* 95, no. 4 (Winter 2021): 534.

[321] Art Goldberg, "Vietnam Vets: The Anti-War Army," *Ramparts* 10 (July 1971): 10-17.

[322] "An advertisement for Vietnam Veterans Against the War in Playboy Magazine, February 1971," Vietnam War Era Ephemera Collection, University of Washington Libraries, Special Collections. Hunt, *The Turning*, 68. Membership in VVAW swelled nearly tenfold in early 1971 according to the FBI (FBI File 100-HQ-448092 - Section 2, p. 106), and writing for *Ramparts*, Art Goldberg noted that VVAW had approximately 11,000 members and employed 26 regional coordinators (Art Goldberg, "Vietnam Vets: The Anti-War Army," *Ramparts* 10, no. 1 (July 1971): 14.)

[323] Hunt, *The Turning*, 54.

the VA seemed to ignore, like reintegration. Many had experience working with other social movements and recognized that if they wanted something to be done about veterans' difficulties, they would have to take matters into their own hands, which was a form of protesting the war and the government's negligence of Vietnam era veterans at the same time.

VVAW organized public demonstrations like the Winter Soldier Investigation in January 1971 with the primary intent to publicize war crimes by having Vietnam veterans offer public testimony of their personal experiences. The three-day gathering in Detroit, Michigan sought to make clear that the highly publicized and scandalous My Lai Massacre—news of which had only recently gained national attention—was not a one-off but rather par for the course.[324] This was an effort to expand on the type of openness that VVAW members had been experiencing in informal "rap groups" organized by Jan Barry, Yale University professor and psychiatrist Robert J. Lifton, and New York University psychoanalyst Dr. Chaim Shatan since 1970. And while the Winter Soldier Investigation was largely ignored by the media at the time, the event and the documentary created about it provide some insight into how VVAW activists were trying to link their efforts in activism to therapeutic truth telling sessions similar to the kind that took place in the rap groups.[325]

Lifton and Shatan had initially been drawn to VVAW because of their own antiwar activism, but they soon found they could help these veterans help themselves. The rap groups were informal meetings without any special formula or set procedures. Veterans and therapists got together each Saturday for two hour sessions that sometimes stretched further. Arthur Egendorf, one of the VVAW vets, explained that vets "talked, argued, made up, hugged, got confused, told stories, asked for advice, gave advice, complained, and occasionally laughed…. The rap groups

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[324] Ibid. 55-58.
[325] Nicosia, *Home to War*, 93.

became known as the place where you could tell your story, even the most horrible parts, and people would listen."[326]

The rap group concept spread through VVAW chapters throughout the country. In San Francisco, Jack McCloskey—a combat veteran and therapist—saw the rap groups as a natural extension of VVAW's activism. A way to "take care of its own, as well as trying to stop the war."[327] These groups took on a political edge—they were still an extension of the VVAW—but they remained primarily focused on providing help and mutual support by offering an understanding environment where the veterans could engage with emotions and trauma without the traditional machismo. McCloskey noted that "it was amazing to see the vets open up. The guys actually… became their own therapists. I thought that was beautiful."[328] And the concept soon expanded beyond VVAW.

In Southern California, Army veteran and social worker Shad Meshad took a job with the Brentwood VA Hospital to run a Vietnam veterans' clinic to address the needs of the area's transient veterans. Meshad set up off-site rap groups, visited transient populations along the Venice Pier, and coordinated with area facilities and service providers like the Hollywood Sunset Free Clinic to get veterans hooked up with essential services, but also to give them an opportunity to access the communal support found in these informal rap sessions.[329]

The apparent success of these rap groups in helping veterans process their feelings about the war and the effort to readjust to civilian life sparked calls in veterans' and professional circles for the expansion of community-based care models. These accomplishments were notable, but not

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[326] Arthur Egendorf, *Healing from the War: Trauma and Transformation After Vietnam* (Boston: Houghton Mifflin Co., 1985), 115. Quoted in Hunt, *The Turning*, 87.
[327] Hunt, *The Turning*, 87.
[328] Ibid, 88.
[329] Jessica L. Adler, Shad Meshad Oral History, May 14, 2018, 68, War and Health Collection.

a panacea, and they highlighted the ways in which the government was failing to adapt to the changing veteran environment, despite years' worth of warnings.

In 1969, former Army Captain Max Cleland offered testimony about his experiences in the VA healthcare system to the Senate Subcommittee on Veterans' Affairs. Like Kovic, Cleland volunteered for service in Vietnam in 1967 believing it was his duty to serve his country.[330] During the Battle of Khe Sanh on April 8, 1968, Cleland stepped off a helicopter and noticed a grenade lying on the ground. Thinking it was unarmed and had fallen off his kit, he reached to retrieve it when it exploded, taking both his legs and his right arm.

Originally assigned to Walter Reed Army Medical Center for treatment and recuperation, Cleland was initially assigned to the Officers' Amputee Ward, where he was in the company of peers—young officers who experienced grievous wounds. Cleland credited this company with helping him adjust to his new circumstances, and over the next eight months he began to come to grips with his injuries and grew determined to walk again with the aid of prosthetics. He had just begun the process of being fitted for a pair of prosthetic legs when, on Christmas Eve 1968, he received notice that he had been medically discharged from the Army and would be transferred to a VA facility.[331] Apparently, during his early, painkiller hazed days at Walter Reed, Cleland had signed papers authorizing his discharge and transfer. Such transfers were common in the Vietnam era as the VA worked to alleviate stresses on the military hospital system.

The Washington D.C. VA hospital was a very different experience than Walter Reed. Rather than being surrounded by peers in the Officers' Amputee Ward, he found himself assigned

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[330] Max Cleland, *Heart of a Patriot: How I found the Courage to Survive Vietnam, Walter Reed and Karl Rove* (New York: Simon & Schuster, 2009). Cleland received his commission in 1965 but spent his first two years of service stateside and had to extend his service commitment twice for the opportunity to serve in Vietnam.

[331] Cleland, *Heart of a Patriot*, 77-96.

to a bed in a room with over thirty other men, the majority of them veterans of World War II and Korea. He noted that that "the VA seemed like an old folks' home peopled with doped-up, spaced-out guys, many of whom seemed to have no hope of making it in the outside world." Worse, he noticed that "the most catastrophic war wounds are often the ones that don't leave a visible scar," and that he "had lost my sense of personal identity, my confidence, and my sense of safety and justice."[332] Despairing of a potentially bleak future in the VA hospital, Cleland decided to get an apartment and pursue his rehabilitation on an outpatient basis. One of his neighbors in the apartment building was Pete Lassen, a paraplegic former Special Forces officer and executive director of the Paralyzed Veterans of America—a veterans' advocacy group dating back to the Second World War. Lassen asked Cleland to give testimony at the Senate Subcommittee on Veterans' Affairs because "he wanted the committee to hear from someone with firsthand experience of the VA system."[333]

The subcommittee was chaired by Senator Alan Cranston—then a freshman senator from California. In his testimony, Cleland noted that the Vietnam veteran was "a different animal from veterans of earlier wars, primarily because those who served in Vietnam did not feel like they sacrificed for a noble or just cause…. To the devastating psychological effect of getting maimed… or in some way being unable to reenter American life as you left it, is the added psychological weight that it may not have been worth it."[334] Cleland expressed that, even years after their return home, veterans can be filled with doubts going off like "secondary explosions."

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[332] Ibid., 90-92.
[333] Cleland, Heart of a Patriot, 96.
[334] Cleland, *Heart of a Patriot*, 96; "Examination of the Problems of the Veterans Wounded in Vietnam," Senate Hearings before the Subcommittee on Veterans' Affairs of the Committee on Labor and Public Welfare (1969), 273.

Cleland's testimony—and certainly his physical appearance as a triple amputee—provided the subcommittee with a profound view of the costs of the war in Vietnam and the difficulties many veterans experienced in trying to return from it. His allusion to "secondary explosions" summed up the experience well. While neither Cleland nor anyone else in that hearing room knew it, he was describing a condition that would, in just over a decade's time, become irrevocably associated with the experience of combat veterans.

**Authority: Claiming Ownership of Disability**

Psychiatrists had long recognized the detrimental effects of war on a soldier's psyche, even if they were ambivalent about the precise causes. In the American Civil War, which witnessed some of the most brutal combat experienced by Americans.[335] Yet, very few Civil War soldiers were diagnosed with mental health or nervous disorders. Of those who were, most were given rather vague diagnoses like "nostalgia" or "sunstroke," which was most analogous to a Second World War diagnosis of "combat fatigue."[336] After the war, however, accounts of hospitalized veterans start to show a more familiar pattern. One nurse's account noted a veteran who "fought the rebels all day, tearing his bed and clothes until exhausted."[337] Another hospitalized veteran's notes recorded that he was "restless and sleepless, suicidal…. Imagines he is bleeding to death from imaginary wounds."[338] Many Civil War vets self-medicated with alcohol, laudanum, or opiates.[339] Others sought help from neurologists and often received the vague diagnosis of

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[335] Drew Gilpin Faust, *This Republic of Suffering: Death and the Civil War* (New York: Vintage, 2008), 41. Faust notes that fatalities in the Civil War were proportionately six times that of World War II and sixty-nine times that of Vietnam.

[336] Allan V. Horwitz, *PTSD: A Short History*, (Baltimore: Johns Hopkins University Press, 2018), 21. Eric T. Dean, *Shook over Hell: Post-Traumatic Stress, Vietnam, and the Civil War* (Cambridge: Harvard University Press, 1991), 121, 146.

[337] Brian M. Jordan, *Marching Home: Union Veterans and Their Unending Civil War* (New York: W. W. Norton, 2014), 128.

[338] Dean, *Shook over Hell*, 111.

[339] Horwitz, *PTSD: A Short History*, 24.

"nerves."[340] Despite the lack of any contemporary mental health tracking among these veterans, Civil War historians have uncovered a wealth of anecdotal examples that suggests psychic trauma from the war was widespread indeed.

By the First World War, with the professionalization of psychiatry as a field, it was clearly evident that there was a connection between war and psychiatric trauma. But the cause of that link was up for debate. Soon after the shelling in Europe began in 1914, droves of soldiers began to experience hysterical paralysis, tremors, heart palpitations, loss of sight and hearing.[341]

Many physicians and officers were inclined to label such soldiers as malingerers and cowards, but psychiatrists were not so sure. Some medical professionals theorized that exposure to high explosives could cause small lesions in the brain that could account for the observed symptoms. In 1915, English physician Charles Myers coined the term "shell shock."[342] The term stuck, even though most soldiers who were actually wounded by shells never developed the telltale signs of the condition.[343] While the American experience of the First World War was relatively short, American psychiatrists including Thomas Salmon noted the effectiveness of a particular treatment in dealing with immediate presentations of shell shock. By following the "PIE" treatment—meaning proximity to the battlefield, immediate response, and expectation of a quick recovery—Salmon and his colleagues found that many soldiers, once supplied with a "hot and a cot," would often return to their units of their own accord.[344] But as with the experience of the Civil War, many cases of psychiatric trauma took years to surface. This time, however, there was

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[340] Andrew Scull, *Madness in Civilization* (Princeton: Princeton University Press, 2015), 274.
[341] Horwitz, *PTSD*, 53.
[342] Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge: Harvard University Press, 2000), 97.
[343] Franklin D. Jones, "Military Psychiatry since World War II," in *American Psychiatry after World War II: 1944-1994*, ed. Roy W. Menninger and John C. Nehemiah (Washington, D.C.: American Psychiatric Press, 2000), 3.
[344] Shephard, *A War of Nerves*, 59.

a veterans' health tracking system in place in the form of the Veterans' Bureau and the Veterans' Administration.

In 1933, the VA experienced an unexpected increase in hospitalizations for psychoneurosis. Diagnoses ranged from generalized depression and anxiety to shell shock and psychosis. Out of 71,139 first-time admissions to VA hospitals that year, 60% reported neuropsychiatric distress.[345] But with the Great Depression in full swing, VA officials were inclined to assume the increase was due to "the possibility of a connection between hard times and illness."[346]

By 1941, when the United States began preparedness efforts in the event of entering the Second World War, military officials implemented induction screening policies intended to prevent men "susceptible to breakdowns" from donning the uniform. The notion that a simple fifteen-minute interview could identify such men was supported by psychiatrist Harry Stack Sullivan, who argued that shyness, irritability, substance use, or homosexual tendencies indicated a man likely to be affected by psychiatric casualties.[347] Additional psychiatric screening after induction resulted in another three-quarters of a million draftees' separation from the service.[348] Rather than being based on empirical evidence, screening criteria often fed on contemporary social biases and assumptions. In any event, it quickly became apparent that this screening was not effective as psychoneurotic casualties poured into Army hospitals as soon as Americans saw combat. Indeed, roughly twenty percent of all battlefield casualties in the war were psychiatric in

[345] VA Annual Report, FY 1933, 11.
[346] Adkins, 146.
[347] Horwitz, *PTSD*, 68. Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (Hove, UK: Psychology Press, 2015), 104.
[348] Jones, "Military Psychiatry since World War II," 7.

nature.[349] By 1944, military officials abandoned screening altogether because it had not reduced the incidence of combat neuroses.[350]

By 1945, Army officials recognized that many of their psychiatric casualties faced significant social stigmas and worried that these stigmas would create an employment crisis after the war.[351] Officials tasked Army Major and famous Hollywood director John Huston with making an educational film that would highlight the Army's efforts and successes in treating psychiatric casualties.[352] Huston spent significant time documenting efforts at Mason General Hospital on Long Island, creating a documentary that not only highlighted the efforts of Army psychiatry to treat these casualties with the latest techniques, but one that had an impact on Huston himself. Suffering what he called a "mild form of anxiety neurosis" after having spent months filming the fighting in Italy, Huston found himself relating to the raw depictions of mental and emotional trauma captured at Mason General, and he was encouraged by the care the hospital staff provided the patients. He called the film *Let There Be Light* in reference to Genesis 1:3 and alluding to the effect of revealing truths previously concealed as too frighting or shameful to acknowledge.[353]

But by the time Huston's film was ready for publication in 1947, the context had changed significantly, and Army officials decided to censor *Let There Be Light*.[354] The passage and success of the G.I. Bill of 1944 combined with a booming postwar economy meant that the vast majority

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[349] J. L. Henderson and Merril Moore, "The Psychoneuroses of War," *The New England Journal of Medicine* 230, no. 10 (March 9, 1944): 273-278; Roy R. Grinker and John P. Spiegel, *War Neuroses* (Philadelphia: The Blakiston Company, 1945).

[350] Carl Schultz Vento, "World War II Psychiatric Wounds of War," *Defense Media Network*, May 2, 2012. https://www.defensemedianetwork.com/stories/world-war-ii-psychiatric-wounds-of-war/, accessed April 25, 2022.

[351] Christina Jarvis, "'If He Comes Home Nervous': U.S. World War II Neuropsychiatric Casualties and Postwar Masculinities," *The Journal of Men's Studies* 17, no. 2 (Spring 2009): 97-115.

[352] Gary Edgerton, "Revisiting the Recordings of Wars Past: Remember the Documentary Trilogy of John Huston," in Gaylyn Studlar, David Desser, and John Huston, *Reflections in a Male Eye: John Huston and the American Experience* (Washington: Smithsonian Institution Press, 1993).

[353] Studlar, Desser, and Huston, *Reflections in a Male Eye*.

[354] Daniel Eagan, "A Restored Version of Let There Be Light Available Online," *Smithsonian Magazine*, May 25, 2012.

of Second World War veterans, including psychiatric casualties, had no issues securing employment after the war. And the looming threat of the Cold War meant that military officials were likely more concerned with presenting a show of strength to the Soviet Union than they were about undermining well-established stigmas surrounding military mental health casualties.[355]

Meanwhile, psychiatrists were still interested in pinning down the language of mental health disorders, including military psychiatric trauma. In 1952, the American Psychiatric Association published the first *Diagnostic and Statistical Manual* (DSM), creating a "classification system consistent with the concepts of modern psychiatry and neurology."[356] The point being to provide consistent diagnoses across the psychiatric specialty. Under the section of "transient situational personality disorders," the DSM listed "gross stress reaction," describing an overwhelming but temporary fear response brought on by the extreme emotional or physical stress of combat or a natural disaster.[357] This diagnosis reflected the postwar state of psychiatry and a desire to understand the relationship between war trauma and mental health, and it was timely.

By 1954, the Veterans' Administration hospital system was inundated with psychiatric patients, making up nearly 44% of the total patient load—by far the largest category of hospitalizations.[358] Perhaps more surprising, the majority of these patients were from the Second World War, not the recently concluded (by armistice) Korean War, meaning psychiatric cases were a growing, chronic concern.

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[355] Unfortunately, we can only speculate at official motives for the censorship of *Let There Be Light*. FOIA requests have yet to be answered, and that is assuming that such motives were recorded in the first place.

[356] *Diagnostic and Statistical Manual of Mental Disorders* (Washington, D.C.: American Psychiatric Association Mental Hospital Service, 1952), 9.

[357] Ibid., 40.

[358] VA Annual Report FY 1953, 7.

By 1967, the VA hospital system was treating nearly 850,000 patients on an in-service basis—the highest number to that point.[359] The administration was, at that time, actively trying to reduce its hospital burden by shifting appropriate cases to outpatient, nursing home, foster care, and halfway house programs. But psychiatric patients remained a chronic burden on the system, with the longest hospital stays and lowest turnover rate compared to other categories like general medical, surgical and tuberculosis.[360] That the DSM provided a link to a certified diagnosis like "gross stress reaction" ensured that more veterans were able to receive service-connected status for their care. But with the publication of the second edition, *DSM-II*, in 1968, "gross stress reaction" was left out without anything to replace it.[361]

This omission conjoined with an increased rate in the use of administrative discharges by the military. Administrative discharges are, essentially, the military's way of firing someone from the service and was generally done "under other than honorable conditions."[362] They are also known as "bad paper." Department of Defense policy stipulated that bad paper could be issued for a wide variety of infractions ranging from alcoholism and substance abuse to "financial irresponsibility," from "homosexual tendencies" to failure to "expend effort constructively."[363] Combined with the beginning of the draft in late 1969, it is clear that the military began using bad paper as a means of ridding itself of what it considered to be "problem" servicemembers.[364] The problem, according to veterans' advocates, was that many of these "problem" soldiers, sailors,

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[359] VA Annual Report FY 1967, 7. The specific number of hospitalizations was 846,396 VA beneficiaries.
[360] Ibid., 16.
[361] Adler, "Help Without Hassles," 540.
[362] 32 CFR Section 724.109 - Types of administrative discharges.
[363] Norman B. Lynch, "The Administrative Discharge: Changes Needed?," *Maine Law Review* 141 (1970): 147-148.
[364] Adler, "Help Without Hassles," note 43. Between 1965 and 1969 there were 11,500 bad paper discharges per year. That number grew to more than 40,000 by 1972.

airmen, and Marines may have been discharged due to the military's failure to recognize the mental health consequences of war.[365]

Servicemembers who received bad paper discharges were, by nature of their discharge status, barred from receiving care through the VA in any capacity. And while they could challenge the nature of their discharge, the lack of any official diagnosis related to military traumas like "gross stress reaction" made establishing service-connection for mental health issues particularly difficult.[366] Even more frustrating for veterans' advocates, this conjunction of bad paper and no diagnosis made determining the scale of the problem of readjustment difficulties for Vietnam veterans particularly difficult.

Even so, the VA itself recognized the difficulties of many Vietnam veterans in readjusting to civilian life. In 1971—the same year Administrator Johnson was compelled to respond to the AVM's sit-in protest—the administration's annual report to Congress noted that Vietnam era veterans "tend to feel powerless about their ability to effect change and, compared to older veterans… feel isolated in a VA hospital. Such feelings are understandable, because the young veterans do represent a decided minority group amidst all hospitalized veterans."[367] What's more, Vietnam veterans surveyed responded with "a desire to have greater opportunity for professional counseling, educational and vocational planning, [and] small-group discussions to explore and understand personal feelings and the like."[368] Thus, the veterans themselves were making clear to the VA exactly what they thought they needed, and surprisingly—at least to the VA's surveyors—they were joined in this desire by World War II and Korean conflict veterans.

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[365] Adler, "Help Without Hassles," 540.

[366] Stephanie Smith Ledesma, "PTSD and Bad Paper Discharges: Why the Fairness to Soldiers Act Is Too Little, Too Late," *Elon Law Review* 10 (2017): 189-237.

[367] VA Annual Report FY 1971, 13.

[368] Ibid., 14.

This should not have been a surprising view to VA officials. After the Second World War, sociologist Willard Waller was a central figure in an academic effort to address the problems of veterans' social readjustment. In his 1944 book, *The Veteran Comes Back*, Waller used the readjustment problems for First World War veterans to model expectations of experiences for Second World War veterans and noted that many vets would likely experience difficulties—that such men would be, essentially "a sort of immigrant in his native land."[369] Waller came to the dramatic conclusion that "unless and until he can be renaturalized into his native land, the veteran is a threat to society," highlighting the importance of prompt readjustment intervention. And Waller was not the only one calling for action.

In 1946, noted psychiatrist William C. Menninger advocated for a "renewed appreciation of the importance of stress from social forces as a major factor in the causation of psychiatric casualties."[370] During the Second World War, Menninger led the committee responsible for establishing military psychiatric nomenclature and diagnosis—work that formed the basis for the first edition of the *DSM*—and noted that acute traumas like "gross stress reaction" could be reversed if treated promptly. And while he acknowledged that a chronic state of such trauma could exist, he reserved classification of such trauma "until a more definitive diagnosis is established."[371] Certainly, VA and military officials should have been aware of Menninger's work, even if officials were not aware of Waller's. Then again, the VA has always been a large, hierarchical institution. Even if some officials in the VA were aware of this work and cognizant of its implications, translating that into policy can be difficult.

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[369] Horwitz, *PTSD*, 75; Willart Waller, *The Veteran Comes Back* (New York: Dryden Press, 1944), 180.

[370] William C. Menninger, "Lessons from Military Psychiatry for Civilian Psychiatry," *Mental Hygiene* 40 (1946): 581.

[371] DSM-I, 40.

Regardless of the reasons, the failure to heed or recognize expert advice conjoined with factors that made the experience of the Vietnam war rather exceptional to that point. First, the political objectives of the war were unclear. Many had a hard time explaining how it would stop the spread of communism or to describe the threat the enemy posed to Americans or their way of life. Second, unlike previous (and later) conflicts, where entire units were rotated in and out of combat together, troops in Vietnam rotated individually.[372] They flew to war aboard a commercial airline then linked up with their unit. After their tour, they would return home roughly the same way, making for an isolating experience that offered few, if any, opportunities for the communal construction of meaning regarding the war. Instead, they faced concepts constructed by external and social factors—the very kind Menninger warned about—like the antiwar movement, civil unrest, and social upheaval that very likely made it even harder to "readjust" to a society that seemed to be at war with itself.

Readjustment was made all the more difficult by the reception many Vietnam veterans received from their older peers. Vietnam vets "found themselves outcast and humiliated in American Legion and Veterans of Foreign Wars posts where they had assumed they would be welcomed, supported, and understood. [But] time and again they were assailed as 'losers' by World War II veterans. The pain and rage at being blamed for defeat in Vietnam was beyond bearing and resulted in many brawls."[373] Prevailing cultural images of the war only exacerbated the issue as "veterans' problems became entangled with the moral revulsion that many people felt

[372] Mark Depu, "Vietnam War: The Individual Rotation Policy," *Vietnam Magazine* (Dec. 2006).

[373] Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York: Atheneum, 1994), 7.

toward the war."[374] Perhaps ironically, this hostility to the war was part of the impetus for the American Psychiatric Association's review of the *DSM-II* in the 1970s.

In 1974, the APA appointed Robert Spitzer to head a task force to revisit the *DSM-II*. With a team of research-oriented psychiatrists, Spitzer sought to create a reliable, more scientific diagnostic system. He took input on a new diagnosis for war-related trauma from noted antiwar psychiatrists Robert J. Lifton and Chaim Shatan—the same psychiatrists that had been working with the VVAW rap groups. Lifton and Shatan worked to secure a diagnoses that would shift the blame from notions of soldiers' predisposition and pin it on the traumatic event itself.[375] In this, they were successful in shaping the diagnostic criteria for post-traumatic stress disorder (PTSD), which was included in the *DSM-III* published in 1980.

Unlike other diagnoses in *DSM-III*, PTSD had not gone through field trials, tests, or statistical analyses. Instead, sociologist Allan Horwitz argues, PTSD was included in the *DSM-III* precisely because of the "political agitation of antiwar psychiatrists and veterans' advocates who relied on the moral argument that failing to include a PTSD diagnosis in the new manual would be tantamount to blaming victims for their misfortunes."[376] In essence, then, the new diagnosis was heavily influenced by veterans' advocacy and activism in the face of official negligence of the issues facing Vietnam veterans. And with the inclusion of PTSD, veterans had a new tool to use in seeking care by making disability claims on the basis of their experience.

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[374] Horwitz, *PTSD*, 87.

[375] Wilbur J. Scott, "PTSD in *DSM-III*: A Case in the Politics of Diagnosis and Disease," *Social Problems* 37 (1990): 294-310.

[376] Horwitz, *PTSD*, 98; Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 1995).

## Conclusions: PTSD and Patient/Veteran Advocacy

While psychiatrists worked to include PTSD in the *DSM-III* and thus create the diagnostic basis for veterans to seek disability claims and care access, veterans interested in the establishment of readjustment counseling and improved care access continued their efforts even as informal efforts like the VVAW's rap groups continued to spread through veteran communities across the United States. Senator Alan Cranston repeatedly introduced legislation to fund an official readjustment counseling program despite significant resistance from government officials.[377] Donald Johnson, in particular, questioned whether an expansive counseling program was even necessary—noting in Senate hearings in 1970 that such counseling wasn't necessary for veterans of earlier conflicts.[378] This initially stiff resistance eventually eroded in the face of persistent veterans' advocacy with the support of mental health professionals who noted that the VA's traditional hospital-centric programs were not suited to emerging circumstances.

Official views on readjustment counseling shifted with a change in administrations. When Jimmy Carter assumed the presidency in 1977, he did so noting that veterans of the Vietnam War were also victims of that war and promising to address their concerns. Two years into his presidency, many of Carter's promises remained frustratingly unfulfilled.[379] But he did fulfill one important promise on Inauguration Day, 1977, with the appointment of Max Cleland as Administrator of the Veterans Administration.

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[377] Wilbur J. Scott, *Vietnam Veterans Since the War: The Politics of PTSD, Agent Orange, and the National Memorial* (Norman, OK: University of Oklahoma Press, 2004), 54.

[378] "Unemployment and Overall Readjustment Problems of Returning Veterans," Hearings Before the Subcommittee on Veterans' Affairs…91-2, November 25 and December 3, 1970, pg. 125-26.

[379] Ward Sinclair, "Vietnam Veterans Still Feel Chill From the White House," *The Washington Post*, April 28, 1979.

After giving his testimony before the Senate in 1969, Cleland finished his rehabilitation at the Washington, D.C. VA hospital, secured artificial legs—and learned how to use them—and decided to pursue a career in politics in his home state of Georgia, winning a seat in the state senate, where he became an advocate against the war, for veterans, and to expand access for people with disabilities—he proposed a bill that would later serve as a model for the Americans with Disabilities Act.[380] In Georgia, Cleland became acquainted with then-Governor Jimmy Carter. After winning two terms in the Georgia senate, he went to work for Senator Alan Cranston, helping the Senator investigate VA hospitals and push for reforms. After the 1976 election, Senator Cranston suggested Carter appoint Cleland to head the VA.

Cleland was 34 years old when he took over as Administrator. His executive experience consisted of leading a platoon in Vietnam. And he was only seven years removed from being a patient in the VA hospital system—an experience that did not impart fond memories.[381] But Cleland knew what it was like to be a patient in the system, where it needed reform, and he understood the experience of the Vietnam veteran. He knew the context in ways that didn't need explanation.

Administrator Cleland found a bureaucracy at the VA run by the "Class of '46," so called because they had come aboard the VA during the Truman administration, when Bradley and Hawley were shaking up Hines's old bureaucracy dating back to the Great War. Cleland now had his own shaking to do. Under Cleland's administration, VA psychiatrists recognized PTSD as a service-connected disability in 1978, two years prior to the publication of *DSM-III*, whose inclusion of the disorder only served to validate the designation. And on Cleland's

[380] Cleland, *Heart of a Patriot*, 118.
[381] Cleland, *Heart of a Patriot*, 127.

recommendation, President Carter agreed to push for a new readjustment counseling service similar to the type proposed by AVM and practiced in an ad hoc manner by VVAW.

On June 13, 1979, and to little public fanfare at the time, President Carter signed Public Law 96-22, the "Veterans' Health Care Amendments of 1979," into law, creating federal support for readjustment counseling services.[382] Within five months of the bill's passage, the VA was working on setting up "85 store-front facilities across the country, staffed by outreach teams that will go into the community to locate and assist Vietnam-era veterans," with an emphasis "on peer counseling in a non-formal setting so as to encourage the participation of those veterans distrustful of normal VA and other governmental efforts."[383]

Initially limited to Vietnam era veterans, eligibility to other vets soon expanded—to post-Vietnam vets in 1991, Second World War and Korean War vets in 1996, and Global War on Terror vets and their families in 2003, which effectively made all veterans potentially eligible for Vet Center services. Other than the initial period requirements, eligibility criteria for Vet Center services diverged immensely from the rest of the VA healthcare system. Qualification of discharge, disability status, and service-connection are not considerations. And while Vet Centers primarily offer psychological counseling and referral services, they retained the original rap group foundations that emerged out of the ad hoc efforts of Vietnam era veterans to help each other come home from the war and make meaning of it.

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[382] "An Act to Amend Title 38, United States Code, to Revise and Improve Certain Health Care Programs of the Veterans' Administration, to Authorize the Construction, Alteration, and Acquisition of Certain Medical Facilities, and to Expand Certain Benefits for Disables Veterans; and for Other Purposes," Public Law No. 96-22, 93 Stat. (1979).

[383] "Veterans Day 1979: An Historical Perspective—Senator Cranston Aids Veterans," in Congressional Record—Senate (Washington, D.C.: Government Printing Office, 1979), 31924.

The Vet Center story demonstrates that patient advocacy, agency, and authority can drive change in modern healthcare systems and force rigid bureaucracies to accommodate new modalities. When the VA failed to properly address the needs of readjusting Vietnam vets, the veterans took it upon themselves to do the work as part of their ongoing advocacy. When modern psychiatry failed to provide an official diagnosis of the experience of so many combat veterans, advocates and activists reformed the system from within. And when given the opportunity to enact reform, Vietnam era veterans empowered their fellow veterans with new options to engage with the VA.

To return to Junger's work in *Tribe*, it may well be that American society is particularly, if inadvertently, structured to exacerbate feelings of isolation in those coping with the long term psychological effects of trauma like combat veterans. Interactions with civilians can be full of platitudes and potential pitfalls. Established bureaucracies can be overwhelming. And self-coping mechanisms may eventually fail. But with access to resources from trusted sources—as Vet Centers are for many veterans—these obstacles can be easier to navigate.

This begs questions about current VA policies regarding care access. Vet Centers are only authorized to serve combat veterans, victims of military sexual trauma, family members of those veterans and of those who committed suicide, and certain categories of active duty and reserve servicemembers. That said, given that these facilities are staffed primarily by veterans who know the system and who are motivated to help those in need, even veterans who are unable to receive care through RCS are likely to receive support in the form of referrals, advice, or even just a friendly ear. This makes them approachable, without fear of judgment, rejection, or paperwork.

Shouldn't such care-first, paperwork-second models be utilized by the Veterans Health Administration as a whole?

## 4) MEDICAL CULTURES: CREATING OPPORTUNITIES FOR CHANGE

### "Thank You For Your Service"

There is a certain type of performative patriotism to which our society subjects our veterans. It's so pervasive, in fact, that many of the rites of this performance have become cliches, like the phrase "thank you for your service" (TYFYS). It's a common courtesy these days, and yet such platitudes can hold significant power. That's certainly the case with TYFYS.

I can't tell you how many times I have been thanked for my service by strangers. Every time it happens, a lot runs through my head. Part of me is appreciative, recognizing that many vets never received such acknowledgment. I also recognize that it is offered as a courtesy, with good intentions. But I also recognize how it draws a line between veterans and the society we served, even as it puts us on a pedestal of sorts. It is an isolating honorific, and therein lies its power.

Take, for example, the passage of the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics Act of 2022, also known as the PACT Act. Intended to expand VA health care and benefits to millions of veterans, the PACT Act of 2022 was the largest veterans bill in decades, adding tens of billions in new funding to the Department of Veterans Affairs to provide medical and compensation benefits to affected veterans.[384] Its broad bipartisan support demonstrates the value that folks place on things like veterans' service and sacrifice, even though few seemed to question why new legislation was needed in the first place.

Veterans seeking health care benefits have to meet eligibility criteria that include length of service, character of discharge, and demonstrating a service-connected disability—meaning that a

[384] Congressional Budget Office, "Estimated Budgetary Effects of H.R. 3967, Honoring our PACT Act of 2021," June 6, 2022. https://cbo.gov/publication/58177. The CBO estimated that the PACT Act would cost roughly $680 billion over a decade with $118 billion in new spending and the rest reclassified from discretionary to mandatory spending.

disabling condition was either caused or exacerbated by one's military service. And that service-connected requirement has traditionally been a significant obstacle between many veterans and the benefits that most civilians assume all vets receive.

Service-connection is generally established through documentation. If a soldier has medical records that corroborate a disability-causing injury, it's relatively easy to establish. But if a veteran develops cancer years after their service, how are they to demonstrate the necessary service-connection component? This was a struggle faced by Vietnam veterans over Agent Orange exposure and Gulf War veterans over the still mysterious conditions that make up Gulf War Syndrome.[385] The easiest way to address such cases is to get Congress to create a carve-out to service-connection requirements by making certain conditions or types of service presumptive—to essentially say that when a disability occurs under certain circumstances that the U.S. government presumes that disability to be the result of military service. So, when Global War on Terror vets started developing devastating illnesses assumed to be linked to toxic exposures, those veterans and their allies turned to Congress to pass the PACT Act of 2022.

To be clear, veterans' legislation has an advantage in Washington, D.C., as many politicians are eager to demonstrate their commitment to honoring the sacrifices of those who served. That explains, perhaps, why a bill with a potential price tag of more than $300 billion over ten years like the PACT Act faced so little resistance as it made its way through Congress. Introduced in June 2021, it passed the House by a vote of 256-174 on March 3, 2022, and the Senate by a vote of 84-14 on June 16. And when a technicality in the reconciliation process required new votes, expectations were that the bill would pass both chambers again easily.

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[385] National Academy of Sciences, "Gulf War Service Linked to Post-Traumatic Stress Disorder, Multisymptom Illness, Other Health Problems, But Causes are Unclear," News Release, April 9, 2010.

The day the Act was up for its second vote in the Senate, Senator Rick Scott of Florida sent out a tweet to the effect that he was "honored to join [the USO] today and make care packages for our brave military members in gratitude for their sacrifice and service to the nation."[386] Scott's tweet was not very remarkable for its content—practically every member of Congress has sent a similar tweet at some point. Rather, this particular tweet was notable for what Scott did a few hours after he sent it when he and twenty-four of his colleagues changed their vote on the PACT Act.[387] By a vote of 55-42, the proposed law failed to achieve cloture and was shelved because twenty-five Senators changed their votes.

The failure of the PACT Act to achieve cloture in the Senate on July 27, 2022 caused a political squabble. Democrats accused Republicans of sabotaging the law in retaliation for the surprise passage of an unrelated bill. Republicans argued that their change of heart had more to do with honoring amendment processes and budgetary concerns.[388] But while the political finger pointing played out, the incident demonstrated another side to the power of performative patriotism in creating opportunities for change. Such platitudes can present a positive veneer on one hand, tying politicians to ideals held in high esteem by the American people. But once so tied, those same platitudes can be used to force accountability in service to those ideals, which is precisely what those pushing for passage of the PACT Act decided to do.

Comedian and activist John Stewart used his celebrity to give a platform to the cause of families affected by the passage of the law and to present a human element to the story. He called the vote against the bill an act of "abject cruelty," noting that veterans and family members

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[386] Rick Scott, July 27, 2022, 2:03 PM, https://twitter.com/SenRickScott/status/1552414341198188546.

[387] Mike DeBonis, "Senate Republicans block bill to help veterans exposed to burn pits," *Washington Post*, July 28, 2022.

[388] Justin Sweitzer, "Pa. Sen. Toomey faces heat from Jon Stewart, veterans over burn pit legislation," *Pennsylvania Capital-Star*, July 30, 2022.

"thought they could finally breathe. You think their struggles end because the PACT Act passes? All it means is they don't have to decide between their cancer drugs and their house."[389] That veterans would be in such a situation, having to decide which bills to pay, was something that not only demonstrated the hypocrisy of folks like Senator Scott—voting against veterans' benefits after so loudly claiming to support the troops—it was something that threatened to shatter the veneer of the idea that the United States takes care of its veterans by exposing the public to the nuances of VA benefit eligibility requirements.

Veterans who developed serious illnesses due to toxic exposure were being denied VA disability claims and thus access to VA care because the system required proof of service-connection for their illnesses. The PACT Act would classify several categories of illness as presumptive, providing a carve out from standard eligibility requirements for designated veterans. The bill's failure, then, increased the possibility that more Americans would ask questions about this process. Combined with continued lobbying by veterans' service organizations and the visibility of protestors on the Capitol steps, Senator Scott and his colleagues backed down.[390] On August 2, 2022, the Senate voted 86-11 to pass the bill. Among those voting in favor was Senator Scott.[391]

Platitudes are not limited to the halls of Congress or interpersonal interactions like TYFYS, of course. They are rife in the Department of Veterans Affairs, too. For instance, the VA's style guide insists the word "veteran" should be capitalized, "even when used as a common noun," to

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[389] Jon Stewart, comments outside the U.S. Capitol, July 28, 2022. Video by *The Washington Post*, included in Debonis, "Senate Republicans block bill."

[390] Patricia Kime, "Veterans Protest at US Capitol as Pressure Mounts on Senate Republicans over Toxic Exposures Bill," *Military.com*, August 1, 2022.

[391] U.S. Senate, Roll Call Vote, 117th Congress, 2nd Session, Vote Number 280, August 2, 2022.

denote respect for those who served.[392] Part of the power of platitudes is their ability to work as either a smokescreen to obscure potential hazards—to simplify something as messy and complicated as eligibility requirements into generic displays of support, for instance. But they also have the power to clear the air and bring attention to long-neglected problems and to shift entire cultures, like the culture of medicine in the nation's largest healthcare system.

This chapter examines how platitudes influenced the development of the veterans' healthcare system in the 1980s and 1990s. It examines how official efforts to reshape the national narrative regarding veterans after the Vietnam War led to the elevation of the VA and the national tendency to put veterans on a pedestal and to thank them for their service even as the government attempted to cut veterans' healthcare costs. It shows how the elevated stature of veterans and concerns about costs conjoined to shift the culture in veterans' healthcare, to adopt modern quality control and evidence-based metrics to improve processes—essentially, to shift the medical culture at the VA. And it examines how that new culture brought attention to longstanding, persistent problems like race- and gender-based healthcare disparities, medical shortcuts and shortfalls—particularly in mental health care—and the influence of non-VA actors in shaping VA care eligibility.

Conjunctions of historical developments reflecting contemporary cultural and social priorities—reflected by platitudes—contributed to the shape and function of the modern veterans' healthcare system. They explain the persistence of bigotries and stigmas that run counter to veterans' modern venerated status. They demonstrate intersectional factors and structures that shape the system. And they help explain why eligibility determinations are a foundational piece of veterans' health today and the potential future of the veterans' healthcare system moving forward.

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[392] VA.gov Content Style Guide, https://design.va.gov/content-style-guide-word-list#v

## Politics: Elevating Veterans' Status

On November 10, 1987—the day before Veterans' Day—President Ronald Reagan made a surprise announcement during a meeting with veterans' service organization officials and members of Congress. "Tomorrow our nation will pause and remember those veterans who've served in the Armed Forces, both at home and abroad. And we'll remember those who gave their last measure fighting for what our country represents: freedom. There's not a better time or better way to salute those valiant men and women than to announce today my decision to support the creation of a Cabinet-level Department of Veterans Affairs."[393]

This announcement was a surprise, in part, because it went against Reagan's own politics. When he assumed the presidency in 1981, Reagan promised to shrink the federal government, not expand it. What's more, members of Congress had been trying to elevate the Veterans Administration to the Cabinet since the 1920s, introducing a bill to that effect every year since 1963. But previous presidents saw no need to support such legislation until President Regan made his surprise announcement in 1987—more than six years after he assumed the presidency and just in time for both Veterans' Day and the beginning of the 1988 presidential election cycle.

The elevation of the VA to the Cabinet was essentially a means of attaching the cause of veterans to President Regan and the Republican Party—a point made clear when Reagan Administration officials clarified that the elevation of the VA to the Cabinet would not, in fact, change much regarding the function, funding, or form of the organization.[394] Indeed, the head of

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[393] "Informal Exchange with Reporters," Ronald Reagan Presidential Library & Museum, November 10, 1987. https://reaganlibrary.gov/archives/speech/informal-exchange-reporters-4

[394] "Reagan Would Elevate V.A. to Cabinet Level," *The New York Times*, Nov. 11, 1987, pp. A16. White House spokesman Marlin Fitzwater noted that the move would not change the VA's size or budget, but that the move "would give it a greater say in the councils of government." VA spokesman John Sholzen noted that the move would only cost about $30,000 in increased salaries for top officials—a pittance against the VA's $27 billion annual budget.

the VA already reported directly to the President and little more influence would be added by the attendance of Cabinet meetings, where the new Secretary of Veterans Affairs would be competing for time with fourteen other Cabinet heads.

Still, the leadership of influential veterans' service organizations and members of veterans' committees in Congress favored the move because it was a public recognition of veterans' importance and because they believed it would help insulate veterans' programs from further budget cuts, which was a concern in the Reagan era.[395]

Ronald Reagan won election in 1980 promising to increase military spending, balance the budget, and cut "big government." As the Veterans Administration was the second largest federal agency at the time, behind only the Department of Defense—which Regan promised to expand—so it stood to reason that the VA would be a target of budget cuts. It took until 1986 for significant cuts to materialize, but the Office of Management and Budget's proposal for fiscal year 1987 amounted to the largest cuts to veterans' funding and support since the doomed Economy Act of 1933.

The OMB budget for 1987 stipulated cuts by raw numbers of services provided without consideration for the need or quality of those services and by leaning on long-established eligibility requirements. It required VA to find ways to cut hospital visits by up to 1.2 million per year and trim outpatient visits by up to 16.5 million annually. OMB proposed VA achieve this by requiring veterans without service-connected disability status to use other systems, noting that "this freeform would allow VA to sustain quality care for the most deserving veterans."[396] The use of service-

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[395] Ibid. Representative "Sonny" Montgomery (D-MS), chairman of the House Veterans Affairs Committee, noted that "some feel the V.A. is run now by the Office of Management and Budget."

[396] U.S. Office of Management and Budget, *Budget of the United States Government, Fiscal Year 1987* (Washington, D.C.: Government Printing Office, 1986), 5-135.

connection was not necessarily new in eligibility requirements, but framing it as the OMB did—as though veterans with service-connected disabilities were *more deserving* of healthcare—was certainly a new development. And the OMB's proposal was not limited to prioritizing certain types of veterans over others.

The proposed budget for 1987 also cut into the VA's infrastructure and personnel funding. It required VA to find efficiencies in the system that would allow it to shrink the workforce by 22,000 employees. It made no appropriations for new VA nursing homes despite the aging Second World War veteran population, instead requiring VA to shift the burden for such care to state and local facilities. It cut the VA's requested construction budget in half, meaning the agency had to put off urgent infrastructure and construction projects and extend the use of facilities that were falling apart. And it required VA to identify "surplus property" with a market valuation of at least $364 million to be sold by the General Services Administration.[397] VA Administrator Harry N. Walters, who had been appointed to the post by President Reagan in 1982, warned that the proposed cuts would result in reduced services without much economic benefit, which is precisely what happened.

By 1989, the newly elevated Department of Veterans Affairs noted a 16.5 percent drop in VA hospitalizations concurrent with a 7.4 percent increase in outpatient visits—precisely the desired effect of the OMB budget proposal in shifting healthcare burdens to less expensive systems. But the number of vets seeking care did not diminish. In fact, it grew, as one would expect of an aging population. But these numbers demonstrated that the VA was prioritizing "the most deserving veterans" with hopes of cutting costs. But in this regard, the effort failed. The budget

[397] Robert Pear, "U.S. Health Care for Veterans Cut in Budget Draft," *The New York Times*, Dec. 27, 1985, pp. A1.

for the veterans' healthcare system climbed 5.8 percent in 1987—significantly more than in either of the previous years.[398] And yet, Reagan's administration faced little criticism for such ineffectual economic cuts. This was due, at least in part, to Reagan's efforts to tap into America's growing esteem for its veterans through the elevation of the VA.

Reagan's actions—both his budget and his decision to support the creation of the Department of Veterans Affairs—reframed veterans' healthcare in significant ways. They simultaneously elevated the status of veterans in general while entrenching the definition of who counted as "the most deserving veterans." This shift was possible because many veterans and influential veterans' service organizations bought into it.

The reputation of the American veteran suffered from the public's ambivalent reaction to the Vietnam War and rising awareness of the mental health struggles of combat veterans. Perhaps ironically, the awareness of postwar struggles was due, in part, to efforts to transparently deal with such issues.[399] By the 1980s, media depictions generally portrayed Vietnam veterans as victims of both the war abroad and an ungrateful public at home.[400] There was some truth to this depiction. Many Vietnam veterans saw themselves as victims of the war, like those in VVAW who participated in the Winter Soldier hearings.[401] Many experienced alienation within the veteran community as Second World War vets—who still retained a numerical advantage over younger generations—fought bitterly to prevent veterans' benefits allocations for younger vets from

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[398] U.S. Department of Veterans Affairs, *Annual Report 1988* (Washington, D.C.: Government Printing Office, 1988), 6.

[399] Matthew J. Friedman, "Post-Vietnam Syndrome: Recognition and Management," *Psychosomatics* 22, no. 11 (1981): 931-943; Peter G. Bourne, "The Viet Nam Veteran: Psychosocial Casualties," *Psychiatry in Medicine* 3, no. 1 (1972): 23-27. Eric T. Dean Jr., "The Myth of the Troubled and Scorned Vietnam Veteran," *Journal of American Studies* 26, no. 1 (1992): 59-74.

[400] "The War and the Arts; There Has Been a Cultural Turnaround on the Subject of Vietnam," *New York Times Magazine* (March 1985), 51.

[401] See Chapter 3.

affecting their own benefits. Some Vietnam veterans noted that their Second World War peers had a tendency to see them as failures, having "lost" their war.[402] And it was in this context that Ronald Reagan launched a crusade to redeem the legacy of the Vietnam War in the American consciousness as part of his 1980 presidential campaign.

At the 1980 convention of the Veterans of Foreign Wars (VFW), then-candidate Reagan noted that "it's time we recognized that ours was, in truth, a noble cause."[403] This was, in one sense, a way to pander to the VFW for votes. But it was also an expression of a nostalgic and patriotic view of America as a noble champion of freedom and American values—views that many veterans were eager to adopt. In this framing, Vietnam veterans were not the neglected, scorned, troubled individuals many believed them to be; rather, they were honorable warriors who fought the spread of communism and buttressed the notion of America as an example for the free world. This was a framing that appealed to many veterans' sense of nostalgia and patriotism—it offered a higher purpose for military service.

With such framing, Reagan enjoyed fairly broad support in many of the major veterans' service organizations throughout his time in office, despite efforts by his OMB to cut veterans' benefits spending. Besides the invitation to speak at the 1980 VFW convention, Reagan received the American Legion's Distinguished Service medal in 1982 for prioritizing national defense and for "untiring efforts and patriotic devotion in perpetuating American principles."[404] The Disabled American Veterans praised Reagan's proclamation marking the Disabled American Veterans

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[402] Gerald Nicosia, *Home to War: A History of the Vietnam Veterans' Movement* (New York: Carrol & Graf, 2001), 290-91.

[403] Ronald Reagan, "Veterans of Foreign Wars Convention, Chicago, Illinois: Ronald Reagan Presidential Library - National Archives and Records Administration." https://www.reaganlibrary.gov/8-18-80.

[404] American Legion, Distinguished Service Medal Recipients, "President Ronald W. Reagan," https://legion.org/distinguishedservicemedal.

Vietnam Veterans National Memorial in New Mexico a site of national significance.[405] And the elevation of the VA to the Cabinet seemed to mollify any hard feelings among the VSOs' leaders about proposed budget cuts, particularly since the VSOs were able to block most of the proposed cuts by working with Congress.[406] Thus, the careful employment of platitudes provided a convenient screen for budget austerity efforts.

Despite the elevation of the VA to the Cabinet, the veterans' healthcare system positively languished through the 1980s and into the 1990s. Congress continued to pass appropriations increases, but not enough to keep up with the costs of inflation.[407] At the same time, the VA implemented many of the OMB's austerity recommendations internally, including rigid adherence to service-connected disability status and means testing, finding alternatives to inpatient care programs, cutting transportation costs that allowed veterans to make medical appointments, and delaying planned infrastructure projects, among other efforts couched as efforts to focus on "the most deserving veterans."[408] Given this, it may be difficult to see how such a system could transform into a standard-setting leader in healthcare within a decade. But that transformation was also due, in part, to the power of platitudes and the newly-elevated status of the American veteran.

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[405] Ronald Reagan, "Proclamation 5742 — Recognition of the Disabled American Veterans Vietnam Veterans National Memorial as a Memorial of National Significance," Nov. 16, 1987. Ronald Reagan Presidential Library.

[406] William Welch, "Veterans Groups Angry About Reagan VA Cut Plans," *Associated Press*, January 5, 1987. https://apnews.com/article/8fd4255528d0c95269633a0e600944c0

[407] Helen C. Lazenby and Suzanne W. Letsch, "National Health Expenditures, 1989," *Health Care Financial Review* 12, no. 2 (1990): 1-26 demonstrated that health expenditures grew 11.1 percent from 1988 to 1989; Edward J. Derwinsky, Secretary of Veterans Affairs, *Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1989* (Washington, D.C.: Government Printing Office, 1990) showed a 7% increase in medical care costs from 1988 to 1989.

[408] VA Annual Report FY 1989, 17-20. The annual report couched these austerity measures in more flattering terms, like highlighting the fact that the DAV established a volunteer transportation network without mentioning directly that such a network was necessary because the VA cut funding.

## Policies: The Kizer Revolution

By the mid-1990s, the VA healthcare system faced a political crisis due to intersecting factors that made it appear to be simultaneously expensive and ineffective. An aging patient population necessitated a shift towards geriatric care but also created issues in facility utilization as many older veterans migrated from the Northeast and Midwest to the Sunbelt after retirement. This meant some hospitals had too few patients while others had too many. Medical costs continued to climb as medical inflation—still over 9% in 1990 per the Bureau of Labor Statistics—outpaced appropriations, meaning the VA had to do more with less despite the appearance of larger budgets. And those larger budgets continued to motivate fiscal hawks to seek economic efficiencies in the system along the lines of the 1987 OMB budget proposals that recommended limiting care access to even smaller sections of the veteran population. Compounding this, in response to budget constraints, VA management had reverted to a Hines-style, centralized system that required field offices to secure permission from headquarters for such trivial expenses as basic office equipment.[409]

All of these factors combined to create fodder for press reports about the VA that were less than flattering. The *Wall Street Journal* framed the situation as "The VA's War on Health" and the *Washington Times* proclaimed VA care to be "The Worst Healthcare in the Nation."[410] If the VA was a model of socialized medicine, as its critics claimed, it appeared to be something that Americans ought to avoid. It was a system in need of reform.

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[409] Kenneth W. Kizer and R. A. Dudley, "Extreme Makeover: The Transformation of the Veterans Healthcare System," *Annual Review of Public Health* 30 (April 2009):313-339.

[410] Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Barrett-Koehler, 2012), 46-47.

When Bill Clinton assumed the presidency in 1993, he immediately set out to fulfill a key campaign promise by organizing a task force to develop a plan for healthcare reform. Initially, the Clinton Plan called for subsuming the veterans' healthcare system into a larger, market-driven, managed care system.[411] From the task force's perspective, such a system would be more responsive to the types of challenges facing veterans' health care while opening up VHA resources to all Americans. From the perspective of veterans' service organizations, this appeared to be a proposal to cut benefits and a slight against veterans' privileged status.[412]

The American Legion and other VSOs vehemently opposed the idea and added their voices to the chorus of critics of the Clinton Plan. In response, First Lady Hillary Clinton changed tack and proposed an alternative: the VA hospital system would remain, but it would compete with other healthcare providers. This proposal garnered the support of important members of Congress like Senator John D. Rockefeller IV, chairman of the Senate Veterans' Affairs Committee. But many contemporary experts expressed doubts about the VA's ability to effectively compete, which was precisely the point.[413] Either the VA could compete and demonstrate the viability and value of a large, socialized healthcare system, or it couldn't, and it would make way for something that could.

To oversee the proposed transformation of veterans' healthcare, President Clinton tapped Dr. Kenneth W. Kizer, MD, MPH, to head the Veterans Health Administration as the Under Secretary for Health. Dr. Kizer was then a professor at the University of Southern California and

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[411] Bill Clinton, Address on Health Care Reform, September 22, 1993.

[412] This echoes many VSOs' response to FDR's Economy Act of 1933, and for much the same reasons. Both FDR and Clinton wanted to provide healthcare access to *all* Americans, not just veterans. But because such access is part of the veterans' benefits system, it creates opportunities for opponents to reframe healthcare expansion as an attack against veterans.

[413] Bill McAllister, "VA Hospitals Face Competition Under Clinton's Health Program," *The Washington Post*, Sept. 18, 1993.

had built a reputation in healthcare management overseeing California's response to the HIV/AIDS epidemic and by establishing the California Tobacco Control Program.[414] Holding board certifications in six medical specialties in addition to his extensive health system management experience, Kizer was also a Navy veteran who had experience practicing health inside the VA system, making him an ideal candidate to all the vested interests.

Dr. Kizer understood that the task would be difficult. He was a relative outsider to the VHA—most of the administration's top management came up "through the system" at this point. And the VA had a reputation of being particularly "politically hidebound and sclerotic" in health policy circles.[415] But he believed in the VA's mission of keeping patients healthy without the burden of pleasing shareholders or maximizing profits, and he saw the potential to make real and meaningful change in the system. That potential rested in the fact that the VA was a system that had the ability to shape veterans' health holistically, even if its parts didn't always work together as they should. What's more, Dr. Kizer recognized that he had an important tool at his disposal in shaping his reforms with the VA's Decentralized Hospital Computer Program (DHCP).

Developed by VA physicians and computer scientists in the late 1970s to make keeping and sharing patient records and notes easier, DHCP was initially suppressed by VA management between 1977 and 1981 because it appeared to bypass the authority and control of the central office in Washington. But when it gained the support of influential members of Congress, VA leadership issued an executive order officially adopting it as part of the Department of Medicine and Surgery in 1982.[416] This system provided the architecture for an effective electronic health record (EHR) system, and it was one tailored to the needs of physicians.

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[414] David Payne, "How Kizer Healed the VA," *BMJ* (2012): 344. https://www.bmj.com/content/344/bmj.e3324.
[415] Ibid.
[416] "History of the Hardhats," http://hardhats.org.

Kizer recognized the potential of EHR technology in collecting and analyzing data to shape effective policies, and he made DHCP a central part of his plan to enact reforms, though he changed the acronym. The Veterans Health Information Systems and Technology Architecture (VistA) would form an important part of Kizer's reforms, but he knew that he also needed to achieve buy-in from career VA staff and interested parties like the VSOs and members of Congress.

To that end, Kizer explained his essential task: "The basic thesis of the transformation, when I was talking about it to people within the VA, as well as outside… was that we have to be able to demonstrate that we have an equal or better value than the private sector, or frankly, we should not exist."[417] This amounted to a culture shift in veterans' healthcare.

Achieving that shift required establishing metrics of quality that would allow officials to analyze and adjust policies. To this point, the veterans' healthcare system was measured by the number of facilities it operated, how many inpatient and outpatient visits it conducted, and the number of personnel on hand to keep it all running. Such an organization made categories like service-connection and disability rating especially important in times of tight budgets—they operated as a means of controlling the veteran population serviced by the system and thus shaped the apparent effectiveness and economy of that system. But such metrics were not based in medicine or standards of care.

Kizer's revolution shifted the emphasis from the focus on brick-and-mortar inpatient services prioritized for the use of veterans with service-connected disabilities to metrics that focused on patient services, health, satisfaction, and outcomes. From one perspective, this was a continuation of established trends in achieving economical outcomes in VA facilities. But unlike

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[417] Longman, *Best Care Anywhere*, 51.

his predecessors, who made such decisions on administration metrics, Kizer's emphasis was on patient experiences. How long did veterans have to wait for appointments? How many received treatment based on best practices? What were their health outcomes, and how satisfied were they with their care? How did all that compare to private sector systems? This shift towards the patient—while common today—was a relatively novel concept in the 1990s.[418]

What Kizer proposed was essentially a shift towards evidence-based medical practice, and he spent his first year in office putting together a reorganization plan along these lines. He aimed to make the VA a "more efficient and patient-centered health care system."[419] This was potentially the first time an American healthcare official used the term "patient-centered" in articulating a healthcare system. Today, it's ubiquitous.

Kizer established what he called the "value equation." Value would be calculated as the sum of measurements of technical quality, care access, patient satisfaction, and cost of care delivery. VistA made obtaining the data for these measurements tremendously easier, and Kizer could point to that data to justify policy changes that would have been politically complicated, if not impossible.

For instance, to address hospital utilization problems, Kizer argued that facilities that lacked patients ran the risk of having their staffs fall out of practice in addition to being a drag on the VA's efficiency. It's not a good thing when a surgeon performs a surgery only a few times a year, and many VA hospitals in the Northeast and Midwest faced that very problem as aging veterans migrated to the Sunbelt after retirement. The best, data-based solution, Kizer argued, was

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[418] Charles M. Kilo and John H. Wasson, "Practice Redesign and the Patient-Centered Medical Home: History, Promises, and Challenges," *Health Affairs* 29, no. 5 (May 2010).

[419] Kenneth W. Kizer, Under Secretary for Health, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, March 17, 1995, pp. 7.

to open up underutilized facilities to veterans with non-service-connected disabilities.[420] This was essentially the same argument that longtime VA Administrator Frank T. Hines made in opening up hospital care to all veterans in the 1920s and 1930s to ensure maximum efficiency in the system. The move helped some VA facilities in the Northeast and Midwest keep their numbers up and their staffs up to speed, but it wasn't enough to save all underutilized facilities. Some simply had to be closed.

To that point, when a closure took place, it was standard procedure for the government to return funds allocated for that facility to the Treasury, but Kizer wanted to shift those funds elsewhere. Cutting facilities and losing their associated funding would not only cause problems from a political perspective—it smacked of the same type of ruthless budget cuts proposed by Reagan in the late 1980s that VSOs feared—it would be wasteful from a systemic perspective. Instead, Kizer worked with Congress and the Clinton Administration's OMB to allow VHA to reallocate funds for closed facilities to other areas in the system that needed more resources. And to mollify budget haws in Congress who were likely to complain that such moves resulted in no savings for taxpayers, Kizer argued for the continuation of policies that allowed the VA to defray costs by billing veterans' private insurance and Medicaid/Medicare for non-service-connected veterans. This redistribution of resources not only avoided the ire of VSOs and budget hawks, it garnered their praise.[421]

Kizer found a solution to the calcified and overly-centralized management system in another predecessor's reforms. Following in the footsteps of Omar Bradley and Paul Hawley, Ken Kizer decentralized the VHA's bureaucracy to make the agency more responsive to veterans' local

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[420] Ibid.
[421] Bill McCallister, "A Surgeon of the VA System," *The Washington Post*, Nov. 4, 1997.

needs. He created 22 Veterans Integrated Service Networks (VISNs, pronounced "visions") within the VHA system—each VISN was essentially a miniaturized VHA in itself. Each contained about 8 hospitals, 27 outpatient clinics, 6 long-term care facilities, 12 counselling centers, and a residential care unit.[422] Semi-autonomous, the VISNs had the intended effect of making the system more responsive to local needs while simultaneously shifting the focus of veterans' healthcare from expensive inpatient care to more affordable and convenient outpatient services.

And when data collected from the electronic health records system showed an alarmingly high incidence of medical accidents, Dr. Kizer reached out to former Air Force flight surgeon, astronaut, and NASA investigator James P. Bagian to create a new VA National Center for Patient Safety.[423] Bagian supervised NASA's investigation of the *Challenger* disaster in 1986 and was a champion of "fault tolerant" systems. This meant that safety could only truly improve if faults are honestly acknowledged and addressed rather than covered up for fear of reprisal. Bagian's philosophy stated that small parts of complex systems will inevitably fail—that the key to improving safety is to understand *why* they failed and address the faults before they fail again.[424] This is essentially the same type of safety system utilized by the National Transportation Safety Board (NTSB) when it investigates civil transportation accidents.

The safety system adopted by the VA through Kizer and Bagian was remarkable not for the emphasis on patient safety but for its transparency. This is a rare factor in private healthcare due to risks of litigation. In private practice, if a healthcare provider gives a patient the wrong medicine resulting in injury or death, that private system's first response is often to avoid or defray

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[422] Payne, "How Kizer Healed the VA," *BMJ*.

[423] University of Michigan Institute for Healthcare Policy & Innovation, "James Bagian, M.D., P.E., Systems engineering and patient safety." https://ihpi.umich.edu/our-experts/jbagian.

[424] Robert Wachter, "In Conversation with… James P. Bagian, MD," Patient Safety Network, PSNet, https://psnet.ahrq.gov/perspective/conversation-withjames-p-bagian-md.

litigation and malpractice costs. There will likely be an internal investigation that determines the nature of the mistakes, but the fruits of that investigation will more likely than not end up being sealed by out-of-court settlements between the provider and the patient.[425] But the VA's position as a public entity allowed it to pioneer patient safety systems transparently.

Kizer and Bagian understood this fact and how the VA's position provided an opportunity to shift the focus of traditional safety programs. The VA National Center for Patient Safety implemented a system similar to the NTSB, wherein VA personnel could anonymously report mistakes and near misses, allowing officials to investigate issues and make reforms that addressed underlying causes. This may seem like a small matter, but that is only because the VHA is still the only healthcare system that has such transparent safety protocols, where mistakes are openly admitted, investigations are focused not on renumeration but on process improvement, and as a result, the VHA's incidence of medical accidents is likely much, *much* less than in the private sector.[426] The word "likely" is necessary here because, while the VA has a safety metric against which it measures itself, private care systems continue to sweep safety data under the rug.[427]

Kizer's reforms were a good start. In his widely acclaimed book *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone*, Phillip Longman argued that "future historians may well record that among Clinton's greatest legacies was the reform of the VA, which transformed it from one of the biggest arguments against socialized medicine into one of the best arguments for it."[428] Indeed, Kizer's transformation of veterans' healthcare not only allowed it to

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[425] Longman, *Best Care Anywhere*, 61; R. Monica Klevens, et al., "Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002," *Public Health Reports* 122, no. 2 (2007): 160-166; Elizabeth A. McGlynn, et al., *The First National Report Card on Quality of Health Care in America*, RAND Corporation, 2006. https://www.rand.org/pubs/research-briefs/RB9053-2.html.

[426] Longman, *Best Care Anywhere*, 65-70.

[427] Lucian L. Leape and Donald M. Berwick, "Five Years After To Err is Human: What Have We Learned?" *Journal of the American Medical Association* 293, no. 19 (2005): 2384-2390. Doi: 10.1001/jama.293.19.2384..

[428] Longman, Best Care Anywhere, 48.K

navigate the political struggles of the mid-1990s and continue to operate as the nation's largest and only fully-subsidized healthcare system, it changed the culture of medicine at the VHA.

Kizer's reforms ultimately resulted in VA care becoming an industry leader, setting trends and influencing the course of healthcare throughout the U.S. both by example and through training. More than two-thirds of all healthcare providers in the United States undergo at least some training at VA facilities—it is reasonable to assume they carry practices learned at those facilities with them to other sectors. And Kizer challenged prevailing distinctions within the VA between service-connected and non-service-connected disability categories by demonstrating that such divisions were not only unnecessary but medically, ethically, and economically indefensible. Though the VA still retains such designations and still uses them to prioritize care access, the culture of evidence-based, patient-centered medicine Kizer established continues to raise questions about inherited bureaucratic categories like service-connected disability and how it applies to veterans' health care access.

**Pharmaceuticals: Shortcuts and Shortcomings in VA Care**

One of Kizer's reforms had to do with the establishment of the VA Formulary—the list of approved drug regimens that have passed extensive screening and testing for safety and effectiveness in the treatment of various diseases. For new drugs to make the approved list, they are first compared against existing regimens and evaluated according to metrics of safety, efficacy, and cost—reflecting Kizer's general "value equation." If a drug provides significant benefits over existing drugs, it makes the list. Such evidence-based practices improve, or at least maintain, patient health outcomes and insulate veterans from potentially harmful new drugs. But the availability of effective pharmacotherapies can have potentially negative ramifications for veterans with certain disabilities, particularly regarding mental health.

It is no mystery that the nation as a whole suffers a shortage of qualified mental health practitioners, but this problem is perhaps particularly acute in the VA.[429] Mental health workers at the VA suffer high rates of burnout, absenteeism, and turnover. A 2015 study on burnout rates among VA mental health providers hypothesized that the problem was due to compassion fatigue—the notion that rehashing traumatic events with patients will eventually wear down care workers.[430] This seemed like a rational hypothesis, given that VA patients tend to be exposed to severe and complex service-related traumas. But the findings of the study did not bear out this theory. Instead, researchers discovered that workload, perceptions of organizational politics, and bureaucracy were the primary factors in determining whether a mental health worker at the VA would burnout.

Problems like this are self-sustaining. When one provider burns out, others have to pick up their caseload, resulting in higher risks of burnout for them. And this not only affects VA's ability to staff mental health clinics, it inhibits effective service as many disabled veterans find themselves having to re-establish trust with multiple different providers.[431] Part of the problem, researchers claim, is that the VHA has to enforce regulations and national standards of care—just as they do for the Formulary, as these are essential to the "value equation" Kizer established—with the result being that many providers end up feeling micromanaged. The proposed solution? Hire more mental health workers and give them more leeway in how they do their jobs. But as the shortage

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[429] Kathleen C. Thomas, et al., "County-Level Estimates of Mental Health Professional Shortage in the United States," *Psychiatric Services* 60, no. 10 (October 2009):1323-1328.

[430] Hector A. Garcia, et al., "The Influence of Trauma and Patient Characteristics on Provider Burnout in the VA Post-Traumatic Stress Disorder Specialty Programmes," *Psychol Psychother* 89, no. 1 (2016): 66-81. Doi: 10.1111/papt.12057.

[431] Office of Research & Development, U.S. Dept. of Veterans Affairs, "Bureaucracy, not trauma exposure, is cause of most mental health provider burnout in VA," March 24, 2015.

of mental health professionals is a nationwide problem, this may be easier said than done. It's also not a new problem for the VA.

Indeed, military psychiatry has been extremely interested in the debilitating effects of trauma on mental health since at least the First World War. Physicians have worked diligently over the years to describe, diagnose, and treat various presentations of anxiety, depression, mood swings and other disorders that take otherwise healthy soldiers out of the fight and create categories of disability that carry significant stigmas for veterans. Lacking refined diagnoses, military psychiatrists tended to lump service members presenting such disorders into one of two categories: psychosis and neuropsychiatric (NP) cases.

By the Second World War, the military hospital system was utilizing well-developed inpatient care including psychoanalysis, hypnosis, insulin shock therapy, and so on.[432] But wartime military hospital systems had at least two significant advantages over the veterans' healthcare system. First, due to wartime necessity, they had easy access to healthcare professionals because maintaining and rehabilitating members of the armed forces was a national defense priority. Second, these hospitals did not have to deal with their patients over the long term. A typical NP case would be diagnosed, sent to a hospital for a relatively short but intense period of treatment, then discharged from the military and referred to the VA for long term care.[433]

The VA, on the other hand, had to balance the needs of its NP patients with other types of disabled veterans in a system with limited resources. For the better part of the 20th century, this meant the establishment and maintenance of an extensive network of inpatient psychiatric hospitals across the country. But even in these institutions, staffing was a perennial issue.[434] But

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[432] John Huston, *Let There Be Light*, Film, 1946.
[433] Ibid.
[434] See VA Annual Reports, 1945-1987.

inpatient care was not appropriate for many veterans with NP disabilities, and until the last few decades of the twentieth century—when its cost benefits began to outweigh its control concerns—outpatient care was a second-order priority in the VA. To patch over this gap in mental health services, the VA relied primarily on the judicious use of pharmaceuticals.[435]

An example of this practice was relayed by journalist Albert Deutsch in his 1945 investigation of VA healthcare. Noting that over 50,000 veterans of the Second World War living in New York City alone had received NP-related discharges and been referred to outpatient services, Deutch found that only one in five such vets were actually pursing treatment and that a smaller fraction were actually receiving it due to limited access. Many, according to Deutsch, were merely given prescriptions for sedatives—generally barbiturates at the time—to help them sleep.[436] Deutsch argued that such sedation was a poor substitute for effective psychiatric treatment. The drugs were addictive, potentially dangerous, and merely masked mental traumas, often resulting in the development of comorbidities like alcoholism down the road.[437]

Advancements in pharmacology and the development of milder tranquilizers and new classes of antidepressants in the 1950s and 1960s provided the VA with more and safer medications, but the practice remained little more than a bandage on what has been, at times, a gushing wound.[438] Today, VA policies still prescribe the use of selective serotonin reuptake inhibitors (SSRIs) as a "first-line therapy for PTSD," even as the VA's own studies demonstrate

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[435] Brett J. Deacon, "The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research," *Clinical Psychology Review* 33, no. 7 (Nov. 2013):846-861.

[436] Albert Deutsch, "VA Neglects Veterans with Sick Minds," *PM* vol. V, no. 183 (Jan. 17, 1945), 1.

[437] United States Veterans Administration, *VA Annual Report, FY 1954* (Washington, DC: Government Printing Office, 1954).

[438] Todd M. Hillhouse and Joseph H. Porter, "A brief history of the development of antidepressant drugs: from monoamines to glutamate," *Exp Clin Psychopharmacol* 2015 Feb; 23(1): 1-21. Doi: 10.1037/a0038550.

that "efficacy results from clinical trials have been variable."[439] In other words, pharmacological interventions for mental health disorders only mask or manage symptoms of disorders faced by many veterans. But, lacking viable alternatives, management of symptoms through cheap and relatively effective drug therapies continues to serve.

VA research efforts are building evidence-based data sets that demonstrate competing medical trends. On the one hand, the shortage of mental health providers is a serious problem that seems to be exacerbated by value equation priorities—enforcing standardized care based in best practices. But on the other hand, the Formulary offers a relatively inexpensive, relatively effective way to manage mental health symptoms. The question is, then, whether access to cheap and effective medications provides more value than seeking alternatives to the mental healthcare status quo. But the question of mental health care access is far from the only problem revealed and explored by the new patient-centered VA culture.

**Prejudice: Disability and Explaining Persistent Disparities**

The VHA Office of Health Equity recently released a 224-page report detailing health and healthcare disparities in the veterans' healthcare system. The *National Veteran Health Equity Report* (NVHER) aims to identify and close gaps in differential health care outcomes by providing stakeholders with "the 'quantitative tools' needed to advocate for a more fair and equitable healthcare system."[440] The emphasis on "quantitative tools" is precisely what Dr. Kizer championed in developing his value equation models, demonstrating the continued influence of

[439] Walter Alexander, "Pharmacotherapy for Post-traumatic Stress Disorder in Combat Veterans," *Pharmacy and Therapeutics* 37, no. 1 (2012): 32-38.

[440] Donna L. Washington, ed., *National Veteran Health Equity Report 2021: Focus on Veterans Health Administration Patient Experience and Health Quality* (Washington, DC: VHA Office of Health Equity, 2022), iii.

his reforms. But the data generated does not paint a pleasant or simple picture. Rather, it demonstrates the existence of intersectional factors that influence care access.

These factors include disability determination—what the VA calls a "disability rating"—race, gender, sex, age, type of military discharge, characterization of service, and more. Ostensibly, the VA is supposed to provide equitable access to care and benefits to disabled veterans without regards to many of these factors. But as the data demonstrates, intersectional elements and circumstances play a large role in health care access and health outcomes, beginning with determinations of disability. This is, then, a case where the theory of intersectionality, combined with a solid understanding of historical developments, has the potential to build on the VA's relatively new patient-centered medical culture with the hopes of making care access more equitable, in line with the VA's stated values.

Intersectionality is a critical framework that provides the language necessary to examine connections between categories and systems. This is particularly relevant to the VA because the bureaucratic categories on which it operates—like disability rating and service-connection status—are not determined by the VA alone. Congressional legislation, the military branches, and factors within the VA and society at large all play a role in shaping eligibility requirements, and each are subject to intersectional considerations. Therefore, an examination of the relevant history utilizing an intersectional lens can be useful in mapping out the general scope of the problem regarding health and health care disparities in the veterans' healthcare system.

The NVHER's authors analyzed patient data in three primary domains of veteran-patient experiences: access to care, communication, and coordination. By using VistA data and breaking studied veterans down into specific groups according to medical condition, traditional demographics—race, ethnicity, gender, age, socioeconomic status, and so on—and designations

unique to veterans like disability rating and service-connected disability status. After normalizing the numbers, the study's authors looked for patterns in the data.

It found that the largest observed disparity gap had to do with age. Veterans over 65 report generally better experiences in VA care than those under 45. But it also found, perhaps unsurprisingly, that racial differences continue to play a significant factor in the determination of health care access and health outcomes.[441] I say "unsurprisingly" here because race historically plays a significant role in the determination of care access and quality in other healthcare systems.[442] This despite the fact that explicit race-based determinations have been illegal in this country since 1964. Yet observable disparities exist, some argue, due to the presence of implicit biases and the intersectionality of factors that exacerbate impacts of individual elements.

The demographics of American veterans at any given time reflects both the demography of the nation and contemporary social and cultural values. These numbers change over time, of course, but one thing remains a relative constant: American veterans have always been a diverse group. But an unfortunate part of that diversity can be seen in how the nation honors, or fails to honor, the service of different types of veterans. A useful example of how this works—given that many studies into disparities focus on differences between Black and white populations—can be seen in the history of Black soldiers in the U.S. Army.

The Army is the oldest of the military branches—older than the nation it serves, in fact, having been established on June 14, 1775. And there have always been Black soldiers in its ranks

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[441] Washington, ed. National Veteran Health Equity Report 2021, 8-11; Agency for Healthcare Research and Quality, *National Healthcare Quality and Disparities Report Chartbook on Healthcare for Veterans*, AHRQ Pub. No. 21-0003 (November 2020).

[442] Michael C. Gibbons, "A Historical Overview of Health Disparities and the Potential of eHealth Solutions," *Journal of Medical Internet Research* 7, no. 5 (2005): e50. Doi: 10.2196/jmir.7.5.e50. While focused on the impact of eHealth applications in overcoming disparities, Gibbons provides a concise, well-sourced historical summary of the development of observed health disparities in the United States. Oprah Winfrey's *The Color of Care* special for the Smithsonian channel is another recent example. https://www.smithsonianchannel.com/special/the-color-of-care.

and they have served in every war. During the Civil War—when veterans' benefits were systematically established—more than 186,000 Black soldiers fought for the Union. And like their white peers, many of these veterans qualified for disability pensions through the 1862 General Law.[443] The rules governing the pension system were based on the medical determination of disability—determinations generally made by a board of contracted physicians following Pension Bureau guidelines—and made no distinction based on race.

Initially, Black veterans were roughly as likely to have a pension claim be approved. In 1862, 85 percent of Black veteran claims were approved compared to 89 percent for whites. As pension laws liberalized to include larger portions of the Union veteran population, significant disparities in approval rates began to appear. By 1890, 81 percent of white applicants had been approved while only 44 percent of Black veterans received pensions.[444] Pension laws passed after 1890 made explicit reference to racial categories, making it more difficult for Black veterans to receive pensions and paying less when such pensions were approved. But the General Law of 1862 made no such race-based distinctions, meaning the observed disparities were due to human factors. Boards of physicians and administrators who reviewed claims under the General Law were simply less likely to approve the claims of Black Civil War vets.

By the turn of the twentieth century, the United States had adopted a form of legal race-based discrimination with segregation. This is generally attributed to the 1896 Supreme Court decision in *Plessy v. Ferguson* that established the doctrine of "separate but equal."[445] But it is important to note that the Supreme Court's decision came *after* many laws and practices in the

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[443] Dora L. Costa, "Pensions and Retirement Among Black Union Army Veterans," *Journal of Economic History* 70, no. 3 (2010): 567-592.

[444] Ibid.; Costa notes that the boards of physicians tasked with examining pension applicants were more likely to designate the existence of disabilities for whites than they were for Blacks.

[445] U.S. Supreme Court, *Plessy v. Ferguson*, 163 U.S. 537 (1896).

states sought to formalize racial discrimination, including in medicine. The National Medical Association (NMA) was established in 1895 to provide Black physicians an organization to provide professional support, education, and networking. Its establishment was necessary because the older American Medical Association (AMA) and many state and local medical organizations excluded Black doctors and health professionals until the late 1960s.[446] This meant that the medical advice upon which the Pension Bureau (1862-1920), Veterans Bureau (1921-1930), and Veterans Administration relied to make disability determinations was almost exclusively that of white, and almost exclusively male, physicians.

By the First World War, the U.S. Army still enlisted Black soldiers, but it followed strict policies of racial segregation that not only kept units separate but also restricted the roles that Black soldiers could perform in the military. Colored units—as they were called at the time—were often relegated to manual labor and menial tasks. They were generally denied the honor of combat assignments, even when the men of such units volunteered for the duty. But as the United States entered the Great War to "make the world safe for democracy," it was a Black unit—the 369th Infantry Regiment, also known as the Harlem Hellfighters—that ended up seeing the most combat duty of any American unit in that war. Ironically, this was due to the Army's segregationist policies.

While the 369th was denied combat duty in American formations, political pressure from civil rights leaders like W.E.B. DuBois convinced General John J. Pershing and the other commanders of the American Expeditionary Forces to allow the 369th to be "lent out" to the French Army in April 1918—before most American units were ready to enter the line.[447] As a

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[446] Jade L. Dell and Steven Whitman, "A History of the Movement to Address Health Disparities," in *Urban Health: Combating Disparities with Local Data* (New York: Oxford University Press, 2011), 8-11.

[447] Max Brooks and Caanan White, *The Harlem Hellfighters* (New York: Del Rey Books, 2014).

result, the 369th was in the trenches when the Germans launched their final, last-ditch, no-holds-barred offensive in an attempt to break Allied lines before the full force of the American Army could be brought to bear. The Hellfighters experienced 191 days of frontline duty, losing not an inch of ground in the process, despite taking heavy casualties.

One of those casualties also happened to be the first American to receive the Croix de Guerre, France's highest military honor. Private Henry Johnson had been working as a porter at Union Station in New York City before the war. He volunteered when the war broke out, and found himself on guard duty the night of May 14, 1918, when a German raiding party attacked his position. Johnson single-handedly repelled that raiding party, saving the life of a fellow soldier in the process, despite suffering about 21 grievous wounds, including gunshots to the face, side, arm, and hand.[448] Johnson received his award and a promotion to Sergeant and was able to recover from his injuries enough to participate in a victory parade up Fifth Avenue in New York City with the rest of the Hellfighters in February 1919. But his injuries were such that he was not able to work as a porter again after the war.[449]

By 1923, Veterans Bureau records show that Henry Johnson was receiving compensation benefits at a "permanent, partial" rating, meaning he was able to draw $90 per month (about $1,700 in 2023). But the reason for Johnson's claim was that he had contracted tuberculosis—his records made no mention of the injuries or physical disabilities he sustained in combat despite the fact that his injuries prevented him from pursuing his former profession. In 1927, his disability rating was upgraded to "permanent, total," indicating the progression of his tuberculosis. In 1929, Johnson

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[448] Gilbert King, "Remembering Henry Johnson, the Soldier Called 'Black Death,'" *Smithsonian Magazine*, Oct. 25, 2011.

[449] Irvin S. Cobb, "Young Black Joe," *Saturday Evening Post*, May 15, 1918. Equal Justice Initiative, *Lynching in America: Targeting Black Veterans* (Montgomery, Alabama: EJI, 2017), 21.

passed away and was buried at Arlington National Cemetery. Johnson's story made news again in 2015 with the discovery of a commendation for his unit in the papers of General Pershing paving the way for President Obama to honor Johnson and the Harlem Hellfighters by posthumously awarding him the Medal of Honor.[450] But the fact that he never received disability compensation for his combat-related injuries is noteworthy in that it reflects the types of difficulties that many Black veterans experienced in trying to secure disability claims.

Indeed, while the nation welcomed the establishment of the Veterans Bureau in 1921 as part of its obligation to those who fought in the First World War, Black veterans across the country were learning that their service was no guarantee to receive support from the Veterans Bureau. In fact, they found that Blackness itself was essentially medicalized.

The initial veterans' hospital system established by the Veterans Bureau was a bit of an ad hoc affair, hastily assembled.[451] But its planners were able to recognize the value of having institutions that specialized in the treatment of certain medical conditions ranging from orthopedic surgery to tuberculosis and mental health care. Such specialization made the system more efficient and effective. But Black veterans witnessed the establishment of a different type of specialty institution: the Tuskegee Veterans Hospital, which specialized in treating Black veterans regardless of their medical condition or disability.

The Tuskegee hospital—which was originally called the Hospital for Sick and Injured Colored World War Veterans—was purpose-built to provide care for hundreds of thousands of Black veterans who could not otherwise receive quality care at segregated Veterans Bureau (and later Veterans Administration) hospitals due to the agency's policy of "respecting local

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[450] Dan Lamothe, "How the White House and media got it wrong on Medal of Honor recipient Henry Johnson," *The Washington Post*, Jun. 11, 2015.

[451] See Chapter 2.

customs."[452] Influential Black and civil rights organizations like the National Association for the Advancement of Colored People (NAACP) and the National Medical Association (NMA) lobbied for the creation of a hospital specifically for Black veterans, seeing it as a step toward racial equality, a place to provide opportunities for Black medical professionals, and an opportunity to improve care for Black veterans.[453] At the same time, the existence of Tuskegee allowed the Veterans Bureau to justify segregation in its other hospitals—a nod to the "separate but equal" doctrine. And nearly a century after its establishment, observed healthcare disparities in veterans' health data can be traced to the intersecting structures and forces that led to the Tuskegee hospital.

The geographic location of the hospital, its staffing, and its uniqueness among veterans hospitals at the time contributed to race-based disparities in veterans' care. Black veterans had to travel to Alabama or deal with often second-class care in segregated facilities elsewhere. Despite the NAACP and NMA securing promises from President Harding himself, the initial doctors, nurses, and administrators at the hospital were white.[454] And because the Tuskegee hospital existed as an all-Black veterans hospital, it essentially allowed other facilities across the country to adopt local policies of segregation and justify those policies by pointing to Tuskegee as an alternative.

Each of these factors alone represented a barrier or inconvenience that did not concern white veterans. Indeed, white veterans benefitted from official efforts to locate veterans hospitals conveniently close to veteran populations.[455] White veterans did not have to worry as much about whether their doctor would believe their complaints or relate to them. And they did not have to

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[452] Pete Daniel, "Black Power in the 1920s: The Case of Tuskegee Veterans Hospital," *Journal of Southern History* 36 (1970): 368-388.

[453] Vanessa Northington Gamble, *Making a Place for Ourselves: The Black Hospital Movement, 1920-1945* (New York: Oxford University Press, 1995), 70-104.

[454] Jessie Redmon Fauset, ed., "The Tuskegee Hospital," *The Crisis* 26, no. 3 (July 1923): 106-107.

[455] Annual Report of the Director, United States Veterans' Bureau, for the Fiscal year Ended June 30, 1925 (Washington: Government Printing Office, 1925), 38.

worry about receiving second-class services due to "local customs." Black veterans had to deal with all of these things, and that was, of course, assuming they were able to secure a disability designation that made them eligible for hospital benefits in the first place.

Eligibility determinations are a key factor in the historical development of health and health care disparities for veterans, and these determinations have not, until recently, been seriously scrutinized. To be eligible for benefits, a veteran must receive an honorable discharge and have a medically-recognized disability—generally a condition that would interfere with the veteran's ability to perform manual labor. These conditions are compounded by the nature in which the disability was incurred. Service-connected disabilities—those with documented proof to be caused or exacerbated by military service—receive higher priority than non-service-connected disabilities. And while the VA is bound by law to consider these factors in providing access to care, other institutions are primarily responsible for establishing eligibility requirements.

The authority to determine veterans' benefits eligibility ultimately rests with Congress, who writes the legislation that define the criteria. For instance, Congress defined a "veteran" as a "person who served in the active military… and who was discharged or released therefrom under conditions other than dishonorable."[456] But because discharge characterizations can vary, the VA has traditionally presumed that all veterans with other-than-honorable (also known as administrative) discharges were released from service under dishonorable conditions, meaning these folks are not legally "veterans."[457] Such presumptive exclusion prevents many former servicemembers from accessing benefits, regardless of whether or not they have a qualifying

[456] 38 U.S.C. Section 101(2).

[457] Connecticut Veterans Legal Center, *Discretionary Injustice: How Racial Disparities in the Military's Administrative Separation System Harm Black Veterans*, November 2022. http://ctveteranslegal.org/wp-content/uploads/2022/11/Discretionary-Injustice-Report.pdf.

disability, and this presumption is based on decisions by the military branches—not the VA—meaning oversight of the process is extremely difficult. The potential for presumptive exclusion to intersect with racist military policies or officials is high, as the history bears out.

Upon separation from the military, servicemembers receive discharge papers that characterize the nature of their service into roughly five categories: honorable, general, other than honorable (OTH), bad conduct, and dishonorable. The first three categories—honorable, general, and OTH—are considered to be administrative discharges, meaning the military effected the discharge without need of a court-martial. Bad conduct and dishonorable discharges can only be imposed by a military court-martial because the consequences of such discharges are such that servicemembers are allowed the benefit of a court hearing to determine whether such a discharge status is appropriate.[458] But as noted above, only an honorable discharge has historically been guaranteed to allow a veteran to begin the eligibility determination process.

Veterans have a name for general and OTH administrative discharges: bad paper. Such discharges gained particular popularity during the latter years of the Vietnam war. Between 1965 and 1969, the various military branches used administrative discharges at a rate of 11,500 per year. But by 1972, that number climbed well north of 40,000 per year.[459] The increase corresponded with the government's use of the draft to supplement troop levels in Vietnam and shifting public perceptions of the war.

The draft was not a novel concept in the Vietnam war. The U.S. military implemented drafts to fill in the ranks in the Korean Conflict and both World Wars. Draftees have generally

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[458] OutVets and the Harvard Legal Services Center, *Turned Away: How VA Unlawfully Denies Health Care to Veterans with Bad Paper Discharges*, 2020. https://www.legalservicescenter.org/wp-content/uploads/Turn-Away-Report.pdf.

[459] Peter Slavin, "The Cruelest Discrimination: Vets with Bad Paper Discharges," *Business and Society Review* 14 (1975): 25-33.

served as honorably and capably as volunteers. But with shifting public perceptions of the war in Vietnam, particularly after the Tet Offensive of 1968, many draftees brought their objections to the war with them into the military, creating headaches for military commanders, and servicemembers cannot be fired like civilian employees. A pragmatic solution—from the commanders' perspective—was the administrative discharge. But the system was certainly abused. Black and other non-majority-conforming servicemembers often found themselves on the wrong end of bad paper discharges that prevented them from accessing VA benefits.

Veterans with bad paper could (and still can) seek to upgrade their discharge designation for the purpose of accessing VA benefits, but the process is tedious, potentially expensive, and there is no guarantee of success.[460] And discharge characterization is not the only place for potential discrimination. The VA disability claim process is another.

In November 2022, Conley Monk Jr., a Black veteran of the Vietnam war, managed to secure nearly two decades' worth of records through a Freedom of Information Act request concerning disability claims applications to the Department of Veterans Affairs. The data showed that from 2001 to 2020 there was "a statistically significant difference in claims outcomes for Black and white veterans."[461] In response to this revelation, Mr. Monk filed suit against the VA. Monk volunteered for service in the U.S. Marine Corps during the Vietnam War. He drove trucks through combat zones but, despite earning several medals for his service, received a bad paper discharge in 1971 after he got into two fights that he blames on undiagnosed and untreated PTSD. The characterization of his discharge prevented Monk from receiving earned benefits for decades,

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[460] U.S. Department of Veterans Affairs, "Your Steps for Upgrading Your Discharge," https://www.va.gov/discharge-upgrade-instructions/guidance.

[461] American Homefront Project, "A Lawsuit Alleges a Racial Disparity in VA Benefits and Says the VA Isn't Doing Enough About It," Texas Public Radio, Dec. 14, 2022.

including disability compensation. Conley Monk fought his discharge designation—an expensive and lengthy legal process that, for Monk, was not resolved until 2015 with an upgrade to an honorable discharge. In the intervening 34 years, Monk founded the National Veterans Council for Legal Redress to help others with bad paper discharges navigate the system.[462] In partnership with the Veterans Legal Services Clinic at Yale Law School, he was able to obtain the VA records in question.

Those records showed that the average denial rate for disability claims for Black veterans was nearly 30 percent—roughly six percentage points higher than for white veterans.[463] In other words, even in the twenty-first century, the VA is more likely to approve disability claims from white veterans than from their Black peers. Keep in mind that this only applies to those vets who are able to meet the discharge qualification requirements in the first place.

Monk's lawsuit "seeks to pinpoint where the discrimination occurs—whether that's during medical exams, the disability rating process, or somewhere else."[464] VA Press Secretary, Terrence Hays, noted that the agency is working to combat institutional racism, that officials are reviewing policies to serve veterans with bad paper, and that "throughout history, there have been unacceptable disparities in both VA benefits decisions and military discharge status due to racism, which have wrongly left Black veterans without access to care and benefits…. We are actively working to right these wrongs."[465]

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[462] National Veterans Council for Legal Redress, "What do we do?," http://nationalveteranscouncil.com/our-mission.

[463] American Homefront Project, "Lawsuit Alleges a Racial Disparity in VA Benefits."

[464] Ibid.

[465] Alex Horton, "Racist Discrimination by Veterans Affairs Spans Decades, Lawsuit Says," *The Washington Post*, Nov. 28, 2022. https://www.washingtonpost.com/national-security/2022/11/28/veterans-affairs-lawsuit-racial-discrimination/

Part of the reason bad paper is still such an issue is due to the failures of institutions like the VA and the military branches to go beyond surface-level reforms that ostensibly end discriminatory practices. President Truman issued Executive Order 9981 to desegregate the armed forces on July 26, 1948. President Eisenhower issued a similar order to integrate veterans' hospitals across the country in 1954.[466] By October 1954, VA officials confidently, even proudly, declared that all of the agency's facilities had been desegregated.[467] But as the Monk lawsuit and the NVHER data demonstrate, orders banning official discrimination are not enough to prevent the effects of implicit bias in disability determinations and health outcomes.

In this light, the NVHER report on health equity shows signs that the VA medical culture shift might help the agency live up to its stated ideals "to care for [them] who shall have borne the battle" regardless of their race, ethnicity, gender, sex, sexual orientation, or criteria other than that stated in the agency's motto.[468] The report represents a concerted effort to identify, quantify, and work to address persistent health and health care disparities in the veterans' healthcare system.[469] The data may not always present pleasant pictures that match up with press releases and platitudes, but it represents the beginning of a data-collection and interpretation process that fits with Kizer's medical culture forms, offering hope that the same shifts that transformed the VHA from an on-the-brink healthcare system into one that is still leading in most patient quality metrics can create

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[466] Thomas Grillot, Pauline Peretz, and Yann Philippe, "'Wherever the Authority of the Federal Government Extends': Banning Segregation in Veterans Hospitals (1945-1960)," *The Journal of American History* (2020): 388-410.

[467] Chief Medical Director to Administrator, "Elimination of Segregation-Report 1," Oct. 27, 1953, "Veterans Administration (3)" folder, box 54, subseries C. Subject file 1953-1958, Maxwell M. Rabb Papers, Dwight D. Eisenhower Library, Abilene, Kansas; "Report 2," Dec. 1953, "Report 3," Jan. 1954, and "Report 4," Mar. 1954.

[468] This is an adaptation of the VA's official motto, derived from President Lincoln's second inaugural address.

[469] NVHER, 2. Black and American Indian or Alaska Native Veteran groups had the greatest disparities compared with non-Hispanic white Veterans, with worse care quality on 40% or more measures in at least one domain of care quality. Women Veterans age 65 and older had large gaps in quality compared with their male counterparts, whereas gender differences were less apparent for younger veterans. Quality gaps were present for vets with low SES in healthy living and preventative services. And across domains, quality gaps were present for vets under 65 compared to those over 65.

an evidence-based framework to examine and address intersectional factors and implicit biases.[470] Nothing the VA—nor anyone else, as yet—does can change the past. But by taking an open, transparent, and honest approach to the lessons of the past in shaping policies, the VA has an opportunity to address persistent disparities in the veteran population.

## Conclusions: Medical Cultures

Cultural shifts have indelible influences on historical developments, and changes in medical cultures are no exception. It was the shifting contexts of the Progressive Era with its emphasis on scientific expertise that shaped possibilities and laid the foundations for a fundamental shift with the medicalization of veterans' benefits. Public support and esteem for both veterans and modern medicine in the Second World War assisted the VA's move toward academic affiliation. That partnership took years to develop, in part, because influential officials at the VA like Administrator Frank T. Hines were more concerned about avoiding scandal than they were about the possibilities of contemporary medicine. When Bradley and Hawley took over, they did not share Hine's compunctions, and so a new culture of medicine—one that embraced academia and research—took hold. And when Vietnam veterans struggled to readjust to a passionately ambivalent society shaped by activism, they found allies in contemporary psychiatry who shared their activist cultures. Together, these activists influenced the system by leveraging its mechanism—specifically by defining PTSD as a service-connected disability—to the benefit of not only Vietnam veterans, but future generations as well.

But just as cultural shifts create opportunities for change, they also have a remarkable tendency to create opportunities for continuity. The development and employment of

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[470] Claire O'Hanlon, et al., "Comparing VA and Non-VA Quality of Care: A Systematic Review," *Journal of General Internal Medicine* 32, no. 1 (2017): 105-121. This study found that in terms of safety, effectiveness, and efficiency, VA care demonstrates "generally favorable performance… compared to non-VA facilities."

pharmaceuticals has not given VA physicians the ability to cure mental health disorders veterans face, but it has made those disorders more manageable. It relieved the system of pressures that may have spurred different developments if left unchecked. This is not to play the tempting but futile game of "what if" that so often accompanies historical study; rather, it's to point out that continuities simply do not garner the same attention as changes, even if the implications of those continuities are relatively clear. It is much harder when those same implications are hidden.

That's precisely why Dr. Kenneth W. Kizer's medical culture revolution at the VHA was (and remains) so profoundly influential. By finding ways to create metrics of care quality and safety, Kizer created a medical culture that builds upon previous developments and enables VA staff to examine, measure, analyze, and potentially address problems hidden in the unchallenged continuities of care. By taking stock of health and health care disparities, the VHA is working to establish an evidence-based approach that applies useful metrics on the effects of implicitly discriminatory policies. It is hoped that such data will inspire future policy reforms, but it is also possible that the medical culture shift begun in the 1990s will inspire policymakers to reevaluate other unchallenged notions like discharge characterization, disability ratings, and service-connected disability status.

Some of these issues are entirely internal to the veterans' healthcare system. Others—like eligibility based on discharge characterization—are bigger than the VA alone. The veterans' healthcare system today is rated among the best healthcare in the country. But it is a system that, in a way, selects its own patients, which potentially skews the numbers in its favor. The law limits eligibility for care and benefits, often based on inherited and unchallenged criteria like the ability to perform manual labor, the nature in which a disability was incurred, and the characterization of a veteran's military service. Success under such circumstances runs the risk of fostering a false

sense of security among lawmakers and an unfair burden of accountability on a system working with factors beyond its control. Why worry about veterans' health? The VA has that covered. At the same time, why are so many veterans suffering addiction, homelessness, and suicide? What's the VA doing about it?

Intersectional challenges are complicated and generally larger than the scope of any single federal agency—even one as large as the VA—particularly if such challenges remain hidden by platitudes or shame. Health and health care disparities in the veteran population did not begin in the 21st century, when VA researchers started to examine them. Their roots were in the historical development of the veterans' healthcare system and subject to contemporary biases, prejudices, and priorities. And if the VHA truly is a model of better healthcare for all Americans, as Phillip Longman and others argue, then the implications of how the VA and its partners respond to intersectional challenges are both significant and worthy of further examination.

The next chapter will explore one such issue in veteran suicides. It will explore the history of the problem, how it intersects and interacts with other factors, and identify the key actors and concerns in the hope that an honest truth can inspire honest reconciliation.

## 5) Deadly Disability: Bureaucratic Barriers to Care

### Mantras and Mentalities

I first encountered the mantra "my mission, my men, myself" in Basic Training. I first thought it was just another military idioms or mnemonic devices employed to help new soldiers find ways of retaining the flood of new information we were learning. But throughout my time in the Army, this mantra kept popping up, and I realized that it reflected core military values of selfless service and leadership.

It's a priority list. Ensure the success of the mission above all other considerations. Take care of those responsible for the highest priority—give them the training, information, equipment, and support they need. Then, only after higher priorities had been satisfied, take care of yourself. In other words, prioritize others before yourself. That's a remarkably useful mentality in a military context, and in my experience, successful soldiers made a habit of this mantra. Putting others first was honorable, it demonstrated commitment to duty and loyalty, and it encouraged others to follow that lead. Do your job, take care of your buddies, and they'll take care of you in turn.

Those who violate the mantra—or who are perceived to have violated it—run the risk of being effectively ostracized. Break faith with the mantra and you were likely to be perceived as selfish, lazy, unreliable, or even dangerously incompetent. At best, you were "shamming" or trying to get out of duty by shifting the burden onto your buddies. At worst, you could be seen as a liability to the team. So, in a way, "my mission, my men, myself" is a reflection of the peer dynamics that make the military work as well as it does. But it sometimes presented in strange ways, like sick call.

Sick call is the Army term for going to see the doctor, and again, in my experience, it was something to be avoided at all costs. It wasn't avoided because it was an unpleasant experience. I

mean, the few times I had to go to sick call, it *was* unpleasant, but that's not why I tried to avoid it. I mainly evaded sick call because I didn't want to be seen as a shammer—as someone malingering and thus increasing others' burdens. I was worried that my buddies would think I was putting myself above them and violating the mantra—that I had my priorities wrong.

This meant that I ended up "pushing through" a lot of illnesses and injuries in my time in the service. When I hurt my knee in Airborne School and it swelled up to the size of a football and protested with each step, I just put ice on it, took ibuprofen, and made sure I was in formation the next morning for the culminating five-mile run. It hurt like hell, but I didn't want my buddies to think I was broken. It meant that when I caught a cold or minor illness—something that was admittedly rare—I pushed through. A broken finger or minor laceration in the field was something to patch up yourself and only bother "Doc" (an infantryman's term of endearment for their medic) if it didn't improve. The only time it was acceptable to go to sick call was if you were ordered to do so by a superior, which meant it became part of your mission and thus not a violation of the mantra.

I didn't realize that this behavior would make applying for veterans' benefits more difficult at the time. But to be honest, even if I had known, I'd still avoid sick call because my mentality—like that of my peers—was to put the consideration of others first. I didn't want my buddies to have to work harder because I wasn't there. And because this mindset became a useful habit in the military, it stuck with me as I made the transition to becoming a veteran.

That transition from service member to veteran is a relatively isolating experience. There is no official guidance or regimen to it. When one joins the military, there are support structures that help inductees habituate to their environment. New soldiers are introduced to the military's rigid, hierarchical, well-defined, and largely effective system of education and acclimation. Drill

sergeants teach the basics, experienced NCOs show younger soldiers the ropes and confer the benefits of their experience, officers define mission objectives and give orders, and fellow soldiers are an ever-present support network. New soldiers thus make the transition from civilian to soldier relatively easy. But new veterans don't have such systems. They're simply cut loose and given the freedom to figure things out on their own.

That's quite a shock for many vets. No one telling you what to do, how to do it, or why. And without that structure, many new veterans—myself included—fall back on established habits like "my mission, my men, myself."

I mentioned before that I didn't register with the VA after getting out of the Army in 2006. I specifically refused to even apply at the time for a number of reasons, but chief among them was that I didn't think I needed or deserved the benefits as much as others. I didn't see myself as disabled and knew that others had much more serious complaints than I did.

Yes, my joints ached, even then. And yes, those aches grew worse over the years. Today, the mere act of shoveling snow off my driveway is likely to make my right shoulder hurt so bad that it keeps me up at night. My knees, ankles, and back creak and crack and protest at even the thought of using stairs, or walking too far, or standing still for too long. I'm constantly shifting my posture and changing my stance to keep my joints and back from aching. But I can still shovel snow off my driveway, walk up and down stairs without support, and do all the rest—provided I'm willing to put up with the pain that follows.

Yes, my ears rang with tinnitus, even in 2006. That ringing makes it difficult to make out conversations in a noisy environment. It keeps me up at night and makes me avoid places that are too quiet. But I adapted to these things. I picked up basic lip reading and paid more attention to body language. I have a fan running when I go to sleep so the room isn't too quiet. My tinnitus has

been an inconvenience, no doubt, but a disability? It has never prevented me from being able to work or pursue an education.

Yes, I had nightmares and stretches of serious depression and anxiety, even back in 2006. But those episodes were always temporary and posed no serious threat to my wellbeing—or so I told myself for years. Over time, the symptoms got worse and eventually did become a significant issue that spurred me to seek VA care because I knew the VA was best situated to help deal with what I suspected to be chronic PTSD. But for more than fourteen years, I told myself that I was handling it and reminded myself that others had it worse. Besides, I always figured that I could apply for benefits down the road when my complaints became actual impairments.

I found a measure of pride in my refusal to acknowledge these issues as disabilities. I was still toughing it out, pushing through, and I ignorantly believed that not taking my benefits was making it easier for the system to direct important resources to folks who needed them more.

Let me be clear on this point: that perspective was wrong. But it is also rather common. Ask anyone working with or on behalf of veterans and you're likely to hear similar things. Others need the benefits more than I do. I'm not disabled, so why make a claim to that effect? These statements are rooted in "my mission, my men, myself." Put others first. Don't be a liability. Don't be "broken." Instead, adapt and overcome. That's another useful mantra, another useful mentality.

That's essentially what new veterans have to do when they make the transition from service member back to civilian—they adapt and overcome. But that can be a perilous journey, in part, because the lessons of adapting to military life are not always well suited to a civil environment.

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There are many obstacles that stand between a veteran and the benefits they earned. The first is often the veteran themself.

Many vets who are eligible for benefits do not apply.[471] Their reasons vary, of course. Some may not be aware of the benefits, others may feel they do not need them, and many grow frustrated with a complicated application process that often denies claims over incorrect paperwork or lack of documentation and quit trying. Whatever the reason, the fact that the system requires veterans to apply for benefits they earned—combined with a mindset cultivated in the military that indoctrinates service members to avoid perceptions of being a liability—means the first obstacle of simply applying can be one of the most difficult obstacles to overcome. And there are several more obstacles that compound the issue of access. Should a veteran apply for benefits, they enter a complicated series of eligibility tests.

Eligibility is ultimately determined by laws passed by Congress. These laws are codified in the Code of Federal Regulation, Title 38, "Pensions, Bonuses, and Veterans' Relief," also known as Title 38 or 38 CFR.[472] The Department of Veterans Affairs is legally obligated to conform to the stipulations set out in 38 CFR, and other than providing information through its annual reports and testimony before congressional committees, VA officials have little influence in shaping or interpreting Title 38, which stipulates the elements of eligibility.

One element—touched upon briefly in Chapter 4—is the characterization of a service member's discharge from the armed forces.[473] Discharge qualification is determined by the military branches and falls along a defined spectrum including honorable, general, other than honorable, bad conduct, and dishonorable designations. Veterans who disagree with their discharge status have options to have their discharge reviewed and potentially upgraded, but such

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[471] Karin M. Nelson, et al., "Veterans Using and Uninsured Veterans Not Using Veterans Affairs (VA) Health Care," *Public Health Reports* 122, no. 2 (2007):93-100.

[472] National Archives and Records Administration, Code of Federal Regulations, "Title 38 - Pensions, Bonuses, and Veterans' Relief," eCFR. https://www.ecfr.gov/current/title-38.

[473] See Chapter 4, particularly the parts referencing Bad Paper.

processes are done through the legal structures of the various military branches, not through the VA.[474] Ostensibly, only bad conduct and dishonorable designations are automatically disqualifying for veterans benefits, but 38 CFR states that discharges under certain circumstances are "considered to have been issued under dishonorable conditions" even if they are not explicitly dishonorable.[475] This means that VA policy generally errs on the side of caution by assuming ambiguous discharges are disqualifying, requiring affected veterans to appeal as necessary.

One area where VA officials have remarkable agency regarding eligibility is in disability determinations. Title 38 Part 4 provides a rating schedule that "is primarily a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service."[476] It is effectively a list of approved conditions compiled from the long history of veterans' legislation and the deliberations of medical experts, and it gives significant leeway to VA officials. It notes that different examiners, at different times, will describe the same disability differently.[477] With such subjectivity in mind, Part 4 provides guidance for evaluation boards, rating specialists, and others in executing their duties in determining the existence and extent of a veteran applicant's disability and assigning a value known as a disability rating.

Disability rating is a bureaucratic value entirely internal to the VA. It has no bearing on whether a veteran is considered disabled by other institutions regarding employment, eligibility for other government services and considerations, or other matters. Disability ratings are based on

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[474] Swords to Plowshares, "Upgrading your Military Discharge and Changing the Reason for your Discharge," swords-to-plowshares.org, March 9, 2020.

[475] 38 CFR §3.12 "Character of Discharge," eCFR :: 38 CFR Part 3 -- Adjudication. Such designations include vague phrasing like "willful and persistent misconduct" and "an offense involving moral turpitude." 38 CFR §3.12.d.5 still explicitly mentions homosexuality as a disqualifying escalator under certain circumstances.

[476] 38 CFR §4.1 "Essentials of evaluative rating."

[477] 38 CFR §4.2-4.9.

the severity of service-connected disabilities and are used to determine compensation payments to veterans and access to VA services, including health care.

And while official recognition of a qualifying disability is a significant step in eligibility determination, the process continues with the VA's Priority Group system, which is used to determine access to specific benefits and the priority of services for different groups of veterans based on their circumstances.[478] There are eight priority groups (PG1-8), with PG1 being the highest priority and PG8 being the lowest. Divisions between the groups are determined according to factors including disability rating, the veteran's income, and other specific factors designated by law.[479] Ostensibly, the priority group system helps the VA triage limited health care resources. In effect, it contributes to a problem that journalist Albert Deutch dubbed "pensionitis" in 1945. It motivates some veterans to seek maximum financial compensation or higher priority access with significant implications.

This chapter explores the implications and ramifications of the intersection of military cultures, popular perceptions of veterans, and the VA bureaucracy in the twenty-first century. Essentially, it explores how that bureaucracy can be a barrier to care. It examines the influence of cultural stigmas about disability, concerns about fraud, and why expanding care access is essential for veterans and the society they continue to serve. In doing so, it demonstrates how a system built on the notion of a national obligation—to "provide for [them] who shall have borne the battle" to paraphrase the VA's official motto—can also be a system that is, in some fundamental ways,

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[478] 38 CFR §4.2-4.9. The Priority Group system was established by the Veterans' Health Care Eligibility Reform Act of 1996, which required the VA to both prioritize care and limit enrollment only to those veterans for whom it had sufficient resources to provide timely care. Stephen P. Backhus, Director Veterans' Affairs and Military Health Care Issues, Health, Education, and Human Services Division, testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives, July 15, 1999.

[479] Specific factors are often linked to the circumstances of a veteran's service. For instance, if a veteran was exposed to ionized radiation due to nuclear testing, served in Vietnam between 1962 and 1975, and has no compensable service-connected disability, they are still allowed access to the system as part of Priority Group 6.

effectively broken due to the obstacles it imposes on veterans out of misguided notions of economy, efficiency, and eligibility that do not match up with historical trends or contemporary data.

Perhaps the most explicit example of these intersecting factors is the relatively recent attention paid to the problem of veteran suicides.

**Case Study: 22**

In 2012, the Department of Veterans Affairs published its first report dedicated to the study of veteran suicides with the *VA Suicide Data Report, 2012*.[480] This report is remarkable for a number of reasons. It was the first study to try to understand the problem of veteran suicides by looking at the entire veteran population, not just those enrolled in VHA care. It started a series of VA studies that continue to examine the problem from new angles as VA works to develop evidence-based approaches to suicide prevention. And perhaps the most remarkable aspect of the report was the effect it had on the public's perception of the problem as the number 22 became synonymous with veteran suicides.

The *VA Suicide Data Report, 2012* emerged from the passage of the Joshua Omvig Suicide Prevention Act of 2007 (Omvig Act).[481] The law was named in honor of Joshua Omvig, a 22-year-old Army Reservist who committed suicide in 2005 following a deployment to Iraq and a struggle with PTSD.[482] As a result of their son's death, Randal and Ellen Omvig lobbied lawmakers in

[480] Janet Kemp and Robert Bossarte, *Suicide Data Report, 2012*, Department of Veterans Affairs, Mental Health Services, Suicide Prevention Program (Washington, DC: Dept. of Veterans Affairs, 2012).
[481] H.R. 327 - 110th Congress, Public Law No. 110-110 (11/05/2007).
[482] "Joshua L. Omvig," *Gillette News Record*, Dec. 28, 2005.

Washington, D.C. to pass a law that would promote PTSD care and suicide prevention programs, resulting in the law that now bears his name.[483]

The Omvig Act placed several mandates on the VA, including implementing suicide awareness training and coordination, the establishment of the Veterans Crisis Line and peer support efforts, and it required the VA to scientifically study the problem with the hopes of devising interventions.[484] So, in 2008, VA Mental Health Services established a suicide surveillance and clinical support system that sought to gather data from as many sources as possible to better understand its scope. In addition to internal VHA data, the study's authors included information gathered from the Veterans Crisis Line, the National Death Index for the Centers for Disease Control and Prevention, and mortality data from twenty-three states. Data collection took place between 2009 and 2012.[485] When the report came out, the authors warned that the data was not perfect—that it was not a research-based analysis and there were significant gaps in the data. They emphasized that it was a preliminary effort to identify angles of further inquiry. But even so, its findings were grim.

The study found that, of all suicides reported in the project period, 22.2% were by veterans.[486] Considering that veterans made up less than 7% of the U.S. population at the time, this indicated that veteran suicide rates were significantly higher than civilians. And by extrapolating

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[483] Kay Steiger, "Giving Vets Their Due: Six years after the invasion of Afghanistan, it's time to examine the benefits we give our soldiers once they return home," *The American Prospect*, Nov. 12, 2007. https://prospect.org/article/giving-vets-due/

[484] Leonard Boswell, United States House of Representatives, Public Law No. 110-110 (11/05/2007); Stephen Barlas, "Vets' Mental Health Bill Becomes Law," *Psychiatric Times* 24, no. 14 (2007). It is also important to note that while PL 110-110 established mandates for programs and awareness, it did not provide any additional funding to the VA to support those programs.

[485] Kemp and Bossarte, *VA Suicide Data Report, 2012*, 8. Kemp and Bossarte noted that theirs "was not a research-based analysis and there are significant limitations to the data."

[486] In subsequent studies, the VA clarified that "veterans" in the 2012 study included active duty, reserve, and members of the National Guard who committed suicide—many of whom had not deployed or did not meet the strict legal definition of "veteran" by 38 CFR.

these rates across the total population, the study's authors estimated that "22 Veterans will have died from suicide each day."[487] This number soon became synonymous with the problem in the public imagination.

In 2016, a charity called 22Kill launched the 22 Pushups Challenge, charging people to record themselves doing 22 pushups each day for 22 days, to post the videos to social media, and to charge others with taking up the challenge.[488] The campaign went viral when celebrities like Dwayne "The Rock" Johnson, Chris Evans, and John Krasinski posted videos of themselves completing the challenge.[489] While some organizations welcomed the bump in awareness, others questioned whether awareness alone was enough and whether the campaign was properly educating the public about the problem. Writing for *Task & Purpose*, a popular military-focused outlet, veteran Carl Forsling provided a prescient critique when he noted that veterans who committed suicide were suffering from the "lack of counseling, lack of veterans services, and a lack of money… not a lack of pushups."[490]

While the challenge played out in social media, the VA continued to study the issue—perhaps under some additional pressure due to the increased public awareness of the problem. For subsequent reports, the VA worked with a wider network of public and private partners and refined its collection methods to develop more granular data.[491] These reports were able to generate higher

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[487] Kemp and Bossarte, VA Suicide Data Report, 2012, 15.

[488] Andrew K. Nguyen, a Marine, veteran of Afghanistan, and founder of multiple veterans' nonprofits founded 22Kill in 2013 to raise awareness about veteran suicides based on the statistic given in the *VA Suicide Data Report, 2012*. https://1tribefoundation.org/programs/22kill/

[489] Libby Hill, "Chris Evans and the Rock support our troops with the 22 Pushup Challenge," *Los Angeles Times*, Aug. 16, 2016.

[490] Carl Forsling, "The 22 Pushups Challenge Isn't Actually Helping Anyone," *Task & Purpose,* 25 Aug. 2016. https://www.military.com/daily-news/2016/08/25/the-22-pushups-challenge-isnt-actually-helping-anyone.html; "Veterans die by suicide for a variety of reasons, but it's unlikely any of them were suffering from a lack of PT on the part of their brothers and sisters in arms. What they are suffering from is something else. Lack of counseling, lack of veterans services, and lack of money are what is killing these veterans, not a lack of pushups."

[491] Partner organizations included SAMHSA, DoD, DHS, the National Alliance for Suicide Prevention, and several of the major veterans' service organizations.

resolution data about the problem by revising data collection methods, but they also paid special attention to two noteworthy demographics: who qualifies as a veteran, and whether or not the person that committed suicide was enrolled in VHA care. Both points seem to serve internal VA priorities, and—like a social media awareness challenge—and neither seemed particularly productive in devising solutions.

By 2018, possibly in response to the viral social media awareness campaigns and the impressions they made of the problem, the VA National Suicide Data Report series highlighted certain aspects of the data in an apparent attempt to correct misinformation. First, it noted that it would not emphasize the number of suicides per day because it is "a measure that is commonly misinterpreted."[492] Instead, the report focused on demographic information about veteran suicides including method and subpopulation groups including age, VHA user status, gender, and a more precise interpretation of the word "veteran."

The definitional emphasis on which suicides counted as a veteran suicide makes sense from a data integrity standpoint. 38 CFR strictly defines a "veteran" as "a person who served in the active military, naval, air, or space service and who was discharged or released under conditions other than dishonorable."[493] So sticking to that definition, the elimination of suicides involving members of the Reserve and National Guard who were never activated as part of wartime service does result in a more-defined dataset. The result was numbers that showed the actual number of daily veteran suicides was closer to 16.5, not 22.[494] Even so, the report demonstrated that veteran

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[492] U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016*, September 2018, pp. 2.

[493] 38 CFR §3.1(d).

[494] Ibid. The report never *explicitly* mentions the daily rate, but it provides numbers that calculate to 16.5 veterans per day, plus another 2.5 suicides per day from Reservists and National Guard members who were never activated or deployed.

suicides were occurring at rates between 1.5 and 1.8 times higher than civilian populations.[495] So, changing who qualified as a veteran from the definition in the 2012 report, while more precise, did not significantly add to the understanding of why these problems were occurring.

Similarly, the 2018 report's emphasis on demographics information provided more resolution while clarifying misconceptions but not necessarily a clearer understanding of the problem. By breaking decedent cases down by age, for instance, it demonstrated that younger veterans (age 18-34) were committing suicide at higher rates, but that the bulk of decedents (58.1 percent) were from older cohorts (55 and older).[496] That the bulk of cases were older veterans could indicate that the problem was not necessarily related to recent combat experience, as many assumed. Something else could be a larger factor for the majority of decedent cases. But at the same time, increased rates among younger veterans demonstrated a strong potential link, particularly since there were fewer younger veterans in the total population.

Another demographic provided similarly ambivalent results. Suicide rates among VHA-veteran decedents—meaning those who were enrolled with VHA and made at least one appointment in the year prior to their suicide—were actually higher than for other veterans. Perhaps in response to assumptions that the opposite would be true, the report's authors offered as explanation that VHA-veterans "have physical and mental health care needs [that] are causing disruption in their lives. Many of these conditions—such as mental health challenges, substance use disorders, chronic medical conditions, and chronic pain—are associated with an increased risk of suicide."[497] This explanation was assumptive. Yes, the conditions listed do have an increased risk of suicide, and yes, VHA-veterans do experience these conditions at higher rates than the

[495] Ibid., 3.
[496] Ibid., 7.
[497] Ibid., 8.

civilian population, but correlation is not necessarily causation. Still, this explanation offered a roadmap to obtain more clarity by looking at veteran suicides and VA disabilities.

The *2022 National Veteran Suicide Prevention Annual Report* (2022 NVSPAR)—the most recent as of this writing—examines two decades of veteran suicide information ranging from 2001 through 2020.[498] With the benefit of better data thanks to years of established relationships among interested partners, this report was able to break down the demographics in more meaningful ways than its predecessors, especially for 2014-2020. Rather than simply examining whether decedents utilized VHA services or not, the report's authors dived into VHA-veterans' eligibility for care access by VA Priority Group—essentially exploring whether veteran suicides were related to VA disability designations, and their findings are telling.[499]

In each of the six years with detailed analysis by priority group, PG5 had the highest levels of suicide among studied decedent cases by relatively wide margins.[500] Veterans in this priority group have recognized disabilities, but those disabilities have not been designated as service-connected. They also have incomes below adjusted limits and are eligible for Medicaid programs. This essentially means that PG5 veterans are not able to access the VA healthcare system as easily as veterans in other priority groups, with the possible exception of PG7—vets without a recognized disability and with low incomes.

Veterans in PG1-3 have priority access to the system by dint of their service-connected disabilities. Those in PG4 have disabilities that are not service connected but are recognized as

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[498] U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, 2022. https://www.mentalhealth.va.gov/suicide_prevention/data.asp. (2022 NVSPAR).

[499] Ibid., 30. For the following table, PG6 criteria includes veterans without a diagnosed disability who served under specifically-authorized conditions, including those discharged from active duty on or after 1/28/2003 who were discharged less than five years ago.

[500] Analysis of the data shows that PG5 had rates per 100,000 cases that were well above the mean for all groups in each year, often doubling the next highest category.

catastrophic. Income is not a factor for vets in these groups. PG6 is something of a holding area for recently-separated veterans who qualify for VA healthcare through an enhanced eligibility periods recently authorized by Congress.[501] It allows those vets to get access to the system regardless of disability or income limits, which in turn allows the VA time to sort those veterans into the system while providing care.

The 2022 NVSPAR reiterates that suicide prevention remains the VA's highest priority, that a public health model is the best approach, and that the officials believe a whole of Government and whole of Nation approach is crucial to intervention. It notes that the problem is too big to be addressed by VA clinical intervention alone, citing that the majority of veteran suicide decedents (60.3%) were not recent VHA users and that more data to understand the intersections of veteran suicide and problems like unemployment, disability, mental health, and homelessness is needed.[502] The report highlights the VA's efforts to address known risk factors like financial insecurity, disabilities, and lack of access to care through existing provisions—but such provisions only apply to those veterans with access. And access is key.

The report concludes that "access to evidence-based interventions inside and outside the VA system for Veterans at risk for suicide requires significant expansion, and part of our work… is considering new models of access to care" that can take advantage of the evidence-based treatments being established.[503] And access begins with getting veterans to apply for benefits.

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[501] Public Law 110-181, "National Defense Authorization Act of 2008" extended enhanced eligibility access to VA healthcare for 5 years after service.

[502] 2022 NVSPAR, 36.

[503] Ibid., 43.

## Cultural Stigmata's: Medical, Military, Political, and Social Influences

In Roman Catholicism, stigmata are bodily wounds that appear in locations corresponding to the crucifixion wounds suffered by Jesus Christ. They were often interpreted as signs of religious significance, but they could also be viewed as cultural markers—as marks of the imprint of a given culture. It is also a concept closely associated with stigma—a mark of shame. In this way, the term is useful for describing the marks left by military service and how they play a role in shaping veterans' access to care and willingness to engage in the veterans' healthcare system.

Successfully acclimating to military service requires adapting to and adopting the cultural practices of the military to the point that many of those adaptations become useful habits. This means service members express the core values of the military without thinking about it. The Army developed an acronym for its core values: LDRSHIP. Loyalty—to bear true faith and allegiance to the U.S. Constitution, the Army, and your fellow soldiers. Duty—to fulfill your obligations. Respect—to treat people as they should be treated. Selfless Service—to put the welfare of others before your own. Honor—to live up to the values of the Army and the Armed Forces. Integrity—to do what is right, legally and morally, even when no one is watching. And Personal Courage—the ability to face fear, danger, and adversity.[504] These values are intrinsic to what it means to be a soldier, and adapting to them creates habits that are often difficult to break—assuming that a former soldier would even want to break them.

Selfless service is one of those values that forms habits that are remarkably hard to break and which can inadvertently harm the veteran. It boils down to taking care of one's peers, and its expression can be seen in everything from explaining why soldiers are able to deal with the stresses

[504] United States Army Center of Military History, "The 7 Army Values," *Corps of Discovery United States Army* (2003).

of combat—that they do it for their buddies—to why so many soldiers avoid using sick call—because they don't want to be seen as weak, broken, or shamming by other soldiers.[505] Essentially, soldiers seek to avoid stigmas that could invoke the pity of their peers. And this tendency does not end when one's military service ends.

VA studies have shown that veterans who felt that they needed treatment for posttraumatic stress were more likely to seek out care, but the motives that drive these veterans to seek help—and what prevents others from doing the same—was less apparent. A VA study published in 2014 sought to understand the social and attitudinal factors that influenced treatment initiation in the hopes of developing effective outreach policies. It found that veterans who sought treatment for PTSD were generally encouraged to seek help by friends and family.[506] In other words, it wasn't until their conditions started impacting those they cared about—those they prioritized through their habits of selfless service—that veterans initiated efforts to seek help. Many veterans certainly knew something was wrong well before they sought treatment. They simply decided to push it down, to try to muscle through it, until they were faced with the reality that those efforts were not working and recognized that they needed help.

But even when veterans seek help, they often struggle with persistent stigmas about mental health and disability that are only exacerbated by military culture. Many associate disability with being broken, useless, or worse: a liability to others. These are significant stigmas that can and often do interfere with veterans' health, decisions to seek treatment, and whether or not they stick

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[505] Marie-Louise Sharp, et al., "Stigma as a Barrier to Seeking Health Care Among Military Personnel with Mental Health Problems," *Epidemiologic Reviews* 37, no. 1 (2015):144-162.

[506] Michele R. Spoont, et. al., "Impact of treatment beliefs and social network encouragement on initiation of care by VA service users with PTSD," *Psychiatry Services* 65, no. 5 (May 2014):654-62. Doi: 10.1176/appi.ps.201200324

with therapeutic regimens.[507] Stigma avoidance is based in the fear of rejection by one's peers, and in that, peer support is an essential element in undermining the influence of stigma perceptions. But such stigma is not limited to fellow veterans and service members. Society at large fosters concepts that can reinforce stigmas, particularly regarding masculinity and mental health.

As early as the First World War, soldiers suffering what would be diagnosed as PTSD found themselves being stigmatized as weak or flawed.[508] British physician Arthur F. Hurst attributed war neuroses to "congenital nervousness, a previous mental breakdown, concussion and chronic alcoholism."[509] Many doctors believed that soldiers experiencing psychoneurotic disorders were predisposed to such disorders by other weaknesses they brought with them into the service. Moreover, they described war neuroses symptoms as "hysterical," associating the presentation of the disorder with contemporary misogyny.

While perceptions of war neuroses have changed dramatically over the past century, some of the original stigma remains, in part, because these disorders seem to represent an inability to live up to cultural expectations of male strength.[510] The same can be said of disabilities that are not readily apparent. Many veterans simply adapt to damage joints, ringing ears, or trouble sleeping. Sometimes they utilize coping mechanisms that ultimately make matters worse, developing substance use disorders as they try to self-medicate.[511] These efforts of denial and coping with undiagnosed disabilities can last years before affected veterans decide to seek care.

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[507] Natalie E. Hundt, et al., "Veterans' Perspectives on Benefits and Drawbacks of Peer Support for Posttraumatic Stress Disorder," *Military Medicine* 180, no. 8 (2015):851-856.

[508] Sheena M. Eagan Chamberlin, "Emasculated by Trauma: A Social History of Post-Traumatic Stress Disorder, Stigma, and Masculinity," *The Journal of American Culture* 35, no. 4 (2012): 358-365.

[509] Arthur F. Hurst, *Medical Diseases of the War* (London: Arnold Press, 1918), 1.

[510] Eagan Chamberlin, "Emasculated by Trauma," 363.

[511] Spoont, et al., "Impact of treatment beliefs."

For instance, the First World War ended in 1918 and hospitalization for neuropsychiatric (NP) only grew slightly from about 2,500 in November 1920 to 10,000 in July 1924 (when the Veterans Bureau started tracking such things).[512] But by 1933, NP hospitalizations for Great War veterans had more than doubled to nearly 21,000 cases.[513] Officials at the time attributed the increase to the effects of the Great Depression, but it may also have been exacerbated by many veterans no longer finding themselves able to cope with their disabilities. Similar delayed waves of veterans seeking medical care can be seen in VA data published in the agency's annual reports after the Second World War, the Korean Conflict, and Vietnam.[514] It is perhaps strange, then, that modern efforts to expand VA care access do not take these delayed onset waves into account. They provide for recently separated veterans, but those who may be experiencing delays similar to their predecessors have to go through the standard, complex, and often difficult bureaucratic application procedures.

Further compounding resistance to seek care, American society since the 1980s has venerated its veterans. Some have argued this was a deliberate response to public perceptions of veterans as victims after Vietnam.[515] More likely, any such perception was a brief aberration as American society has a long history of venerating its veterans and building monuments to notions of veterans' sacrifices. Regardless, the effect of elevating veterans and calling them heroes only

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[512] U.S. Veterans Bureau, Annual Report of the Director, United States Veterans Bureau for the fiscal year ended June 30, 1924 (Washington: Government Printing Office, 1924), Table 5.

[513] U.S. Veterans Administration, Annual Report of the Administrator, United States Veterans Administration for the fiscal year ended June 30, 1933 (Washington: Government Printing Office, 1933), 44.

[514] For WW2 and Korean Conflict veterans, the wave can be seen in the numbers of veterans being admitted for the treatment of alcoholism in addition to mental health care. For Vietnam, it was illicit drugs and veterans' activism seeking improved readjustment counseling.

[515] "The War and the Arts: There Has Been a Cultural Turnaround on the Subject of Vietnam," *New York Times Magazine* (March 1985), 51.

exacerbates existing social and cultural stigmas about weakness.[516] Veterans are less likely to speak up about problems and more likely to feel isolated if they believing that asking for help will be a disappointment to others.

There have been some positive developments in veterans' benefits legislation in recent years, including the passage of the PACT Act of 2022 and other legislation that expand healthcare access. For instance, the PACT Act makes more than twenty conditions presumptive, meaning the VA presumes these conditions are related to or exacerbated by a veteran's military service, which makes receiving a service-connected disability designation much easier.[517] That means affected veterans are more likely to be sorted into the VA's Priority Eligibility Groups 1-3, which provides care access and seems to indicate a reduced risk of suicide.[518] Similarly, by providing VA health care for recently separated veterans in PG6, VA personnel will be more likely to identify, diagnose, and document these veterans' service-connected disabilities resulting in those veterans' receiving priority group upgrades and enabling higher priority access in the future.

But the large number of veterans who are not covered by these enhanced eligibility markers are more likely to be sorted into PG5, 7, or 8 once they apply, where they will likely remain until and unless they are able to navigate the system's bureaucratic requirements. Such administrative measures into another exacerbating factor to personal, cultural, and social stigmas.

All of this begs the question: if care access is key to suicide intervention, and if veterans in PG5 are the most likely to commit suicide, why are veterans in this group barred from access to care? The answer, it seems, lies in concerns about fraud.

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[516] Sharp, et. al. "Stigmas as a Barrier to Seeking Health Care"; National Veterans Foundation, "Troubling Veteran Mental Health Facts and Statistics that Need to be Addressed," March. 25, 2016.

[517] H.R. 3967 - Honoring our PACT Act of 2022, 117th Congress.

[518] See Table 1.

## Subjective Disability and the Return of Pensionitis

Access to the veterans' healthcare system is intrinsically tied to the VA's disability rating system, which in turn is tied to disability compensation—monthly, tax-free payments for veterans who became sick or injured while serving in the military and those whose service exacerbated an existing condition. The VA assigns a disability rating based on the severity of service-connected conditions.[519] That means that a veteran may have a medically-diagnosed disability, but if that disability is not directly connected to their service, it is not included in their VA assigned disability rating. So establishing service-connection to a given disability is important in the process.

To acquire a disability rating, veterans must submit a claim and submit to a compensation and pension (C&P) exam. These exams, conducted by health care professionals who work for the VA directly or those contracted by the VA for the service, are essential for establishing the medical bases of a disability claim and the extent of the disability.[520] Not all claims require C&P exams—if there is sufficient clinical evidence in a veteran's service records or elsewhere, for example, the VA may forego the exam—but most do. The VA schedules an appointment for the veteran, the exam takes place, and the health professional writes up a report for the agency.[521] The VA then uses the report to craft a Decision Letter, informing the veteran of the VA's decision on their claim and advising them of administrative processes to appeal the decision, if desired.

In making their decision, the VA uses medical records provided by the veteran, exam reports from C&P exam providers, results of any additional medical tests, statements from the

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[519] U.S. Department of Veterans Affairs, "About VA Disability Ratings," va.gov. About VA Disability Ratings | Veterans Affairs.

[520] U.S. Department of Veterans Affairs, "VA Claim Exam (C&P Exam)," va.gov. VA Claim Exam (C&P Exam) | Veterans Affairs.

[521] Ibid. Veterans can secure copies of C&P exam reports through Freedom of Information Act requests or in person at their regional VA office, but these reports are generally not provided to the veteran unless requested.

veteran and others, and military medical and personnel records. If the documentation and the exam provide proof of a disabling condition that is service connected, the agency assigns a disability rating for each condition in question. These ratings range from 0% to 100% and are regulated by 38 CFR Book C, the Schedule for Rating Disabilities.[522]

The VA intends for the whole process to be relatively simple and transparent. But with something as complicated as making disability determinations, with the medical and administrative jargon, the opportunity for subjective determinations, and all the legal regulation, achieving simplicity is a difficult task. It creates opportunities for meaning to get lost in translation, including the meaning of the disability rating itself.

As mentioned earlier, disability rating is not to be confused with disability. 38 CFR Book C is full of recognized disabilities, their presentations, and how they are to be used in the process. For instance, regarding the musculoskeletal system, 38 CFR states:

Disability of the musculoskeletal system is primarily the inability, due to damage or infection in parts of the system, to perform the normal working movements of the body with normal excursion, strength, speed, coordination and endurance. It is essential that the examination on which ratings are based adequately portray the anatomical damage, and the function loss, with respect to all these elements. The functional loss may be due to absence of part, or all, of the necessary bones, joints and muscles, or associated structures, or to deformity, adhesions, defective innervation, or other pathology, or it may be due to pain, supported by adequate pathology and evidenced by the visible behavior of the claimant undertaking the motion. Weakness is as important as limitation of motion, and a part which becomes painful on use must be regarded as seriously disabled. A little used part of the musculoskeletal system may be expected to show

[522] 38 CFR Book C, Schedule for Rating Disabilities. https://www.benefits.va.gov/warms/bookc.asp.

evidence of disuse, either through atrophy, the condition of the skin, absence of normal callosity or the like.[523]

Ideally, descriptions like this codify, as precisely as possible, the nature and extent of a given disability. But as is evident in the description of musculoskeletal disability—a type that generally provides ample anatomical and physiological evidence—there exists ample room for interpretation. What constitutes "normal" in the paragraph above? What are the parameters of an adequate portrayal of anatomical damage and functional loss? How is an examiner to quantify pain? And these subjective and definitional problems are only the tip of the iceberg.

Many veterans end up utilizing the services of veterans' service organizations (VSOs) in preparing their claim documents precisely because recognized VSOs often have experience in dealing with the agency and understand its administrative preferences. For instance, a veteran may complain of knee pain and write as much on the claim form and manage to successfully file a claim for that complaint, but it will almost certainly take longer as the VA will likely rely on the C&P examiner's report and may require an appeal. If, however, the veteran specifies the precise disability listed in 38 CFR that most closely matches their complaint, and if they provide documentary evidence—like military records corroborating the likely cause of the complaint and an independent doctor's diagnosis—the VA is much more likely to reach a favorable decision faster. This is why many veterans groups advise vets to utilize VSO services.[524]

In other words, rather than being relatively simple, the process generally requires what effectively amounts to administrative mediators to ensure it works efficiently. And that adds another layer of subjectivity and perhaps another stigma-related obstacle to the mix in fraud.

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[523] 38 CFR Book C, Schedule for Rating Disabilities, §4.40 Functional Loss.

[524] Veteran.com, "Should You Use a Veterans Service Organization to File a VA Claim?" Nov. 4, 2022. https://veteran.com/veterans-service-organization-va-claims/.

The most common VA disability claims today are made for tinnitus, limitation of flexion of the knee, hearing loss, and post-traumatic stress disorder.[525] Due to lack of objective measures for neurological disorders, disabilities like tinnitus and PTSD hold the potential to be exaggerated or even faked.[526] And it highly likely such fraud is happening. A 2005 investigation by the VA Office of Inspector General determined that many veterans sought more treatment for PTSD until they achieved a maximum disability rating, at which point they stopped seeking treatment.[527] Investigators came to the conclusion that some veterans were seeking treatment simply to increase their disability rating and thus receive greater compensation payments.

Such schemes do serious damage to veterans who truly need help in at least two ways. First, they tie up mental health and other resources that are in critically short supply, and second, they present a possibility that filing a claim for PTSD (or tinnitus, sciatica, or other conditions that are difficult to objectively measure) is, in effect, an effort to "game the system" to increase one's compensation benefits. Many combat veterans actively avoid VA treatment for this reason—they worry about losing their temper around folks who they believe to be milking the system.[528]

It is important to note that gaming the system is not a new phenomenon when it comes to veterans' benefits. Indeed, complaints that veterans were abusing the pension system established after the Civil War helped inspire the shift towards medical rehabilitation efforts after the First

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[525] U.S. Department of Veterans Affairs, Veterans Benefits Administration, *2021 Annual Benefits Report* (2021), 7.

[526] Alan Zarembo, "As Disability Awards Grow, So Do Concerns with Veracity of PTSD Claims," *Los Angeles Times*, August 3, 2014.

[527] Statement of Jon A. Wooditch, Acting Inspector General, Department of Veterans Affairs, before the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs, Hearing on Variances in Disability Compensation Claims Decisions, October 20, 2005. https://www.va.gov/oig/publs/statements/VAOIG-Testimony_20051020.pdf.

[528] Sebastian Junger, *Tribe: On Homecoming and Belonging* (New York and Boston: Twelve, 2016), 89.

World War.[529] In the Second World War, journalist Albert Deutsch described such milking as a disease itself—he called it "pensionitis" and claimed that the contemporary Veterans Administration had established a system that "pays a man to be sick, and pays him more to get sicker."[530] Shifting benefits to a system based on medical expertise was supposed to prevent the types of fraud and abuse that marked the pension system. In actuality, it just shifted the way the system worked.

## Conclusions: A Problem Too Big (for the VA Alone)

Disability need not be a prerequisite for care access—at least not the way the VA uses it as an administrative category to make eligibility and enrollment decisions. Certainly, it seems that lawmakers, veterans' advocates, and at least some researchers in the VA's Office of Mental Health agree that eligibility should be expanded dramatically.

Since the passage of the Omvig Act in 2007, Congress has authorized enhanced periods and categories of eligibility, with more making their way through the legislative process.[531] The *2022 National Veteran Suicide Prevention Annual Report* cites expanded access as essential to both better understanding veteran suicides and forming effective interventions through evidence-based public health approaches. The idea being that the more veterans are in the system, the more they are exposed to intervention policies, and the more researchers can learn.

This is certainly true about the veteran suicide problem, but it also applies to practically every corner of modern medical research. The Veterans Health Administration's patient population serves as the nation's largest medical data set. In the past, the veteran population in this

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[529] See Ch. 1, including Sloane, "Pensions and Socialism," *The Century Illustrated Monthly Magazine*; Hale, "Then Pension Carnival," *World'd Work*; and Hendrick, "Pork-Barrel Pensions," *World's Work*.

[530] See Ch. 2, Deutsch, "How Operation of Vet Laws Breeds 'Pension Neurosis,'" *PM*, January 12, 1945.

[531] 2008 NDAA, PACT Act of 2022, and the EVEST Act; Rebecca Kheel, "House Approves Bill to Automatically Enroll Vets in VA Health Care," *Military.com*, 20 Jan. 2022.

set has been essential for examining the effectiveness of therapeutic interventions in everything from outpatient care regimens to substance abuse treatments to the effectiveness of vaccines and medications. That means that every eligible veteran that is not a part of the system is a potential missing data point in research that could improve the lives of folks well beyond the veteran population alone. So why make it so difficult for them to enroll? Why stop at expanding eligibility to recently separated veterans when the historical trends show that earlier generations of veterans experienced significant delays in recognizing and seeking help for disabilities incurred in or exacerbated by service?

What's more, the VA's role as a leader in modern healthcare, with better health outcomes, higher patient satisfaction, and lower costs of care delivery seems to make notions of limiting access rather strange. If VA provides better value than alternatives in the private sector or in Medicare and Medicaid, why does it make sense to push veterans who lack service-connected disabilities into healthcare systems that are less efficient and more expensive? When the entire nation—and the VA in particular—faces a shortage of mental health providers, how does it make sense to rely on a disability rating system that creates opportunities for some to game the system in the hopes of achieving financial gains, tying up mental health resources in the process.

Perhaps the answer is not to simply tinker with veterans' healthcare and continue treating it as an exceptional system that only serves a small portion of the population. Perhaps the solution is to use the veterans' healthcare system as a template for larger reforms that serve all Americans. In this regard, perhaps the old mantras are still useful. Adapt and overcome.

# CONCLUSIONS: REIMAGINING VETERANS' HEALTHCARE

## Homecoming, Collateral Damage, and Coming Home Again

August 2004, Elmendorf Air Force Base, Alaska

It was already dark when the plane touched down on a familiar tarmac. Cheers went up through the cabin and soon the doors opened and let in the early autumn Alaskan air. We filed down the stairs onto the tarmac and fell into formation before a temporary barrier. On the other side, hundreds of people—the friends and families of the soldiers in formation—crowded the barrier, searching for their loved ones and crying out when they found them.

I knew that no one was waiting for me in that crowd. My parents wanted to be there, of course, but I talked them out of it. I wasn't exactly sure when I would get back to Alaska and didn't want them to have to wait a few days. And plane tickets to Alaska before Labor Day were expensive. Besides, there were rumors that the Army would quarantine us for thirty days after our deployment as a public health measure. I didn't really trust those rumors, but paratroopers are a superstitious lot—I figured that if I ignored the rumor, it would turn out to be true. So, I told my folks that I would see them in Colorado as soon as I had leave, which meant they weren't on the tarmac that night in Alaska. But I saw friends and the families of my brothers in that crowd, and that gave me a preview of the happy reunion to come.

We stood in formation, maintaining discipline while the families cheered and waived. The Lieutenant Governor had come to pay his respects, to give a speech honoring our service and sacrifice, and to welcome us home. Most of us could care less—but we did appreciate his having the courtesy of keeping the speech short. When it was done, the Battalion Commander called us back to attention and let us know that we still had work to do—to unload our gear and turn our

weapons back in to the armory—but that we would have a few minutes before that was necessary. "Fall out!" he shouted, and the formation broke ranks before he finished the words.

What followed was one of the most beautiful expressions of humanity I have ever witnessed. The sense of relief and joy in the crowd was palpable as families who had spent the previous year holding their breath seemed to find the ability to breathe again. It's hard to be moved by moments like that. I instantly regretted telling my folks not to come, but that reunion was not long delayed.

A few days later, my plane arrived in Denver. The rumor mill had been wrong about the quarantine, of course. Instead, I happily went home on leave. But as I stepped into that concourse, I noticed that I was on edge, which was strange. I always used to love the airport as a kid—it was a place of wonder. Now, it seemed to have some sort of menace about it that I couldn't quite pin down. I racked it up to the long flight from Alaska and the fact that I had to pee.

I expected to see my family waiting for me at the escalators in the main terminal, but no one was there. I did, however, locate a restroom and decided to take care of at least one of my concerns before finding a spot to wait for them.

In the restroom, I vaguely noted everyone who came in behind me. It was a habit of situational awareness that I developed in Afghanistan. Such vigilance allowed me to quickly assess whether someone was a threat or not. It felt strange to do it in the civilian world, but it was automatic at this point. Besides, it also felt strange to be in an actual building with actual walls after all those months spent living outdoors and in tents. I was readjusting to many familiar things that now felt strange—as if the world had changed while I was away, but it wasn't the world that had changed, it was my perception of it.

As I washed my hands and prepared to leave the restroom, two men entered. I did a quick threat assessment and decided they were not a threat, but something did seem odd about them. They were wearing the same shirt. What's more, those shirts had *my* face on them. Only then did I notice my brother-in-law and father standing before me. None of us expected to see each other in the men's room near the escalators at Denver International Airport! We laughed and hugged and laughed some more at the circumstances of our reunion.

"Mom's out there, waiting for you," Dad said. And so she was. She and my sisters were standing watch over the escalators. They had those same t-shirts on them—the one with my picture from just before the deployment—and Mom was practically bouncing with excitement as she scanned each wave of arrivals from the escalators, looking for her boy. I walked up and tapped her on the shoulder. More hugs and laughter.

The car ride from the airport to my hometown went by in a flash. Before I knew it, we were pulling up to my parents' house and Robyn Best—who I called my "other mom" growing up because she was around so often—was rushing to make some last-minute adjustments to the decorations in the yard. There were yellow ribbons on all the trees, a big banner hung across the garage, and when she noted the car pulling up, she rushed to hold up a hand-made sign that said "Welcome home, Aaron!" Robyn was in such a rush that she didn't notice she was holding the sign upside down. It was perfect.

Inside the house, I noticed that the Christmas tree was up. It was August, and my folks never decorated so early. "We left it up," Mom said, "so you could have a proper Christmas when you got back. Your presents are all there." Suddenly, I was flooded with emotions as I realized how much I put my folks through. How much they worried about me, and how much their lives

had been put on hold while I was deployed. I was both grateful beyond words and ashamed that I was the cause of such pain.

A few days later, my folks hosted a barbecue with the local military family support group—an ad hoc organization put together by a local Vietnam veteran so that the families of deployed service members in the area could support each other. That group started when a Marine from my hometown was hurt in Iraq by an IED's blast. He was in bad shape and his parents were encouraged to fly to Germany to meet him and possibly say their final goodbyes. With the help of other families of service members, the group scraped together enough to get those folks to meet their Marine. He made it, though his wounds were severe. And the group kept meeting regularly thereafter, supporting each other and sending care packages to deployed service members from the county. My homecoming was a rare happy occasion for these folks.

The barbecue was like a Norman Rockwell painting. Practically everyone I knew from my hometown was there. There were friends, cousins, extended family, my childhood dentist, and even a few of my elementary and middle school teachers. I had never seen so many people in my folks' back yard. At one point, Bill—the Vietnam vet—called for quiet so he could give a speech. I don't remember the contents of that speech to much. It was full of the usual platitudes about service and sacrifice and patriotism, but it also felt more personal, possibly because of the setting and having so many people you know hear it. Then, Bill turned to me and handed me a small glass globe on a pedestal commemorating my service in Operation Enduring Freedom.

I took the gift and everyone remained silent. They expected me to make a speech. I am not usually shy with my words—as you are well aware by now, if you're reading this—but in that moment, I was profoundly uncomfortable. I hadn't thought about how my service fit into the wider themes of patriotism that Bill had just mentioned. I didn't know what to think about my service.

Besides, someone was walking through the kitchen behind me—I could hear them but not see them, and that made me uncomfortable. I couldn't keep my eyes on the whole crowd or see all the exits. I saw the little kids playing between the tables set up and thought of the kids in Afghanistan that came out to see the Americans as we were on patrol, and any words I might have scraped together simply vanished. So, I simply gave an awkward thank you and went inside to get another beer.

Over the years, I began to gain more awareness of how much had changed—how much *I* had changed. For months, I would wake up and reach for my rifle that was no longer hanging from a post near my bunk. That faded fairly quickly. Then, I started noticing that I would tense up and get on edge in crowded places. I stopped going to malls and big stores if they were too crowded. I tried going to concerts with my cousin Tommy. He and his friends kept asking if I was having a good time. I thought I was, but apparently I was scowling constantly and trying to assess the crowd for potential threats. So, I stopped going to concerts. I drank a lot in the first few months back from the war—much more than usual—but I attributed that to having been deprived of access to alcohol for so long.

I met a girl, liked her more than the Army, and got out. I didn't apply for VA benefits, of course, but I didn't think I needed or even deserved them at the time. I was young, healthy, and thought I was handling everything just fine. Sure, there were emotional episodes and the occasional stint of irrational anger, but these things were temporary. I was out of the Army and just knew that whatever I did next, I was going to do it with Bailey.

The war continued, of course, and I got to experience a bit of the worry that a service member's family feels when their loved one gets deployed and they can't do anything about it. I consoled myself by supporting my buddies as best I could. I wrote them letters, sent care packages,

and fulfilled special requests when I was able. Losing friends and soldiers was always terrible. I soon found myself keeping a list of their names that I'd review now and then.

Corbett, Vick, and Hullender all died in relatively quick succession. I helped train Corbett a bit and counted him as a good soldier who learned quickly, worked hard, and kept up a cheerful aspect when the Army tried its best to drive the joy out of everything. Vick was in my Basic Training platoon and had the best sense of humor. He had a funny voice and would get teased but always found a way to turn his tormentors into his friends and share a laugh. Hullender was a medic, and we infantry love our Docs. He was also a damn good soldier who knew how to keep his sights on the important stuff—at least as a soldier sees them. He could fight and he could party. And he helped me run my last platoon before I got out.

I could see their faces, hear their voices and their laughter, and recall the last conversations I had with them. I went to Corbett's memorial in Anchorage and wept like a baby when the bagpipes played *Taps*. My tattoo artist and I cried together over Hullender—he was one of her clients and friends, too. She suggested that the pain of getting a tattoo might be therapeutic. I tried, but it was just physical pain compounded on emotional pain. I could handle the former just fine, but I was out of my element with the latter. I told myself I had it handled.

The years rolled by and my list only ever grew. I went back to school—keeping a promise to my folks that I would finish my education—and used my veterans benefits to pay for it. Bailey and I got married and started a family. Life went on, but my memories of the Army and Afghanistan always seemed larger somehow than the rest of it. Everything I did, I compared to my time in the service. What's the stress of a final exam next to the stress of jumping out of an airplane, or going on a mission where contact is likely, or having to deal with an angry sergeant? I'd been home physically for over fourteen years, but in a way, I still hadn't fully come home.

Then I read that article from *The New York Times*. "U.S. Drone Killed Afghan Civilians, Officials Say," by Farooq Jan Mangal and Fahim Abed, dated December 1, 2019.

> *An American drone strike on a car carrying a woman who had just given birth in southeastern Afghanistan left five people dead, including the mother, three of her relatives, and the driver…. The woman, Malana, 25, had given birth to a son, her second child, at home. But her health had deteriorated soon after and relatives had been taking her to a clinic. On their way home, their vehicle was hit…. The United States military command in Afghanistan confirmed a strike in Khost, saying that three Taliban fighters had been killed.*

Reading that article, something shook loose inside me. My memories of all those kids in Afghanistan seemed to be on pause—as if those kids never aged, never grew up. Now, it was like someone hit fast forward on the tape. I could see that little girl who ran barefoot through the stream on that cold day in December 2003—the one to whom I gave my Christmas orange and last clean pair of socks—suddenly grow up. I went back to Alaska nine months after that day. She stayed in Afghanistan and grew up in a continuous warzone. She watched the American forces go from the liberators we claimed to be to de facto occupiers whose munitions killed innocents by the score and whose lives added up to little more than "collateral damage" in the media reports.

I don't know if that little girl in 2003 grew up to become the woman allegedly killed by an American drone strike in 2019. There's no way I could know for sure. But it didn't matter, really. My blinders were off, and suddenly I was questioning everything, and I mean *every* thing. Was our cause in Afghanistan worthy? Why was it failing if it was? Why wasn't I paying better attention to the war's developments? Why didn't I do something about it? It was like that day in the summer of 2007 when my best friend's wife told me that I wasn't there all over again. And I began to question myself in ways that are difficult to put into words.

I started having nightmares, again. This time, they weren't temporary. I'd wake up in a cold sweat more often than not, and that was when I could find any sleep at all. In my dreams I would find myself deployed again, or on patrol. Initially, this wouldn't be a bad thing, as in my

dreams I was back around my brothers in the platoon, who I missed more than I wanted to admit. But then we'd go on patrol, and see the kids, and those kids would grow up, and then… BOOM! I'd suddenly wake in a cold sweat.

One night, after waking from a nightmare with a gasp, Bailey put her hand on my chest and made shooshing noises to calm me down. I noticed that she did that without even waking up herself. How often must something like that happen that she could do it in her sleep?

My emotions felt ragged, my rationalizations weak, and I couldn't trust any of it. My rationalizations had failed. I had grown cynical about the cause of the War on Terror and its poor yields. Thousands of Americans dead. Hundreds of thousands of others. Trillions of dollars lost. And for what? To "fight them over there so we don't have to fight them over here" or some other bullshit? And if I doubted all that, why not doubt my accomplishments since? I always attributed my success to the discipline I gained in the Army. I was proud to be a soldier. But did that mean I was proud to be a part of the system that killed Malana, mother of two, on her way home from the hospital? Should I be proud of the sacrifices of the men on my list, which just kept growing. Two more of my former soldiers added their names to the list when they committed suicide. Were they just "collateral damage" too?

In this state, Bailey and I got into an argument about parenting. I felt that she had disrespected me in front of our son. Of course, the rational part of my brain knew that wasn't true. Bailey has always and ever been my biggest fan. Besides, she's always been honest. It's one of the things I love about her. If she was trying to disrespect me, she would have said so plainly. But my rational brain was a very small voice in my head at that time. The rest was some sort of wild ball of anger, wounded by real and perceived hurts, fueled by doubts. Suddenly, I thought everyone would be better off without me, and I said as much.

Saying that out loud—hearing myself say the words—knocked something loose. My rational brain knew this was not something I wanted. The rest of me was apathetic to my rational arguments, but something in me was afraid. I wasn't afraid of what I might do to myself. If I'm honest, the thought of suicide almost seemed like a release. But I did fear what it would do to those I loved.

I suspected that I was experiencing some form of PTSD. The nightmares were always about Afghanistan. I knew the VA was the most experienced in dealing with that. So, I called the Crisis Line (877-424-3838 or just 988), cancelled my plans, and drove down to the nearest Vet Center and VAMC, per the suggestions the operator gave me. If you've read the rest of this dissertation, you know the rest of this story.

I've been going to individual and group meetings at the Vet Center ever since. I applied for and received a service-connected disability rating for PTSD, tinnitus, a bad shoulder, bad knees, and a bad back. That has provided me with access to not only one of the best healthcare systems in the nation, but one that specializes in treating my ailments. I'm taking medication to curb my anxiety and depression. I'm learning to engage with my emotions and, ever so slowly, to be kind to myself when all my old habits want to either fight to just slip into sadness and self-loathing. It has not been an easy journey.

But it has been a way to come home again. My homecoming from the war was in 2004, but I didn't really come home. I had a lot of stuff to process, but I didn't want to do that. It seemed easier, for so many years, to just shove everything down, develop coping mechanisms, and to tell myself to tough it out—that I was doing okay. And in many ways, I was. I had a wonderful family, access to a fantastic education that was providing me with the ability to do something I love in educating others, and I never wanted for anything in all that time. But I wasn't really home, yet.

I was, in a way, collateral damage of the war. I had bought into cultures that on one hand made me successful. I had the discipline to pursue a BA, MA, and then PhD in history with tremendous success. I had the motivation to see the value and honor of educating others—it certainly helped that I have been lucky in my colleagues and students, no doubt. But when it came to understanding the meaning of my service, and of the sacrifices of those on my list, that was harder. Patriotic platitudes and coping mechanisms only went so far. The weight became too much, and I collapsed. Thankfully, I had support and help when that happened.

But as Max Cleland said, "many of us have been overwhelmed by war. Many of us have been unable to cope on our own…. Many of us have been left hopeless, lost, and confused about ourselves and our lives in ways we never thought possible. That does not make us victims. It makes us veterans."[532] Many of us try to deal with our confusion and hopelessness alone out of vanity, pride, or an insistence on not being a burden to others. Many do it because we don't know how to navigate the resources available. I fit both categories. It took hitting rock bottom to shake me loose of my long-established and self-imposed shackles, and thank goodness that happened!

It made it possible for me to ask for help.

Asking for help gave me access to the VA system, yes. But more importantly, it put me in touch with other veterans who have been through what I was going through, who could show me the way and help me carry some of my burdens. It gave me a sense of community that showed me the potential for genuine healing through truth and reconciliation. It helped me find what Sebastian Junger describes as a tribe.

In other words, it made it possible for me to finally come home.

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[532] Max Cleland, "An Open Letter to America's Veterans," in *Heart of a Patriot: How I Found the Courage to Survive Vietnam, Walter Reed, and Karl Rove* (New York: Simon & Schuster, 2009), 1. Max Cleland passed away on November 9, 2021, at his home in Atlanta. He was 79.

## Care with Benefits: Integrated, Holistic, Patient-Centered, Evidence-Based, and Research-Supporting Medicine

The future of VA medicine has the potential to be bright, indeed. Since Kizer's reforms of the mid-1990s, VA provided healthcare has become an industry-leading model of quality and efficiency—in health outcomes, patient satisfaction, safety, and cost of care delivery.[533] Compounding these returns, the VA provides quality training to the majority of the nation's medical professionals, shaping the contours of American medicine beyond the veterans' healthcare system.[534] It also provides a unique patient data set upon which medical research can provide dividends not only for veterans, but for patients in general with proven results in everything from outpatient antibiotic regimens, smoking cessation programs, and organ transplants to Alzheimer care regimens, stroke treatments, and neuro-robotic prosthetics.[535] Certainly, VA care appears to be a model of socialized medicine that works, from this perspective. It fits all the modern buzzwords: integrated, holistic, patient-centered, evidence based medicine.

And yet, there remains the matter of access. Is the VA healthcare system so successful precisely because it limits access to veterans who have proven to be, as Reagan's OMB framed it in 1987, the "most deserving?" There are several layers of prerequisites before someone can achieve access to the veterans' healthcare system. First, one has to qualify for military service—a variable standard by branch of service, time, and national need.[536] Having passed that potential obstacle, one must secure an honorable discharge, which holds the potential to entangle

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[533] Rebecca Anhang Price, et al, "Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings," *Journal of General Internal Medicine* (ePub April 2018), doi:10.1007/S11606-018-4433-7.

[534] Association of American Medical Colleges, "Helping Our Nation's Veterans," AAMC.org.

[535] U.S. Department of Veterans Affairs, Office of Research & Development, "History of VA Research Accomplishments," https://www.research.va.gov/researchweek/press_packet/Accomplishments.pdf.

[536] Sanders Marble, ed., *Scraping the Barrel: The Military Use of Substandard Manpower, 1860-1960* (New York: Fordham University Press, 2012).

intersectional biases and prejudices, as the work of the veterans' organization Swords to Plowshares demonstrates so poignantly.[537] Many service members have experienced racism, misogyny, and other prejudicial actions as a result of who they are and/or what they have experienced as a result of their service. Too often, these folks are discharged from the armed forces in ways that specifically block their access to benefits, resources, and support, including healthcare. Other veterans—meaning those who fit the definition of the word per 38 CFR—may experience health difficulties and develop coping mechanisms that provide temporary and potentially harmful relief in the short term only to find themselves become statistics for problems like homelessness, substance use disorders, and suicide.

The general public, however, is not generally aware of or particularly interested in these nuances—neither medical nor bureaucratic. Most Americans believe that veterans have access to the care and support that makes up the nation's obligation to those who served. There have been times where abuse of the system was so rampant that significant portions of the public—or, at least, significant numbers of muckraking journalists—came to see veterans as akin to another Reagan-era myth: that of the Welfare Queen, surviving and thriving off the public dole.[538] But these perceptions and problems are not inherent to the ideals of the nation owing a debt to those who served or even to the idea that war-incurred disability can be rehabilitated. Indeed, the effort to rehabilitate the veterans' benefits system by basing compensation in medicalized notions of disability and rehabilitation that led to the development of modern veterans' healthcare was itself

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[537] Swords to Plowshares, "About Us," https://swords-to-plowshares.org/about. Swords to plowshares recognizes that "war causes wounds and suffering that last beyond the battlefield" and works to "restore dignity, hope, and self-sufficiency to all veterans in deed, and to prevent and end homelessness and poverty among veterans." But their organization also works to ensure that veterans who received other than honorable discharge designations due to a variety of intersecting factors are able to access legal help in upgrading their discharge status and thus gaining access to more resources.

[538] See Chapter 1, "The Problem with Pensions."

an effort to combat fraud by establishing disability in the determinations of medical experts.[539] The existence of a medically-determined disability that could be connected to a veteran's service through documentation was intended to solve the problem of fraud after the First World War.

This approach proved beneficial to the general population with developments after the Second World War. The act of affiliation between the veterans' healthcare system and academic medicine provided symbiotic benefits. Veterans gained access to top-notch medical minds and medical universities gained access to a large, diverse, and geographically distributed patient population.[540] Both sides profited from this new relationship, but the biggest beneficiaries—one could reasonably argue—were (and still are) the general population. With more than two-thirds of all healthcare professionals in the United States receiving training through VA facilities, the veterans' healthcare system stands alone as the largest source of medical training in the nation. Indeed, it is hard to fathom a potential alternative that not only incorporates the latest in medical education but also national standards of care, safety, and practice that provide new practitioners access to decades worth of knowledge and experience.

What's more, this federal system provides patients a measure of agency. This is, in part, due to the venerated status of veterans in the United States, but it is also in part to the fact that veterans have an active and effective political lobby by virtue of that veneration as well as their common experiences. That veterans were able to effectively team up with mental health professionals during and after the Vietnam War enabled the patients of the veterans' healthcare system to help shape the development of that system in ways that benefitted not only Vietnam Era veterans, but all veterans.[541] Vet Centers and outpatient care models continue to relieve stress on

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[539] See Chapter 1, "Rehabilitating Disability…" and "… Requires (Re)Defining Disability."
[540] See Chapter 2, "Institutionalizing Veterans' Healthcare."
[541] See Chapter 3, "The PTSD Pivot."

the veterans' hospital system and provide convenient and effective care for qualifying veterans—meaning both disabled and those whose service meets qualifications of combat and military sexual trauma requirements. More development of these alternative care models remains to be done, and that will require the VA to acknowledge that hospital-centered, centrally-administered care is not, perhaps, the best model. It certainly requires more investment in mental health, social service, and general counseling to meet both the needs and the idealistic hopes of the program. But the Vet Center program's existence and success proves the viability of patient advocacy in promoting and improving health and health care outcomes.

Politics and platitudes have been a constant in veterans' benefits and healthcare, including making determinations about who is eligible for access to the same. Since the 1636 Pequot War waged by the Plymouth Colony against their indigenous neighbors, the notion that those disabled in military conflict should receive provisions from the government has been an American tradition. But just as the definition of who qualifies for citizenship has been a matter of debate underscored by political motives and plastered over with high-minded platitudes, so has the definition of who qualifies for veterans' benefits. In this discussion, disability was only one facet of intersectional factors including race, sex, sexual orientation, and the nature of one's service. Veterans with the most obvious disabilities—amputees, in most cases—were often granted benefits due to the readily apparent nature of their disability. But beyond that, those whose wounds were less apparent—particularly those who suffered from mental health disorders—were subjected to questions about the specificity and origin of their disabilities. This opened the door to prejudices and biases that no amount of medical expertise or scientific reasoning has yet been able to stamp out. And these issues intersected with wider notions of race, gender roles, socially acceptable behavior, and political priorities. By the 1980s, and eager to rehabilitate the public perception of veterans after

the apparently disgraceful event of the Vietnam War, Americans—including the still politically powerful veterans' service organizations—were willing to accept platitudes to better digest the struggles of the veterans' healthcare system. [542] Elevating the Veterans Administration to the Department of Veterans Affairs had little impact on the provision of benefits and services, but it seemed to paper over the fact that economically-minded policies were, in fact, cutting into those very provisions in the face of rising healthcare costs. Those rising costs motivated efforts in the 1990s to re-evaluate the effectiveness of socialized medicine, using the VA as a sort of laboratory experiment. The appointment of a visionary healthcare administrator like Dr. Kenneth W. Kizer to oversee this experiment proved monumental in the developing debate. Kizer's efforts to develop quality metrics and medical cultural reforms like patient-centered, integrated, and holistic care, combined with technological developments like VistA—the VA's electronic health record system—resulted in a healthcare system that not only proved viable but also set standards that the wider array of American healthcare systems would seek to emulate as far as possible.[543] Indeed, Kizer's reforms changed the conversation about the viability of socialized veterans' healthcare, and in the process, these same reforms inspired the VA to take a hard look at the persistence of problems that affect American healthcare in general. Problems like health and health care disparities, outcomes, and access to care.

In the twenty-first century, veterans' healthcare has gained the most public attention through the recognition of the problem of veteran suicides. Initially estimated at 22 veteran

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[542] See Chapter 4.

[543] Longman, *Best Care Anywhere* and Gordon, *Wounds of War* are two prominent, well-circulated examples that highlight the advantages of VA care. Both are based on significant studies by the RAND Corporation and others that effectively argue the same—that VA care is not only an example of functional socialized medicine, but how socialized medicine can be exceptional, even in an environment like the United States and its emphasis on private services over public services.

suicides per day, subsequent studies of the problem have been more effective in refining the definition of which suicides count as a "veteran suicide" and thus reducing the number to about 17 per day. But as the studies note, the number of veteran suicides per day is not really a helpful metric other than to point out the scope and scale of the problem. While the public latched on to the number 22 and the VA sought to refine the data to come up with 17, the fact remained that veterans were (and still are) committing suicide at rates much higher than their civilian peers, meaning that something about military service, or of those being accepted for such service, seemed to impart a significantly higher risk of the ultimate form of self-harm.[544]

Since 2012, VA-sponsored research into the problem has tried to pin down the causes and potentially effective interventions regarding the issue of veteran suicides, and the most recent study—the 2022 National Veterans Suicide Prevention Annual Report—takes these efforts a step further. Rather than limiting the examination to whether a veteran was utilizing VHA service or not, the 2022 NVSPAR broke down the suicide rates among VHA-using-veterans and determined that accessibility is not just *a* factor but *the* factor in the matter by breaking down suicide rates among VA priority groups. Those with arguably the least access to VA care in Priority Group 5—meaning veterans who lack a service-connected disability and low incomes—were the most likely to commit suicide.[545] This data demonstrates the compounding and exacerbating nature of intersectional factors and strongly implies that veterans without access to VA care are even more likely to be at high risk of suicide.

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[544] See Chapter 5.

[545] U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, 2022. https://www.mentalhealth.va.gov/suicide_prevention/data.asp. (2022 NVSPAR).

The particular problem of veteran suicide is emblematic of larger problems—both in scope and historically. In terms of scope, suicides may have the public attention that drives policy priorities, but just as the data shows that veterans are at higher risk of suicide, it also shows that veterans are more likely to experience chronic conditions and other health problems at higher rates than their civilian counterparts.[546] It stands to reason that if access to care is a factor in suicides, it is also a significant factor in other health matters.

Compounding this is the fact that the veteran suicide problem is emblematic of a historical problem in the VA that the agency has only recently—and arguably reluctantly—begun to address with historical trends in the data that goes against the grain of public assumptions. For instance, those assumptions, and the political pressure they generate, have spurred lawmakers to pass legislation extending VA healthcare access to recently-separated service members who meet discharge requirements.[547] The assumption here being that recently-separated veterans are more likely to need care. But the historical data shows that many veterans will forego applying for benefits until a significant time has passed. Veterans of the First World War applied for mental health hospital services in 1933, roughly fifteen years after the war ended. Second World War veterans were hospitalized in significant numbers for alcoholism in the late 1950s—roughly the same time frame. The data shows that many veterans are often reluctant to ask for help until they have reached a sort of critical mass where they simply cannot manage their conditions any longer. Access to recently separated veterans is fantastic, provides good press for the VA and associated lawmakers, and it may well make a dent in the problem of veterans' access moving forward. But it ignores these historical trends that are readily apparent in the VA's own annual reports.

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[546] Jose A. Betancourt, et al., "Exploring Health Outcomes for U.S. Veterans Compared to Non-Veterans from 2003 to 2019," *Healthcare (Basel)* 18, no. 9 (May 2021):604. Doi: 10.3390/healthcare9050604.

[547] The 2008 National Defense Authorization Act extended eligibility to 5 years after service separation.

## A Fundamentally Broken System

The result of all these factors is that, despite it's significant and laudable successes, the veterans' healthcare system in the United States is essentially and fundamentally broken. It provides for only "the most deserving" veterans—meaning those who either suffer from well-documented service-connected disabilities, or those who are destitute and therefore more likely to become the types of statistics that neither the VA nor the general public view favorably. This latter group is more likely to commit suicide, more likely to become homeless, more likely to develop compounding comorbidities like substance use disorder or complications from unaddressed chronic conditions. And that essentially means these underserved groups are either more complicated and require more resources when they *do* get access to VA care, or they become a burden on the general healthcare system in some form or another. Neither is a good option.

Ideally, the system would work such that veterans who need care receive it in a timely fashion. This not only serves the foundational purpose of the VA as it evolved over the 20th and into the 21st century, it serves the American population as well. Each veteran in the VA system is a potential datapoint for crucial research, meaning each that is *not* in the system is a potential barrier to the next breakthrough that can revolutionize modern medicine. Imagine if organ transplants were still considered too risky, or how much more difficult it would be to verify the effectiveness and safety of new medications without a large, diverse patient population like that at the VA.

The only essential reason to restrict VA care access, honestly, is cost. Healthcare is expensive, and even though the VA manages to provide it at rates superior to alternatives, it's still pricey. Similarly, resources are limited. The entire nation is experiencing a mental health professional shortage, and the VA is certainly no exception. In fact, the problem at the VA may in

fact be worse.[548] Under such circumstances, it may seem reasonable to limit access to limited and expensive resources to "the most deserving," as President Reagan's OMB officials suggested in 1987. But that is a disingenuous argument.

Health problems do not go away because they are expensive. They get worse and likely grow more expensive. And if they cannot be addressed at the VA, where cost of care, safety, and quality are generally better than other systems, it stands to reason that treatment of unqualified conditions and disabilities will ultimately end up costing Americans more, not less, even if it is harder to see.

What's more, the VA's policy of linking disability compensation to healthcare access is something that needs serious reconsideration for all of the reasons covered in this dissertation. Many veterans can be prideful, resistant to the labels and trappings of disability, or receiving "handouts" in the form of government compensation, making them less likely to seek VA care. At the same time, other veterans have learned how to work the system to either secure desired access and benefits, or to maximize financial compensation by exaggerating or even faking certain disabilities that are covered and for which resources are remarkably scarce, like PTSD treatment. This "pensionitis" shows up in the data by how many veterans seek care for PTSD until they maximize their disability compensation, at which point many stop seeking treatment, suggesting their aim was to maximize compensation payments rather than to seek care. That produces bad data for research, ties up resources necessary for the treatment of veterans who are truly suffering, and discourages others who want to either avoid the potential stigma associated with seeking compensation or avoid their own reactions to those they perceive to be abusing the system. None of that saves the VA money or improves access to care.

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[548] See Chapter 4.

As long as VA care access policies remain rooted in a system that uses disability rating, service connection status, priority groups, and even character of discharge as qualifying standards, the system will remain essentially broken. Veterans who need care will not receive it due to personal, cultural, and bureaucratic barriers. Others who want to game the system will be able to adapt to any changes of these categories and continue to game the system, tying up resources and frustrating or skewing research data. Veterans who do not fit into standard or enhanced eligibility criteria will continue to have problems that only get worse with time.

The solution, or at least one solution, is rather simple: disconnect disability compensation payments from care access while expanding VA healthcare to *all* veterans, regardless of income, service-connected disability status, or character of discharge. Compensation can be addressed the same way as other financial benefits. Health care, however, needs to be prioritized first.

Yes, this means some veterans that many in the public feel may be undeserving of benefits will get access to care. But that is perhaps an easier price to pay than denying care to those who need it in the interests of maintaining the illusion of a system that ostensibly uses medical expertise to triage resources but in reality places barriers to care that do not need to be there. The current system exacerbates problems that the VA and Congress have, for years now, tried to address through tweaks to eligibility that gloss over the problems that are readily apparent in the data.

Yes, this means that VA care is likely to be more expensive, especially if all of the nation's veterans elect to use it—right now, only half of American veterans are enrolled in VA care, and only about half of those use it on a regular basis. Extending eligibility to all would likely require doubling the VHA's annual budget. But shouldn't that simply be considered part of an honest account of the cost of war? Certainly, a nation that purchases more tanks than the Army asks for, that spends nearly double the allotted amount for the F-35 program, and that spends more than

three-quarters of a trillion dollars annually on defense appropriations has no problem spending a bit more on the human byproducts of all that military spending.

If VA care really is better quality, safer care at lower cost, extending that care to all veterans and providing the resources necessary to meet the nation's obligations to those who wore its uniform is not only the most economically sound option, it's also the moral option. And should it take that path, in the process, the United States may just be able to figure out how to improve healthcare for all Americans, veterans and civilian alike. At the least, it would mean that the VA was living up to its motto: "to care for [them] who shall have borne the battle."

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