Nursing in Japanese American Incarceration Camps, 1942-1945

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Abstract

Japanese Americans living in west coast states had been a marginalized group long before the attack against Pearl Harbor, Hawaii on December 7, 1941 by the Empire of Japan, which accelerated the maelstrom of hysteria and hatred against them. As a result, President Franklin Delano Roosevelt issued Executive Order 9066, authorizing Secretary of War Stimson and designated military commanders to prescribe military areas from which any or all persons could be excluded. United States military leaders identified all Japanese Americans in the western portions of Washington, Oregon, and California as potential subversive persons that might rise up and sabotage the United States from within its borders. Over 110,000 Japanese Americans were forcibly removed from their homes and transported to one of ten incarceration camps until their loyalty to the United States could be determined.

Roosevelt's Executive Order 9102 established the War Relocation Authority on March 18, 1942. This civilian agency provided for the shelter, nutrition, education, and medical care of the excluded Japanese Americans as they waited to be redistributed within the interior and eastern United States. Previous literature describing the medical care furnished to the Japanese Americans in the camps concentrated on early system problems related to supplies and sanitation efforts. The contributions of nurses to the health and welfare of the Japanese Americans incarcerated at the camps over the time the camps were in operation have been overlooked.

The purpose of this study is to identify, describe, and analyze the work of nurses in U.S. incarceration camps holding west coast Japanese Americans during World War II, from 1942-1945. This study employed a social history framework to analyze the nursing care at the Poston and Heart Mountain incarceration camps.

While nurses at both camps strove to deliver competent nursing care, the nurses at the Heart Mountain camp in Wyoming met with considerable difficulty in carrying out basic nursing services as a result of power struggles, frequent turnover in nursing leadership, and lack of administrative support. Nurses at the Poston camp in Arizona benefitted from the organizational support of an established agency and fared much better in their relationships with physicians and administrators, as they negotiated their expected gender and class roles as female nurses.

Analysis of the two camps illustrates three major conclusions: (1) Nurses working in camps with established organizational structures in place found administrative support as they developed the nursing service at that camp; (2) Nurses who did not conform to expected gender roles suffered backlash and resentment from the Japanese American physicians, while those who deferred to their place as women received the support of their superiors and the Japanese American physicians with whom they worked; (3) Nursing leaders who demonstrated cultural sensitivity, nurtured interpersonal relationships, and had a clear vision of the goals they wanted to accomplish, were better equipped to manage and influence hospital personnel and processes.

Dedication

This work is dedicated to the nurses of the Japanese American incarceration camps, 1942-1945, whose voices have yet to be heard.

Acknowledgements

I wish to express my sincere thanks to the dissertation committee, not just for their assistance with the dissertation, but for their support and guidance in preparing me for this undertaking. From the moment I first met Dr. Arlene Keeling, my academic advisor and dissertation committee chair, I knew that I was in for a thrilling adventure. I am forever grateful that she introduced me to the world of nursing history. I appreciate the nursing history roundtables led by Dr. Mary Gibson – it was during these sessions that we discussed and dissected my work, which always left me encouraged and reinvigorated. Dr. Ishan Williams was extremely generous in allowing me to pursue my topic within the structure of her courses. There are avenues within the work that would not have been explored without her flexibility and unique perspective. Transitioning from scientific thinking and writing would not have been possible without the patience and example of Dr. William Hitchcock. I know that I have not yet made the full transition, but I am well on my way with his expert feedback. Dr. Ishan Williams and Dr. William Hitchcock have both provided the critical non-nursing perspective. I thank them for pointing out elements that I overlooked or simply accepted as a fact of nursing. Finally, I would like to thank Dr. Barbara Brodie, for her unfailing support, kindness, and encouragement. She is always eager to catch up on my progress, and offer practical advice. I am so very fortunate to have had the opportunity to work so closely together with her.

The work of locating the data was exciting and fun, and was made possible with the help of the dedicated archivists at the National Archives Building in Washington, DC, and the National Archives at Riverside, California. Nicole Blechynden, archivist at the Heart Mountain Interpretive Center, had just begun sorting through the archival material there, but was very helpful in setting aside related items, as well as items of potential interest, for my visit. I must

also thank Susan McKay, who generously shares her papers from her work for *The Courage Our Stories Tell* at The American Heritage Center at the University of Wyoming in Laramie, Wyoming. This collection contains some fantastic materials related to women's health at Heart Mountain. I am grateful to the archivists and staff at the Cornell University Library Division of Rare and Manuscript Collections who were so helpful during the planning of my visit, as well as the during the time I spent there.

The Eleanor Crowder Bjoring Center for Nursing Historical Inquiry at the University of Virginia is home to medical and nursing texts that support researchers in their work in nearly every era. The center houses a fine collection of some of the texts nurses used as references in the incarceration camps. I am very grateful to Linda Hanson for locating those and similar supporting texts, and for ensuring I had a quiet space to examine these texts. I am also appreciative of Linda's friendship and encouragement in my work.

The Historical Collections and Services in the Claude Moore Health Sciences Library, also at the University of Virginia, contains the medical texts that described the treatments prescribed by camp physicians. The texts also explain how medical practitioners understood disease processes at the time. The Historical Collections and Services department was extremely fortunate to have been under Joan Echtenkamp Klein's special care for over 30 years. Joan was a dear and genuine person; I miss her curiosity, expertise, and friendship.

I will always hold dear the group of professional women that began their PhD journeys with me. I am especially proud of my nursing history peers, as we grow and learn together.

Finally, I am truly thankful for my immediate and extended family and friends near and far, especially my "Jersey girls." They make life worthwhile.

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Chapter 1

Introduction and Methods

The image of a nurse during World War II often conjures a familiar picture: nurses in tents in the deserts of Northern Africa; nurses on large naval ships waiting for young Marine casualties in the Pacific; nurses in U.S. Army uniforms following the invading Allies into and across Europe; or nurses as emaciated prisoners of war (POWs) in the Santo Tomas Internment Camp in Manila, Philippines. Nurses of this era are not often pictured on U.S. soil. Exceptions to this are photographs of young nursing students preparing for military service dressed in U.S. Cadet Corps nursing uniforms, and groups of recently graduated nurses boarding trains or ships, bound for faraway places where they will care for injured servicemen. Rarely do the photographs depict a solitary, civilian figure in a remote location, overseeing the care of thousands of fellow Americans. These photos could portray various scenes here on the American home front, including nurses in factories, in public health districts, or in large medical institutions throughout the country. The photos could also depict nurses serving in Japanese American War Relocation Centers in remote regions of the United States.

Indeed, the role of nurses serving on the American home front during World War II (WWII) has been overlooked in comparison to other ways in which women's home front war contributions have been typically described. Most of the existing literature shares the common theme of women moving away from traditional female work such as clerical work, housework, or domestic service, into a man's world of work, typically factory work or professional government work. In *Home Front U.S.A.*, Alan Winkler discussed the exciting opportunities afforded to women in factory and government work that allowed them to leave behind their jobs

as clerks and maids.[1] His work, mostly based on a review of secondary literature, provides a good overview of how the United States home front responded to total war, and touches on the problems that women faced when suddenly thrust into a man's world of work. Winkler, like most authors writing about women's work on the home front during World War II, did not discuss nurses, which leads readers to believe that nursing, a job traditionally held by women, was neither novel nor contributed to important home front work.[2]

Karen Anderson's *Wartime Women* and Susan Hartmann's *Home Front and Beyond: American Women in the 1940s*, emphasize this point. Anderson's work examines primary sources to explain the heroism and sacrifices that married women, especially, made in leaving their children to work at factories or shipyards to support the war effort.[3] Hartmann elaborates on why historians may not find home front nursing as particularly noteworthy. Nurses, she explained, accounted for 20 percent of women professionals in 1940. Their wages remained relatively unchanged and the education required to become a nurse took several years, and so the surge in women entering nursing was not nearly as dramatic as women entering men's work.[4] The conclusion, then, was that because nursing work stayed essentially the same, it had little effect on women's lives or how we viewed them in these roles.

Yet home front nurses had to adapt to labor and supply shortages, they cared for returning servicemen suffering from injuries they had never seen before, and they, too, left families behind to support the war effort. Their work took them to remote incarceration camps that held thousands of Japanese Americans as prisoners.

Although much has been written about the experiences and injustices of Japanese Americans' incarceration by the U.S. government during WWII, a review of secondary sources reveals a dearth of literature related specifically to nursing in the War Relocation Centers, or

incarceration camps, established by the War Relocation Authority during World War II. Published literature related to healthcare in the camps focuses on physician care or more easily quantifiable aspects of health, such as disease, public health, births, deaths, and hospitalizations.[5]

In a review of the literature on the subject, two perspectives emerge – that of the incarcerees and that of the nurses. Sources authored by the incarcerees provide limited discussion of the care received in the camp. Instead, the predominant theme that emerges is one of lives disrupted by war and fear. Nonetheless, their first-hand perceptions of the care they received provides primary source material for further analysis. One example of the nurse's perspective can be seen in Toshiko Eto Nakamura's memoir, *Nurse of Manzanar*.[6] Nakamura was employed as a registered nurse (RN) in California, before the United States' declaration of war on the Japanese in December, 1941 and subsequent events prompted the forced removal of tens of thousands of West Coast Japanese Americans to the interior United States. Nakamura describes the hospital and the routine of camp life in Manzanar, California. She discusses some patient cases from a nursing point of view, understanding and conveying the human side of caring. However, Nakamura does not provide an objective or in-depth analysis of nursing or medical care in the camps.

Still another perspective is that of Japanese American nursing students. Authors Susan McKay[7] and Thelma Robinson[8] describe the plight of Japanese American nursing students, suddenly evicted from their schools located in the military restricted areas of the West Coast. McKay traces four student nurses' journeys from their respective nursing schools to Heart Mountain War Relocation Center in Wyoming, and their subsequent return to different nursing schools located in the interior and east coast United States. Three of the students left the camp in 1943 once they were accepted into nursing schools in the Midwest and on the East Coast, while

the fourth student chose to finish her education after the camps closed in 1945. While incarcerated at Heart Mountain, the students with any nursing school credit essentially functioned as registered nurses in the short-staffed facilities. Robinson's *Nisei Cadet Nurse of World War II* confirmed that on-the-job training for student nurses took place at the camp hospitals. Comments from the women were similar to those in the McKay article: students were put in charge of a medical or surgical unit, and did the best they could with what they were given.[9] These sources give some insight into the nursing students' general duties and lives while in camp. However, the larger themes that materialize are related to lives disrupted by the war and government policies, much like the themes that appear in histories recounted by the Japanese American incarcerees.

Public health issues are the main focus of the secondary literature related to healthcare in the camps. Author Louis Fiset sets the stage by explaining that some Japanese American communities took it upon themselves to vaccinate fellow Japanese Americans in the community once the signs of forced removal were clear. These local efforts, although well-intentioned, reached less than one percent of the population, and so attention to public health concerns continued in the camps. At the Manzanar camp in California, "… the resident medical staff administered 28,923 typhoid inoculations and 11,475 smallpox immunizations for the center's inmates and Caucasian employees."[10] Specially trained aides worked in designated areas in the camps to help control the spread of communicable disease. Monitoring absenteeism in school helped check potential spread of epidemic illness.[11] One of the major public health issues in the camps was tuberculosis. Others were the spread of infectious diseases such as the measles, and illness related to food and water sanitation concerns.[12]

In addition to describing public health issues, descriptions of personnel and supply shortages in the camps can be found throughout the literature.[13] These accounts note, in particular, a shortage of nursing personnel. Fiset writes that by June 1943, the number of Japanese American RNs at the incarceration camps had declined from 72 to 20, and the number of Japanese American student nurses declined from 79 to 24. By the end of 1943, Japanese American RNs and student nurses numbered only 11 and three, respectively. [14] War Relocation Authority appointed nurses were equally lured back to civilian life – in the latter half of 1943, 29 nurses, including six chief nurses, had resigned. Nurse aides were constantly recruited and trained from within the camps, but difficult to retain once trained. No sooner were a group of aides trained than they would be offered civilian employment. Like the nurses and student nurses, nurse aides were eligible for resettlement with a verified job offer or school acceptance letter.[15] Authors describing the shortcomings of care related to personnel and supply issues, focused on general themes of injustice by the U.S. government, overcome by a spirit of endurance by the Japanese Americans. Research of primary data is needed to determine the impact that turnover of nursing staff and delegation of nursing work to nurse aides had on nursing care delivery. Nursing's response to the constant turnover of personnel and lack of needed supplies are only two examples of areas where further research is needed.

Medical anthropologist Gwenn Jensen discusses racial/ethnic tensions amongst the hospital staff.[16] White American physicians and nurses were in charge of the overall healthcare structures at the camps.[17] The original plan for the camps called for the employment of only white physicians and staff nurses, but the needs of the military and civilian hospitals made this impossible. Many physicians and nurses were lured to the camps with higher than average pay, and by the fact that they had been rejected elsewhere due to "outdated knowledge or a poor

bedside manner."[18] Indeed, a strike at Heart Mountain hospital in Wyoming was related to the lower pay and subordinate roles the Japanese Americans were given, when their duty and skills far surpassed those of their white counterparts.[19] This literature focuses on racial/ethnic inequalities, but further research is needed to determine how the role of gender played into these tensions as well.

Thus, analysis of nursing care provided in Japanese American incarceration camps during World War II provides a tremendous opportunity for further research. The literature regarding healthcare in this setting is mostly limited to the discussion of public health data and the overall theme of personnel, supply, and equipment shortages in the early stages of the camps. Here, I review and analyze archival documents and other primary source data to provide a unique insight to how nurses at the camps adapted care for the ill and injured during a time of great distress, isolation, and uncertainty. This study helps to fill a gap in nursing and women's history literature related to women's work on the home front in U.S. government-run incarceration camps during World War II.

Purpose and Framework

The purpose of this study is to identify, describe, and analyze the work of nurses in U.S. incarceration camps holding west coast Japanese Americans during World War II, from 1942-1945. Traditional historical methods with a social history framework were used for the development of research questions, data collection, and data synthesis. Research questions included: (1) How did nurses contribute to the health of incarcerated Japanese Americans? (2) What were the social, political, economic, and cultural factors influencing nursing care? (3)

How was the nursing role adapted at the camps in Heart Mountain, Wyoming and Poston, Arizona? (4) How did Japanese Americans influence the care they received?

Having described and analyzed the work of nurses at these two camps, there are three major arguments that shape our understanding of this topic. In this dissertation, I argue that (1) organizational systems in place at the camps determined health section processes and nursing support; (2) traditional gender roles of the time significantly influenced the relationship between female nurses and male physicians and administrative leaders; (3) qualities of nurse leaders played a role in their ability to influence personnel and processes within the health sections of the camps. These qualities included cultural sensitivity, interpersonal relationships, and vision. Because the scant prior literature has focused primarily on the racially-based and discriminatory injustices of incarceration, the role of organizational systems, gender, and leadership in these settings have been overlooked.

The camps at Heart Mountain and Poston serve as cases to compare the nursing services established at these camps. The incarceration camp hospitals and clinics were all designed and built in similar fashion, and the War Relocation Authority (WRA) eventually administered all the camps. The WRA also attempted to allocate the nursing and medical skills of the incarcerated population equally across the camps, and employed white personnel to supervise and supplement the staff. However, these camps had some differences that influenced the nursing care at the camps. War Relocation Authority administrative officials at the Heart Mountain camp faced unique challenges in providing care during a brief hospital strike. Besides obvious differences in climate and terrain, Poston was the only camp to have been administered initially by the Bureau of Indian Affairs, due to its location on an American Indian Reservation.

Both camps had logistical and personnel problems, especially in the initial stages of establishing health services, and these early problems have long defined and been accepted as evidence of the overall failure of the health systems in the camps. Evaluation of the overall medical care based solely on the first six months of the health programs' existence provides a limited and simplistic perspective, and discounts the contributions of the nurse leaders and their influence on the nursing service. Senior nurse leaders at the camps negotiated War Relocation Authority policies and gender roles to extend a healthful and caring environment to the incarcerated Japanese Americans. This research gives voice to these and other nurses and their story.

Terminology

The War Relocation Authority, like most government agencies, adopted terms to define and understand its various physical and cognitive structures. These terms are identified here and many have been used in the historical presentation and discussion of the data. In consideration of the recommendations by the Japanese American Civil League (JACL) Power of Words II Committee, some exceptions have been made, to more accurately reflect the true circumstances surrounding the Japanese American experience as we understand it today. For example, the JACL asserts the terms "evacuate/evacuation" and "relocate/relocation" are euphemisms for the more precise term "forced removal." The term *evacuation* refers to the act of temporarily removing people from imminent danger – the JACL states the government used this term to suggest the population was being helped or saved from a disastrous environment, when this clearly was not the case. Likewise, the term *relocation* suggests voluntary movement. In reality, the government forced west coast Japanese Americans to comply with official orders whereby

they had to leave their homes and most of their belongings behind. It is acceptable to retain some terms, as when in use as part of a proper name, such as Santa Anita Assembly Center or Poston War Relocation Center. When used in general discussion, the JACL recommends the terms *temporary detention center* and *incarceration center*, respectively.[20]

The term *Issei* is used to describe the first generation of immigrants arriving in America from the country of Japan. The term *Nisei* is used to describe the second generation of ethnic Japanese in America, or those individuals born in the U.S. to Issei parents. These terms will be used when cultural context is relevant to the analysis. The term *Japanese American* will be used throughout the dissertation when referring to any individual or group of individuals of Japanese ethnicity living in the United States, regardless of their citizenship status.

Research Design and Methodology

This study employed a social history framework to analyze the nursing care at the Poston and Heart Mountain incarceration camps. Nurse historian Cynthia Connolly uses Novick's definition of social history as "that which focuses on the experience, behavior, and agency of those at society's margins, rather than on its elite."[21] Social history provides structure and context in which historians are able to interpret events of the past, holding that human behavior is influenced by predetermined social structures.[22] These structures are offered in what D'Antonio calls "the mighty triumvirate of race, class and gender."[23]

Race, class, and gender played a significant role in the Heart Mountain and Poston incarceration camps. Race, of course, was the defining issue in the forced removal and incarceration of Japanese Americans. After the Japanese attack on Pearl Harbor killed thousands of U.S. servicemen, white Americans vilified all Japanese Americans living in west coast states

in America. Dower notes that racism in the West was marked by denigration of others, and the United States had a long history of disparaging the Japanese in America. The Japanese "…were more hated than the Germans before as well as after Pearl Harbor….They were perceived as a race apart, even a species apart – and an overwhelmingly monolithic one at that."[24]

But race was not the only issue to affect individuals in the incarceration camps. The issues of class and gender also surface in this analysis. Class and gender relations were interwoven in the experiences of camp life between several groups: white Americans and Japanese Americans; the first-generation Issei and second-generation Nisei; and physicians, nurses, and nurse aides. The Issei traditionally held power and positions of leadership within Japanese American communities. At the camps, however, the U.S. government stripped away their power by denying the Issei positions of authority. Women, accounting for the majority of nurses both historically and currently, are examined in their positions in relation to others – often men, and in the case of nursing, male physicians. The majority of the physicians working in the camps were male Japanese Americans, straining the hierarchical structure designed by the War Relocation Authority, and the accepted social beliefs in America, that Japanese Americans were beneath white Americans. In addition, the intimate work of nursing within and among races and ethnicities in early mid-century America produced tensions that must be understood in context. [25]

Nursing texts and organizational guidelines that describe the scope of practice for nurses provide a framework for analyzing the nurses' work. The time period 1942 to 1945 was chosen because the camps under study were established in the spring and summer of 1942 and closed at the end of the war in 1945.

Data Exploration

All primary sources were carefully evaluated using the methods of internal and external criticism to establish reliability and validity. Most primary source documents were found in larger collections related to the War Relocation Authority or in the personal papers of individuals employed by the agency. Description and timing of some events were verified in multiple documents, thus providing greater certainty and reliability to the interpretation of these events. In other instances, such as the Heart Mountain hospital strike, a conflicting version of events was presented by the Japanese Americans and appointed personnel. In these cases, the meaning and accuracy of the data were interpreted within the historical context.

Primary source data were collected from local, state, and federal archives including:

1. National Archives and Records Administration – The facility in Washington, DC houses several record groups pertinent to this historical study. The Records of the War Relocation Authority, a federal agency created to administer the forced removal, relocation, maintenance, and eventual resettlement of west coast Japanese Americans, are contained here under Record Group (RG) 210. Records and photos are related to all aspects of camp life, including the medical and nursing departments.

The records of the Bureau of Indian Affairs (RG 75), housed at the National Archives and Records Administration facility in Riverside, California, were also used. This agency initially administered the Poston, Arizona camp. The records contain data regarding the development of health services at the camp.

2. University of North Carolina, Chapel Hill. Wilson Library Southern Historical Collections. The Sally Lucas Jean Papers, 1914-1966 (Collection #04290: Folders 74-75: Poston, Arizona –

Japanese-Americans, 1942) – Sally Lucas Jean was a nurse and pioneer health educator who served briefly as Health Education Consultant in Poston. Her papers include official documents (meeting minutes, health education material, etc.) as well as personal correspondence that convey sentiments regarding the incarceration.

3. The University of Wyoming, American Heritage Center, Susan McKay Papers (Boxes 1 and 2) contain transcripts of over 20 oral histories belonging to Japanese American women, some of them nurses, incarcerated at Heart Mountain, Wyoming. These interviews focus on their health experiences, most of which are related to maternal-child care. An interview with a white nurse who worked at Heart Mountain Hospital for nearly three years is also included in the collection.

4. Denshō: The Japanese American Legacy Project is a website containing oral histories, unique photos, and official camp newspapers. All are important sources from which one can appreciate a Japanese American perspective of events.

5. The Cornell University Library, Division of Rare and Manuscript Collections, Japanese-American Relocation Centers Records, 1935-1953 (Collection Number: 3830.) contain data collected by sociologist Lt. Alexander Leighton's observations of day-to-day activities of camp life at Poston. Observations, interviews, field notes, etc. document social welfare (Boxes 10, 17, 18) and health (Boxes 8, 10) and personality studies with key administrative and health figures.

6. The University of Virginia library is a repository for U.S. Government documents. It includes original reports published by the War Relocation Authority. These reports serve as primary data

that reflect the agency's workings and perspectives on the forced removal and incarceration of the Japanese Americans. Medical and nursing texts and journals in the Historical Collections of the Claude Moore Health Sciences Library and the Eleanor Crowder Bjoring Center for Nursing Historical Inquiry were consulted to provide primary data of established policies, procedures, and standards of care of the era.

Secondary Sources

Although many exceptional secondary sources exist to explain the overall incarceration experience, few speak to the health-related aspects of the incarceration. These sources barely mention the role of nurses in the camps. Thus, most secondary sources were used to provide historical context and document events leading to the mass forced removal and relocation of Japanese Americans during World War II.

Methodological Controls: Analysis

Dissertation committee members provided formative critique and expertise in the areas of World War II history, including "home front" history, mid-century nursing history, and cultural considerations. Prior coursework focused on gaining expertise in historical methodology, cultural considerations in health care, and World War II history. Working with the dissertation committee and presenting preliminary data at nursing and medical history conferences has provided the researcher with critiques of this work. Interpretation and analysis of the data was continually refined during the preparation of the dissertation.

Ethical Conduct of Research: Protection of Human Subjects

Request for institutional review board (IRB) approval was obtained prior to the formal process of data collection through the University of Virginia's Social and Behavioral Sciences Review Board (SBS) committee. The SBS committee determined the status to be exempt, as all data were collected from publicly available archival resources. The researcher completed CITI training and coursework in the ethics of conducting research.

Inclusion of Women and Minorities

This research focuses on the mid-twentieth century, specifically the war years of 1942-1945, when almost all nurses were white or black women. This research examines the nurses' work as well as the community health programs that concentrated on communicable disease and maternal/child health, and the hospital care provided to the detainees. The work explores the sociocultural dynamics of two "War Relocation Centers" where white, Japanese, and sometimes black nurses worked and lived in remote locations in the western United States. Thus, it includes women and minorities. This dissertation provides insight into how issues of time and place, social class, race, gender and ethnicity, as well as shortages in nursing, the availability of governmental resources, cultural influences, and interprofessional relationships shaped and continue to shape health care in the United States.

Inclusion of Children

Entire families were detained in the incarceration camps. A great deal of the health and welfare efforts focused on maternal/child health. Therefore, children of all ages were represented in this analysis. Because this is historical research, all data related to children are located in

archives open to the public. Children's names were omitted when discussing their nursing and medical care.

Chapter Overview

Chapter 1: Introduction and Methods

This chapter provides a brief overview of the dissertation research topic, questions, significance, and methodology.

Chapter 2: Background and Setting: Japanese Immigration, Assimilation, and Forced Isolation in America, 1885-1942.

Chapter Two discusses the arrival of Japanese immigrants to the United States of America, their integration to American culture, and American attitudes and policies related to Japanese and Asian immigration. Events following the Japanese attack on Pearl Harbor, such as the creation of West Coast military areas and the eventual forced removal of all west coast Japanese Americans as a result of Executive Order 9066, are examined. This chapter describes the Japanese American roundup and forced removal to temporary detention centers. Japanese Americans were housed in temporary detention centers, near their homes, as the incarceration camps were constructed. The U.S. Army administered the detention centers, calling on the United States Public Health Service for assistance in meeting the population's health needs. Initial efforts at preventing some infectious diseases began at the temporary detention centers. These efforts need to be considered when evaluating the rates of illness and disease at the incarceration camps. The chapter concludes with an introduction of the War Relocation Authority and the incarceration camps.

Chapter 3: Nursing at the Heart Mountain War Relocation Center, Wyoming

Chapter Three examines the nursing leadership within Heart Mountain, Wyoming hospital and its public health services. Several nurses served as Senior Chief Nurse or acting Chief Nurse during the critical early hospital establishment period. Lack of support and consistency laid an unfortunate foundation where subsequent nurse leaders, such as Margaret Graham, RN, and Anna Van Kirk, RN, were set up to fail before they could begin service. The analysis explains how camp conditions and unique individual qualities of the nursing leaders accounted for strengths, deficiencies, and inconsistencies in their service. Gender tensions between physicians and nurses led to a toxic working environment.

Chapter 4: Nursing at the Colorado River (Poston) War Relocation Center, Arizona

Chapter Four examines primarily the work of Elizabeth Vickers, RN, Senior Chief Nurse of Poston Hospital in Arizona. As Vickers established Poston's nursing service, her work was initially guided and supported by the Bureau of Indian Affairs, in cooperation with the WRA. Vickers built a service that endured terrific challenges associated with nursing in a remote, desert location. The public health nursing service that co-existed under separate leadership is also examined.

Chapter 5: Conclusion

The final chapter discusses conclusions from the data examined in the previous chapters. Data from the two camps are compared as they relate to the larger themes found within both camps.

Notes: Chapter 1

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Chapter 2

Background and Setting: Japanese Immigration, Assimilation, and Forced Isolation in America, 1885-1942

In order to understand the nurses' role in the Japanese American incarceration camps during World War II, it is important to examine the sociocultural, political, and economic factors surrounding the forced removal and incarceration of thousands of Japanese Americans as a response to the 1941 Japanese attack on Pearl Harbor and subsequent U.S. declaration of war. This chapter provides historical context to understand the delivery of nursing care within the Heart Mountain and Poston incarceration camps. This chapter: (1) provides a brief overview of Japanese immigration and discrimination in the late 19th and early 20th century; (2) discusses the events leading to the Japanese Empire's decision to bomb Pearl Harbor, Hawaii; (3) reviews Executive Order 9066 and the decision to remove Japanese Americans from select areas of the western United States; (4) explains the structure and administration of the health care in the temporary detention centers; and, (5) introduces the War Relocation Authority and its guidelines for the provision of health services in the incarceration camps.

Japanese Immigration and a Pattern of Discrimination, 1890-1924

Japanese emigration and American attitudes towards Japanese immigrants cannot be understood without first considering early Chinese immigration and the 19th century anti-Chinese movement, which foreshadowed the 20th century anti-Japanese movement.[1] Chinese immigration began shortly after the California Gold Rush in 1849, and ended with the Chinese Exclusion Act of 1882. Immigrants were almost exclusively male laborers working predominantly as miners

and agricultural and common laborers. In California, racism and nativism that had previously been directed at blacks, American Indians, and Spanish Mexicans, was soon directed towards the Chinese as well. American laborers and labor organizations protested the cheap Chinese labor that they perceived was taking away white American jobs. California state legislature responded as early as 1855 by attempting to pass laws that prohibited any further Chinese immigration. Anti-Chinese sentiment continued to grow nationwide, as Chinese were imported to the east coast to help resolve local labor strikes. However, it was not until the 1882 Chinese Exclusion Act that a law existed that suspended Chinese labor immigration and denied them citizenship.[2] This law set a precedent in the exclusion of immigrants by race/ethnicity. The Japanese would feel the effects of this law once Americans tired of their presence in the early 20th century.

The country of Japan was essentially closed to the rest of the world during the 250 year rule of the Tokugawa dynasty, prior to the Meiji Restoration of 1868. The feudal Tokugawa shoguns, highly suspicious of foreign intervention and colonialism, prohibited Western practice of Christianity and trade with Western nations. Japan had very little contact with the rest of the world, and emigration was not allowed.[3] However, the Meiji Restoration opened Japan's doors to the rest of the world, and allowed for modernization and westernization to occur rapidly.[4]

Britain and Russia attempted to establish relations with Japan early in the 19th century, but it was Commodore Perry of the U.S. Navy that entered Japan in 1853 and finally forced Japan into opening its ports to shipwrecked seamen in 1854. The United States was beginning to be interested in expanding its powers and influence in the Pacific, and desired a commercial relationship with the Asian countries, as well as a safe harbor for American seamen to rest and refuel. A commercial treaty was finally agreed upon in 1858, which opened five trading ports over the next few years. Political tensions increased between pro- and anti-Western Japanese

leaders over the next decade, ultimately leading to the collapse of Tokugawa rule in 1868. Meiji era leaders soon recognized that Western modernization needed to occur in order to strengthen the country, avoid colonization, and to allow Japan to compete on a level playing field with Western countries, such as England, France, and the United States.[5]

In America, Japanese immigrants soon filled the void in immigration and labor that occurred as a result of the Chinese Exclusion Act. The Japanese began arriving in the United States in large numbers, at first in Hawaii, beginning in the 1880s. Hawaiian Japanese were an important source of labor on the sugar plantations, and quickly became the largest single ethnic group in Hawaii. White plantation owners desired the Japanese presence, in part to balance the large Chinese population, which already accounted for nearly one fourth of Hawaii's population. Japanese immigration to the U.S. mainland was more self-directed. The number of Japanese living in the United States never came close to ethnic domination, although they did form small regional communities and dominated certain areas of agriculture and agricultural trade.[6]

Given most Japanese immigrants entered California through San Francisco, it is of little surprise that this city began protesting the presence of Japanese as early as 1891. However, the anti-Japanese sentiment at that time was not enough to spur any meaningful action. In addition, in 1892, the Chinese Exclusion Act had been extended for another 10 years. The declining number of Chinese created a shortage of labor in rural areas, and so California agricultural growers initially welcomed the Japanese. Soon after President Theodore Roosevelt made the Chinese Exclusion Act permanent in 1902, discontent and resistance among the growers began when the Japanese workers demanded higher wages in 1903.[7] In addition, with Japan's unexpected victory over Russia in the Russo-Japanese War in 1905, Japan's sudden military prominence further fueled anxiety and anti-Japanese sentiment on America's west coast. This

was the first time a Western country had been defeated by a non-Western army. Japan's victory over Russia was now viewed in a larger context as a threat that could evolve into an Asian "Yellow Peril" against the entire white race.[8]

By 1900, just over 24,000 Japanese were in the United States.[9] Anti-Asian sentiment continued to grow on the west coast, especially in California, as Japanese Americans became economically more successful. Almost daily editorials in the *San Francisco Chronicle* used inflammatory and derogatory racial words to incite fear and hysteria among white Americans. The editorials were successful in agitating young troublemakers, who physically assaulted Japanese Americans and picketed their businesses. These smaller events came to a climax in 1906 when the San Francisco Board of Education mandated that all Japanese and Koreans attend the ethnically segregated Chinese school. The incident angered Japan, whose leaders were keenly aware and protective of the treatment of Japanese citizens in other countries. In light of Japan's increasing international status and military power, President Theodore Roosevelt interceded, denouncing the actions of the School Board, the public, and organizations in their vicious and relentless assaults against Japanese Americans.[10]

Historian Roger Daniels asserts that this public denunciation was not reflective of Roosevelt's true feelings towards the Japanese in America, but rather for a political show of good faith for the Empire of Japan.[11] Daniels claims that Roosevelt's racist agenda aligned with that of California – for Japanese immigration exclusion. But to address the problem of Japanese immigration, Roosevelt first needed to quell the larger public discriminatory practices in California. Roosevelt persuaded California state administration to cease attempts at anti-Japanese legislature and desegregation of the schools. Only after tensions had somewhat settled down could Roosevelt negotiate an informal Gentlemen's Agreement with Japan in 1907. In this

agreement, Japan voluntarily limited the immigration of male laborers. This created a loophole which allowed wives and children who had originally stayed behind in Japan to enter the United States. Californians felt betrayed by the U.S. government, and tricked by the Japanese government.[12]

As the Japanese American population grew, families began migrating to agricultural areas of California and leasing fertile farming land. The anti-Japanese sentiment now focused on populations in these rural areas. The Alien Land Act of 1913 was a California law which denied land ownership to individuals ineligible for citizenship. The 1870 Naturalization Act allowed white Europeans and individuals of African descent to become citizens – all other non-white immigrants, such as Asians and Mexicans, would remain ineligible for citizenship.[13] Thus, first-generation Japanese Americans could not legally purchase their own homes or land.

Further laws were introduced to restrict the number of Asians and other "undesirable" immigrants over the years until the Immigration Act of 1924. Otherwise known as the Johnson-Reed Act, or the National Origins Act, this law set a quota on immigration, allowing only two percent of each nationality, based on 1890 census figures, entry into the United States. The law also excluded immigration of any alien ineligible for citizenship. Nationality laws from the 18th and 19th centuries prevented individuals of Asian lineage from becoming naturalized citizens. This rescinded the Gentlemen's Agreement and effectively halted all Japanese immigration. In essence, preserving Anglo-Saxon racial homogeneity superseded foreign diplomatic relations.[14]

This first generation of Japanese immigrants that had arrived in the United States were known as the Issei. Most Issei had little formal education in Japan, and, like many immigrants from other lands, never gained English fluency once in America. They retained their Japanese cultural traditions in their homes, neighborhoods, and workplaces. In the first 40 years of the 20th

century, many Issei had gone from common laborers to successful small business owners and independent farmers. They were denied access to most white business and social institutions, and so established their own restaurants, hotels, churches, markets, hospitals, and the like, forming "little Tokyo" communities all along the west coast.[15]

Their children, the Nisei, were born in the United States and were English-speaking American citizens. The Nisei learned Japanese language and traditions from their parents, but were immersed in the American culture as well.[16] Issei parents worked hard to send their children to college. However, Nisei graduates faced similar discrimination as their parents. Many Nisei professionals had to commit their professional lives serving the small Japanese American communities in larger cities such as Los Angeles and San Francisco, as many white employers would not hire them. Many Nisei doctors and nurses only found work in a Japanese hospital, as many white hospitals would neither hire nor serve Japanese Americans. The American education system that schooled the Nisei would not hire them back as teachers. West Coast Nisei were relegated to carry on family businesses, and put their hopes into the Sansei generation that were just being born before the war started.[17] By 1940, the U.S. Census documented over 126,000 individuals of Japanese heritage; nearly 80,000 (63%) were native-born citizens.[18]

Pearl Harbor Attack, Executive Order 9066, and West Coast Exclusion

The Japanese attack on Pearl Harbor on December 7, 1941, was not carried out as a singular act of treachery and malice, but as part of a larger series of events the Japanese felt necessary to ensure Asian superiority and domination of its Greater East Asia Co-Prosperity Sphere. War was a means to an end where this new order would "…become self-sufficient, be

freed from the suppression of the white race, and form a realm where all the countries and people within would co-exist in co-prosperity under the aegis of Japan."[19]

In order to succeed in their goal, Japan planned to disable Hawaiian-based U.S. naval capability, which would then allow the Japanese to strike and consolidate their military forces throughout Southeast Asia, virtually unhindered by the United States. The Japanese knew the United States would strike back, but believed in the strength and willingness of the Japanese Army and Navy to fight as long and hard as necessary. Japanese government representatives were to deliver to U.S. officials in Washington, a memorandum explaining Japan's position, but not a declaration of war, on the morning of December 7, 1941. However, the memorandum was delivered nearly an hour after the attack had begun, further fueling Americans' hatred for the Japanese.[20]

In the hours and days following the attack on Pearl Harbor, agents from the U.S. Department of Justice rounded up and arrested approximately 1,500 mostly west coast Issei males who had some connection to the Japanese government. (As mentioned earlier, the Japanese government remained interested in its immigrants, and helped subsidize the Issei as they established organizations to promote and preserve Japanese culture in the United States.) These suspect enemy aliens were mostly leaders in the Japanese American community: officers of Japanese associations, business leaders, language-school teachers, and Buddhist priests. More than 2,000 such Issei were interned and interrogated in enemy alien camps under U.S. Immigration and Naturalization Service jurisdiction in states such as Montana, New Mexico, and North Dakota. Many remained in these camps for months or years before they were reunited with their families in the incarceration camps.[21]

The swift government response to the Pearl Harbor attack affected all West Coast Japanese Americans. Immediately following the attack, all assets belonging to Japanese Americans were frozen, Japanese banks were closed, and the Federal Government revoked alien business licenses and stationed guards around their places of business. A consequence of these actions resulted in the almost immediate reduction in produce market inventory. Special concessions from the Secretary of the Treasury allowed the Japanese Americans to "show their loyalty" by bringing their produce to market and replacing the depleted inventory. By the end of December 1941, restrictions had eased somewhat, and Issei were allowed to withdraw up to $100 per month from their bank accounts to provide for the needs of their families.[22]

Nonetheless, anti-Japanese hysteria continued. Ordinary brush fires or flashes of light assumed suspicious and sinister meaning. Rumors circulated suggesting Japanese Americans poisoned the produce they brought to market. While these rumors proved to be untrue, Japanese submarine activity along the coast of California was very real during the last two weeks of December 1941. Four American tankers and one freighter were attacked as they cruised the waters of the Pacific Ocean. Only the tanker Emidio was sunk, losing five of its crew, with the remaining 32 survivors making it to life boats where they were later rescued. In addition, the Japanese Army continued to seize territory in Asian countries such as Hong Kong and the Philippines. The culmination of these events fueled anti-Japanese fervor in earnest by the beginning of January 1942. [23]

By the end of January, U.S. Attorney General Francis Biddle identified 99 "spots" on the west coast as prohibited zones for aliens of enemy nationality. These areas targeted land surrounding utility plants and large sections of waterfront, including the whole of Terminal Island, a Japanese fishing village south of Los Angeles. In addition, Attorney General Biddle

identified a 500 mile long by 30-150 mile wide strip of California coast as Restricted Area No. 1. Enemy aliens were to be removed from the less populated prohibited spots by February 15, 1942. Effective February 24, 1942, the larger prohibited spots would be evacuated, and those remaining in the restricted area were forced to obey a nightly curfew and restrict their movement to within five miles of their homes, unless they possessed a special permit. [24]

Meanwhile, California residents, newspapermen, and state and federal legislators, including the mayor of Los Angeles, persisted in their demands for full Japanese removal from California's coast and/or state. On February 13, 1942, the west coast congressional delegation sent a formal recommendation to President Franklin Delano Roosevelt (FDR) that all persons of Japanese descent be removed from the West Coast. In response, Lt. Gen. John L. DeWitt, Commanding General of the Western Defense Command and Fourth Army, wrote to Secretary of War Henry L. Stimson recommending the forced removal of "Japanese and other subversive persons" from the west coast.[25] Walter Lippman, a nationally syndicated, influential, and well-respected columnist, likened Hawaiian and European "fifth-column" sabotage to Pacific Coast Japanese Americans, who would bide their time until the most damage could be successfully inflicted. Biddle, despite designating restricted zones, had urged reason and caution to the President and the American public since the day after the Pearl Harbor attack.[26] In a last effort to persuade President Roosevelt, Biddle sent a memorandum that summarized the current restrictions in effect, emphasized the lack of evidence regarding potential sabotage, and warned what wholesale Japanese American exclusion might do to the economy. Biddle also specifically referred to the dangers for which unofficial rants such as Lippman's were responsible. He also reminded the president that 60,000 of the Japanese in question were American citizens.[27] However, it would be DeWitt's February 16, 1942 memo to Stimson, warning of the "continued

presence of a large, unassimilated, tightly knit racial group, bound to an enemy nation by strong ties of race, culture, custom and religion along a frontier vulnerable to attack constituted a menace which had to be dealt with," that prompted President Roosevelt's decision to sign Executive Order 9066.[28]

On February 19, 1942, approximately two months after the Japanese surprise attack on Pearl Harbor, President Roosevelt signed Executive Order 9066. This order authorized Secretary of War Stimson to prescribe military areas from which any or all persons could be excluded. The order also specifically authorized that provisions be made for the Japanese Americans who were to be removed: food, shelter, and transportation were to be provided by the government. Thus, all Executive Departments, independent establishments, and other Federal Agencies were directed to assist in the delivery of medical aid, hospitalization, food, clothing, use of land, and other supplies and services as needed.[29]

A series of public proclamations, orders, and laws came in quick succession after Executive Order 9066. The U.S. Army, under the direction of Lieutenant General John L. DeWitt, was in charge of evacuation, and initially urged Japanese Americans from the western halves of California, Washington, and Oregon, and the southern third of Arizona (Military Area No. 1) to evacuate and resettle voluntarily in the interior United States. On March 11, 1942, DeWitt established the Wartime Civil Control Administration (WCCA) as a civilian agency of the War Department. Its purpose was to facilitate the initial "voluntary" evacuation. As part of this initiative, 48 WCCA "service centers" were created in each major Japanese populated area within the military zones. In response to this action, approximately 9,000 Japanese Americans *did leave*, some settling in Military Area No. 2, an area that included the remaining areas of the states named in Military Area No. 1 (see appendix B for map of Military Areas Nos. 1 and 2).

Meanwhile, the Federal Reserve Bank, Farm Security Administration, and Federal Security Agency provided representatives to the WCCA service centers to assist the Japanese Americans in packing up and storing their belongings, and providing some monetary assistance for the relocation. But the sudden mass emigration caused problems inland, as other states were reluctant to accept the displaced Japanese Americans. Individuals within those states were often openly hostile to the Japanese Americans.[30]

Adding to the hostile environment was the fact that another Japanese submarine attack occurred, this time against a Santa Barbara, California oilfield on February 23, 1942. Although no injuries and little damage occurred, it was reported (but later found to be untrue) that blinking lights on shore directed the submarine's attack towards the target. The next evening, observations of unidentified objects were interpreted as a Japanese airplane raid on Los Angeles, prompting a blackout and a barrage of antiaircraft fire. The Battle of Los Angeles was quickly determined to have been a false alarm, however, hysteria was now near fever-pitch. These two incidents fueled the intensity of west coast citizens' demands for immediate and total Japanese American exclusion. [31] DeWitt's Proclamation No. 4 ceased the slow process of voluntary migration, and ensured the immediate beginning of planned, supervised, forced removal.

Although DeWitt had directed the construction of two major "reception centers" to temporarily house as many as 10,000 Japanese Americans while efforts to relocate them took place, it was soon evident additional facilities would be needed. Tremendous detail, planning, and time was needed to find employment and housing for the more than 100,000 Japanese Americans who would soon be evicted from their homes. DeWitt decided "intermediate assembly facilities would be a prime essential to the accomplishment of a rapid, compulsory evacuation."[32] Assembly centers, or temporary detention centers, then, would fill the gap

between the time Japanese Americans were removed from their homes to when they could be moved to the more permanent incarceration camps, where the long and tedious process of relocation would now take place.

In response to this new plan, the WCCA contracted the U.S. Engineer Corps to convert selected facilities, mostly fairgrounds and racetracks, into housing and central mess facilities. These types of facilities could be found in closer proximity to many of the more densely populated areas where west coast Japanese Americans resided in the early part of the 20th century. Fifteen sites were ultimately selected; twelve of these were in California, one in Washington state, one in Oregon, and one in Arizona (see appendix C for a map of the temporary detention centers and incarceration camps). The North and South Pacific Divisions of the United States Engineer Corps were allotted only four weeks to complete the centers. One requirement was that facilities had to be constructed so they could accommodate individuals before the entire center was completed. Deadline for completion of the 15 temporary detention centers was set for April 21, 1942. Construction of the "reception centers" at Manzanar, California and Poston, Arizona would continue and these would also be used as temporary detention centers.[33]

Bainbridge Island: The First Evacuation Area

The WCCA control stations worked with cold-hearted efficiency to register and process Japanese Americans for forced removal from their homes. In response to the need for a more expedient and efficient eviction process, the WCCA developed a more formal "block evacuation" system. The coastal area from which the Japanese Americans were to be removed was subdivided into 108 smaller exclusion areas, or blocks, based on the 1940 Census Bureau statistics. Although not all 108 WCCA control stations operated simultaneously, as many as 43

stations were in operation at one time during the peak removal period. An average of 3,750 Japanese Americans per day were moved from their homes to a temporary detention center, some moving directly to Manzanar or Poston, which were in the process of becoming more permanent incarceration camps. Some individuals bypassed the temporary detention centers and went to work as much-needed seasonal agricultural workers, to help alleviate the severe labor shortage caused by the war. These workers did return to the incarceration camps after the work was complete. Some mixed-marriage families, including Japanese American children under care of white foster parents, were eligible for exemption from mass forced removal.[34]

An Exclusion Order with specific reporting instructions would be posted in an exclusion area only a few days before the forced removal began (see appendix D for an example of an Exclusion Order). A Civil Control Station was established within a specified exclusion area, most often in a public hall or school gym or auditorium, for a certain period of time, based on availability of personnel to process the Japanese Americans, and the readiness of the receiving temporary detention centers. Heads of families and those living alone were required to report and register at the station. Representatives from the agencies at the earlier "service centers" were again posted at the Control Stations to facilitate the forced removal. Now, military police were also a part of the scene to provide security.[35]

On March 24, 1942, General DeWitt issued Exclusion Order No. 1 to the Japanese American residents of Bainbridge Island in Washington State. The island's strategic location near Bremerton Navy Yard in Puget Sound, and perhaps the relatively small group of approximately 50 Japanese American families, were reason enough to start the evacuation there. Mass forced removal happened quickly; the process of clearing an exclusion area was generally completed within seven days. The general cycle would take place as follows: The initial

Exclusion Order was posted on Days One and Two; registration of Japanese Americans took place on Days Two and Three; medical processing and preparation of personal affairs occurred on Days Four and Five; transport to assembly centers was completed on Days Six and Seven.[36] Bainbridge Islanders were then herded onto their nearly 1,000 mile journey to Manzanar, California.

Medical Considerations

Anticipating overcrowding and unsanitary conditions, some Japanese American communities began vaccination programs on their own initiative, prior to transport to the temporary detention centers. The Japanese Cannery Workers Association in Seattle sponsored a free typhoid immunization program to more than 600 individuals, while some physicians brought vaccines to those who lived rurally. These noble efforts reached only a fraction of those needing protection.[37] Most individuals would receive vaccinations in the temporary detention centers or incarceration camps.

In its attempt to protect the public health of Japanese Americans, the United States Public Health Service (USPHS) screened all persons for contagious disease prior to departure to a temporary detention center. Individuals diagnosed with a communicable disease, such as tuberculosis, were hospitalized and would rejoin their families once they were medically cleared. Individuals already in tuberculosis sanatoriums were sometimes moved to facilities closer to the temporary detention centers.[38] After finding that some individuals might never be well enough to be evacuated, DeWitt granted them a permanent exemption from exclusion and forced removal.[39]

The medical clearance process involved a team of medical and nursing personnel. A nurse was on duty at the Control Stations during all hours of operation. A physician was either

present or immediately available. Japanese American physicians were not authorized to conduct the medical clearance screenings. Rather, U.S. Public Health Officers versed in maritime quarantine inspection conducted or supervised the screenings. Medical inspection considered general individual appearance, examination of eyes, mouth, throat, and visible areas of skin. Individuals suspected of disease received a more thorough exam in a private area.[40] In reality, however, the exams were embarrassing and insulting to the Japanese Americans, as they were forced to disrobe in the presence of others. Physicians could not possibly provide a thorough exam as they processed 500 or more individuals per day. Some families tried to hide a family member's illness in an effort to keep the family together.[41]

Those unable to travel to the Control Stations for initial medical processing were examined in their homes. Individuals whose physical condition was deemed sufficiently poor to allow safe travel to temporary detention centers were hospitalized. These individuals remained hospitalized until an attending physician medically cleared them or recommended exemption from exclusion, in which case other arrangements were then made for their care. Institutionalized mentally ill persons remained at their facilities for continued treatment. Pregnant women within a few weeks of delivery were often hospitalized until they delivered. Once these individuals were medically cleared for travel, they were reunited with their families at the temporary detention centers.[42]

Travel to the temporary detention centers concluded the week-long registration and clearance process. Buses or trains were used to transport the Japanese Americans, depending on the distance to the destination. Special travel accommodations, such as ambulance or Pullman berth, were recommended by physicians at the control stations for the very elderly or infirm, infants, and pregnant women. One physician and at least one nurse accompanied individuals

traveling with special needs. A nurse and physician accompanied larger bus convoys traveling to the temporary detention centers in the event an emergency situation arose.[43] By June 7, 1942, only six months after the attack on Pearl Harbor, "…nearly 100,000 people of Japanese stock – both aliens and American-born – had been concentrated in assembly centers in Military Area No. 1."[44]

Life at a Temporary Detention Center

Upon their arrival to the temporary detention centers, Japanese Americans received another superficial medical screening. Families were assigned an identification number and a barracks and were searched for contraband items, such as flashlights, alcohol, cameras, knives, and radios.[45] Barracks varied within and among the centers, but all were crowded, primitive, and lacked privacy. As several fairgrounds and racetracks had been converted into temporary detention centers, construction of the barracks included adapting horse stalls into barracks apartments, until newer housing barracks could be built. Traces of hay and horsehair mixed in with the whitewashed walls reflected the construction workers' frantic pace to stay ahead of the crowds daily arriving en masse. Linoleum floors could not contain the manure stains or smells deep within the floor boards they covered. Privacy was virtually nonexistent: more than one family often had to share a 200 square foot room, or "apartment."[46]

The newly constructed barracks were not much better. These facilities conformed to U.S. Army Theatre of Operations type of barracks buildings, where one barracks measured 20 by 100 feet, and was built directly on the ground, sometimes with a concrete or asphalt floor, and sometimes with an elevated wood floor. The barracks were divided into rooms, or "apartments," with wooden partitions that extended to the top of the outside wall line. The elevated roof gables

meant that the entire barracks ceiling was open.[47] A young woman described her experience at Santa Anita Assembly Center:

> At first, Miss H and her family were assigned to an apartment in a horse stall. They were shocked by this. The smell was awful. The floors were made of asphalt and it was generally a very undesirable place. They complained strongly about this and her family moved to a barrack, which in contrast seemed wonderful to them. It was rather crudely built and lacked any comforts. Only a cot, mattress and blankets were provided. Residents built their own furniture out of scraps of wood they found around the center.[48]

Crowded conditions could be found everywhere in the temporary detention centers. The detainees waited in long lines for their meals at common mess halls. The mess halls varied in cleanliness, as many Japanese American chefs and kitchen staff had no prior experience in proper food handling and sanitation procedures. There was little variety in the meals – pork and beans, stews, and hamburgers rotated frequently through the menu. [49] Initially, the U.S. Army Quartermaster Corps provided only B-rations, consisting of non-perishable processed or canned staple foods. Meals improved once A-rations, or garrison rations, could be provided. Garrison rations replaced some of the canned foods with their fresh counterparts. However, the fresh produce was often of inferior quality.[50] Milk was limited to children and to those individuals with special dietary needs. Friends of the Japanese Americans visited the centers to bring food and other items – these packages were also searched for contraband. Some Japanese Americans had hot plates in the barracks, and could prepare simple dishes or tea with the items they received.[51]

The Japanese Americans were also forced to use common latrines. At first, the toilets and showers lacked partitions, and the sinks were simply open troughs. The toilets also lacked seats.

The crudeness and lack of privacy upset the Japanese Americans. After frequent and strenuous objections, some of these problems were slowly corrected, although, in some centers, toilet stalls were outfitted with partitions only; stall doors were never hung.[52] Centers were designed and built for housing and feeding young, healthy servicemen as they prepared for war – engineers did not consider the needs of women, children, or the elderly and infirm.[53]

Japanese Americans had little freedom once in the centers. The WCCA developed specific interior security regulations that included:

> Unnecessary noises or disturbances are prohibited.
>
> Evacuees are prohibited from organizing, participating in or being members of any secret club, organization (excepting Boy Scout activities), association or combination of more than one individual.
>
> All meetings within the Center shall be conducted in the English language…
>
> Meetings for the purpose of discussing the war or any international problem are not authorized.
>
> Stoppage of work by individuals or as a group…is prohibited.[54]

Military police were employed "to prevent unauthorized departure of the evacuees."[55] The police also enforced nighttime curfews and conducted random searches of the barracks.[56] Japanese Americans could receive passes to leave the centers to visit hospitalized relatives, attend to business matters, answer subpoenas and court orders, take professional examinations, and attend funerals of immediate family members. Center managers approved passes so long as they met the strict guidelines set forth by the WCCA. Each center had its own civilian manager in charge of internal organization and management. The manager would work in concert with the

Western Defense Command to secure initial supplies, such as bedding and kitchen needs. Funds from the U.S. Government covered the costs of operating and maintaining the facilities.[57]

Japanese Americans working and living in the centers had no voice in the administration of the centers: "No type of self-government organization is authorized in an assembly center. Advisory committees which have no administrative, executive or judicial power or authority, but which serve as advisers to the Center Manager as hereinafter prescribed are authorized."[58] Members of the Advisory Committee reflected proportionally the number of Issei and Nisei in the center, so long as English-speaking Issei were selected. Sub-committees, such as a Health and Sanitation Committee, would inform the Advisory Committee of matters relevant to that area of concern.

Medical Care in Temporary Detention Centers

The Service Division, along with the Supply Division, Works Division, Finance and Records Division, and Lodging and Messing, were administrative agencies immediately established at the temporary detention centers. Medical, dental, and hospital care were included in the Service Division, with technical supervision under the U.S. Public Health Service (USPHS) and administrative operation under supervision of the center manager. Guidance from the USPHS had to clear WCCA Headquarters before it reached the medical staff at the temporary detention centers, however, the center managers were expected to conform to USPHS public health and sanitation guidelines.[59]

The WCCA determined the policy and procedure for medical and dental service operations in the temporary detention centers,

> …shall embrace the practice of curative and preventive medicine, the latter to include supervision of general sanitation of the premises, immunization, special clinics, health, education and other activities designed to promote the health of the Japanese residents. In carrying out these functions, there shall be operated an infirmary, an outpatient department including a dental clinic and a sanitation division.[60]

Lieutenant General John L. DeWitt, commander of the Western Defense Command, wrote Senior Surgeon W. T. Harrison, USPHS District #5 Director:

> In connection with the establishment of Assembly Centers, Reception Centers and the operation of Civil Control Offices for Japanese evacuees in the Coast States, you are authorized to employ necessary medical and nursing personnel, purchase medical and surgical supplies, and provide necessary hospitalization for the sick. In carrying this out, under your supervision maximum use will be made of the professional services of Japanese doctors and nurses available, except that they are not to be used in Civil Control Offices.[61]

A total of 87 physicians and surgeons and 137 nurses were distributed proportionately amongst the temporary detention centers.[62] On occasion, the USPHS detailed some of their nurses to supplement the Japanese American nursing staff at the centers.[63]

Hospital buildings were constructed under the guidance of the USPHS at the Manzanar, Santa Anita, and Pomona detention centers. Manzanar had a difficult beginning, in that the 10-bed hospital building quickly overflowed to more than 70 patients in five regular barracks. These barracks lacked toilets and running water, posing considerable problems in caring for patients until the hospital was completed. The problem was compounded by a lack of essential medical supplies, a problem seen in most center hospitals. Although the system whereby the USPHS

approved supplies ordered by Japanese American physicians was followed, most supplies were not delivered. Camp managers authorized local purchase of some supplies and equipment, but not all requested items were readily available for purchase. County health officers and hospitals often loaned items such as surgical needles and scalpel handles so physicians could provide their services in the centers. The physicians' powerlessness to adequately serve the population often translated into discord and dissatisfaction between the physicians and camp managers.[64]

Japanese Americans working at the temporary detention centers received monthly wages based on a forty-four hour week: for unskilled labor, $8/month; skilled labor, $12/month; professional and technical labor, $16/month. Unskilled labor included tray service at mess halls and common laborers. Skilled labor included accountants, motion picture machine operators, and nurses. Professional and technical positions included physicians and surgeons, dentists, engineers, and teachers.

The USPHS had responsibility for providing personnel and supervising the overall care provided in the centers. However, the actual health and medical services was provided by the Japanese American physicians, dentists, nurses, and medical technicians within the centers. One Japanese American physician would be placed in charge of services at each center, and retain "professional and administrative supervision over all other physicians, dentists, nurses and hospital personnel and shall be responsible … to the United States Public Health Service or its representative for the proper administration of health and medical services in the Assembly Center."[65]

The physician in charge was responsible for many services critical in the operation of the hospital and clinic. This included preparation of daily illness and weekly census reports, security

and tracking of all narcotic drugs, oversight of sanitation efforts, medical equipment inventory and maintenance, and supply requisitions. The physician in charge could also make

> …additional rules and regulations as are necessary for the operation of medical services, provided these additional rules are not in conflict with those set forth herein by the U.S. Public Health Service and those placed in effect by the Assembly manager, and provided, further, that the additional rules are reviewed and approved by the local representative of the U.S. Public Health Service and the Assembly Center manager.[66]

The temporary detention center physician, then, had tremendous power and authority in the operation and maintenance of all health-related matters and healthcare personnel, including nurses. This would be an important difference in the way incarceration camps were administered.

The WCCA drafted a formal policy and plans for "counter-epidemic measures" within the centers. The USPHS was responsible for coordinating the necessary work between the local and state health departments and the Center Manager, should a health or sanitation crisis occur. The WCCA would spare no expense to ensure that an epidemic was swiftly countered. To avoid the outbreak of disease, the WCCA recommended the following immunizations and vaccinations be carried out as soon as possible: smallpox, typhoid and paratyphoid, diphtheria for individuals under twelve years of age, and whooping cough for individuals under three years of age. All individuals handling food required physical examinations, to ensure they did not inadvertently pass disease to the rest of the population.[67]

The WCCA, aware that communicable diseases could move quickly through the large groups of people in confined and unsanitary conditions, developed a chain of command to monitor conditions at the temporary detention centers. Local health inspectors would visit the centers daily, while USPHS agents would perform weekly inspections of assigned centers.

Should an epidemic emerge that was beyond the scope of the center physician and local health officer, a robust contingency plan included contacting the State Health Department and USPHS. This would further initiate calls to local trained epidemiologists, as well as the National Institute of Health in Washington, DC, the Rickittsial disease laboratory in Hamilton, Montana, and Plague laboratories in San Francisco.[68] State health agencies supplied the names of individuals in treatment for sexually transmitted diseases, so temporary detention centers could follow through with the required treatment. Isolation and quarantine would be considered for most communicable diseases, such as measles, mumps, scarlet fever, meningitis, poliomyelitis, and chickenpox. Stricter measures would be needed for individuals infected with tuberculosis.

Tuberculosis was a public health threat in all the temporary detention centers, and would remain so in the incarceration camps. Tuberculosis (TB) was the leading cause of death in the United States in the first decade of the 20th century, but slowly declined to the 6th leading cause of death (62.5 per 100,000) by 1932 and 7th leading cause of death (22.5 per 100,000) by 1950.[69] Tuberculosis was the third leading cause of death in Japan in 1934, a rate of approximately 130-140 per 100,000. From 1911-1940, the death rate from TB in California consistently exceeded the U.S. rate, most likely due to the near double mortality rate of Japanese Americans (130-112 per 100,000) versus Californians (71.4-56 per 100,000), as recorded from 1935-1940.[70]

Tuberculosis carried a heavy social stigma with the Japanese and Japanese Americans.[71] When a man and women began considering marriage, it was not unusual for an extensive health history to be obtained on both sides of the family, looking back several generations for evidence of TB, as well as other socially stigmatizing diseases such as mental illness and leprosy. The Japanese believed that TB was inherited, thus creating a stigma upon the entire family. The Issei carried this stigma with them, reluctant to submit to X-ray exam for fear that the disease would

be clearly detected and confirmed. The Nisei were more likely to embrace the accepted pathogenesis of TB, ignoring the stigma and sometimes marrying into a family with a history of TB, much to the displeasure and sometimes ostracism of their own family.[72]

The War Relocation Authority hospitalized approximately 250 Japanese Americans for tuberculosis treatment as a result of the initial medical screenings. As the forced removal progressed, the number grew to 400, and later to 600 individuals hospitalized for tuberculosis. Physicians believed the increasing number of cases was not the result of the incarceration process, but rather a result of cases now being diagnosed and in treatment.[73] Although treatment consisted of little more than rest, fresh air, and proper nutrition, the process of removing infected individuals from the population meant that fewer people would be exposed to the deadly disease, and hence fewer infections would result.

The War Department called upon the American Red Cross to conduct a survey of the services provided at the temporary detention centers. The American Red Cross, with over 60 years' experience in caring for refugees and victims of disaster, both domestic and abroad, was well-qualified to conduct this type of work. Ten of the centers were surveyed on July 30-31, 1942, and results were compared to "standards considered acceptable for mass care in meeting the emergency needs of food, shelter, medical aid, and clothing for persons in need of such services as a result of disaster."[74] In this case, the American Red Cross (ARC) identified Japanese Americans in temporary detention centers as people in emergencies as a result of war. Overall findings of the report indicated the WCCA met the mass standards of care in all areas, including provision of shelter, food, medical care, religious observances, and recreation opportunities. A closer look at the findings would reveal several areas for improvement in the Health Sections.[75]

The ARC based many of their conclusions regarding the availability of hospital equipment and supplies on the WCCA's original intent for medical care in the temporary detention centers as providing infirmary care, with all serious cases transferred outside the center. However, the lack of bed space in the county hospitals often allowed for only the most critically ill of the Japanese Americans to be admitted for care. Although elective surgery was never within the scope of services to be provided, the lack of basic medical equipment prevented Japanese American physicians from providing care, such as hemorrhoidectomies, that would enhance the well-being of affected individuals.[76]

Public health efforts were a priority in the centers. Vaccination against smallpox and typhoid were among the first orders of business as the Japanese Americans arrived.[77] Of the nearly 71,000 individuals in the centers at the end of May 1942, over half had been vaccinated for typhoid fever and smallpox. Diphtheria immunization would take place after smallpox and typhoid vaccinations were completed.[78] The lack of X-ray equipment meant that tuberculosis surveys were limited to individuals exhibiting obvious symptoms of active tuberculosis.[79]

The ARC noted the lack of medical personnel that would affect the incarceration camps over the next three years. Japanese American physicians and nurses were sent to temporary detention centers in advance of the general population to prepare the hospital and clinics and receive the incoming individuals. Dentists, laboratory technicians, and pharmacists were in good supply. However, physicians and nurses were in short supply to serve the needs of the entire uprooted population. Although the ratio of physicians to individuals appeared adequate, the ARC predicted that the provision of free medical care would invite abuse of physician services. Some Japanese American physicians and nurses from the east coast of the United States volunteered to work at the temporary detention centers.[80] It is unclear if these east coast personnel proceeded to

the incarceration camps, or if they returned to the east coast after the temporary detention centers were closed.[81]

The lack of registered nurses was of great concern. The United States Public Health Service was able to provide public health nurses at only six of the centers. Student nurses and nurse aides performed much of the hospital bedside care, yet few registered nurses were available to adequately supervise their work. Most temporary detention centers had started nurse aide training programs of some sort. However, the training could not equal the formal training and experience of the registered nurses. Nonetheless, registered nurses delegated more complex nursing tasks, including oral and parenteral medication administration. One nurse commented, "I have tried to teach them [nurse aides] as much in two months as I learned in three years."[82] The detainees' hard work did not go unnoticed; without the "cooperation, character, ingenuity, and industry of the Japanese evacuees….little or nothing would have been accomplished."[83]

Introduction to the Incarceration Camps

The U.S. Army did not have the time, resources, or desire to oversee the forced removal and resettlement process in its entirety, but would continue to supervise the initial round up process. Therefore, President Roosevelt signed Executive Order 9102 on March 18, 1942, establishing the War Relocation Authority (WRA).[84] The WRA was the civilian agency responsible for the supervision, maintenance, and eventual redistribution of all west coast Japanese Americans to the interior United States. Milton Eisenhower, brother of future President Dwight D. Eisenhower, served as the first WRA director. Eisenhower initially proposed Japanese Americans be moved inland to small camps serving as staging areas that would quickly process their resettlement to other areas of the country. At an April 7, 1942 conference in Salt Lake City,

Western state governors except Colorado's Ralph Carr, emphatically opposed Eisenhower's proposal, as they did not want Japanese Americans to settle in their states. Wyoming state governor Nels H. Smith declared that if Japanese Americans were allowed to relocate to Wyoming "there would be Japs hanging from every Pine tree." He further stated that Japanese Americans "should be kept in concentration camps – not reception centers, should be worked under guard, and should be removed at the end of the emergency."[85] Thus evolved the concept of "relocation centers," or incarceration camps. After holding his position for a few months, Eisenhower, feeling uneasy and unable to come to terms with the progression of events, resigned in June 1942. Dillon Myer assumed leadership of the WRA for the remainder of its existence.[86]

Ten incarceration camp sites were selected based on their location outside of the militarized areas, ability to accommodate at least 10,000 people, favorable soil, water supply, climate and growing season, and accessibility to electricity and highway and rail transportation. The camps at Manzanar in California and Poston in Arizona were converted from "reception centers" to temporary detention centers to incarceration camps. Other incarceration camps included Tule Lake in California, Gila River in Arizona, Topaz in Utah, Minidoka in Idaho, Heart Mountain in Wyoming, Granada in Colorado, and Jerome and Rohwer in Arkansas. In reality, these areas were remote and barren places.[87] The Heart Mountain camp, with over 11,000 detainees, became the third largest city in Wyoming. There, the supply of coal for winter time heating could barely meet demand. The Poston, Arizona camp was located on an American Indian Reservation in the desert. All mail, equipment, supplies, materials, and people had to be transported nearly 20 miles through the desert via buses or trucks, in order to reach the camp from the railhead.[88]

Although all camps were similar in many ways, there were also many differences that occurred due to climate, terrain, and proximity/availability of natural resources such as water and fertile soil for farming. Because of these conditions and the remote locations of the camps, management functions were decentralized to each of the camps, with overall operational control maintained in Washington, DC at the federal level.[89] The attitude and ability of the camp directors, then, would influence camp operations and tone.

The incarceration camps, like the temporary detention centers, were designed and built as temporary sites that would normally be found in military areas of operation. Standard wooden barracks, wrapped in black tar paper, were originally designed to house young, unmarried, male military recruits. The reality of housing entire families changed their actual use. These barracks, 100 feet long by 20 feet wide, would be subdivided into four spaces, each space housing four to eight family members or sometimes groups of strangers. These smaller spaces were furnished with Army cots, one drop light, and a stove for heating the space. Japanese Americans attempted to fill these spaces and make them more inviting by hanging curtains on the windows or constructing simple furniture with scrap lumber left on the construction site.[90]

Arrangement of barracks and common buildings also followed a military design. Groups of 10-14 barracks formed a block, each block containing a common mess hall, laundry room, recreation hall, and male and female latrines. Each block formed a community of 250-300 people. Each of the ten centers typically consisted of approximately 30 blocks. These blocks became the "foundations of community life" in the centers.[91] Block councils were formed, composed of an elected representative from each barrack. A block manager was appointed for each block, and was the liaison between the block and the WRA administration. The WRA at first restricted community council membership to the Nisei, not only because they were English-

speaking, but also in an attempt to usurp power the Issei informally held as the respected older generation.[92] This generational tension would surface in a variety of ways in the camps. Women rarely served on these councils.

Although the forced removal, relocation, and resettlement initiatives of the U.S. Government and many WRA policies were directed at fragmenting Japanese culture, the WRA attempted to educate and sensitize WRA staff members on the Japanese culture, in order to facilitate a more collaborative relationship between Japanese American incarcerees and the appointed personnel supervising their welfare at the camps. In October 1942, War Relocation Authority Director Myer issued a memo to all WRA staff stating, "The successful administration of the WRA program, especially in the Relocation Centers, will be dependent to a great extent upon an understanding of the cultural background of the Japanese people and their American children and grandchildren."[93] Accompanying this memo was anthropologist John F. Embree's *Dealing with Japanese-Americans*, a seven-page document that provided "insight" into the Japanese culture. This insight was based on his extensive period of scholarly work and study in the village of Suye, on the island of Kyushu, Japan, from 1935-1937.[94] Embree served initially as head of the Documents Section of the Office of Reports for the WRA in Washington, DC. Shortly after a November 1942 strike at the Poston, Arizona camp, followed a month later by a fatal riot at Manzanar, the WRA adopted Embree's suggestion for a social science program at the camps. Embree created the Community Analysis Section (CAS), where he hired professionally prepared anthropologists and sociologists to track the overall mood of the Japanese Americans in the camps. Another reason for studying the population was to prepare American men and women in understanding the Japanese people in Japan, the country that would eventually be occupied after its defeat in the war.[95]

In the *Dealing with Japanese-Americans* document, Embree began with an explanation of the difference between race and culture. Race, he explained, resulted in a person's inherited physical traits, whereas cultural traits were not inherited, but acquired through learning, education, and social status. Embree summarized these differences by noting that although the young Nisei and older Issei both possessed certain features that made them "look" Japanese, the Nisei were far more likely to share the same beliefs and attitudes as the majority of white Americans than the older Issei, who still clung to Japanese cultural traditions.[96]

Some of the traditions that Embree considered worth noting related to the use of a "go-between," the concept of shared responsibility, outlook on employment, and the importance of the project head's position. Embree wrote that in Japanese culture, the go-between, or third party, was used in negotiating business or personal matters to spare embarrassment where one person might answer another with "No." The concept of shared responsibility was similar, where committees agreed unanimously on decisions, thus making them equally responsible for the outcomes of those decisions.

Embree also explained how anxiety, brought on by the sudden upheaval of forced removal and incarceration, might be expressed in work strikes or riots. To foster a trusting environment, and therefore avoid work disruptions and the circulation of rumors, all staff members, especially the project head, were encouraged to form personal relationships with the Japanese American incarcerees. The project head, "as the man responsible for the whole community…has great authority and prestige." Embree stressed that new policies or developments should always be introduced first by the project head. "Only in this way will the people believe what is said, because it comes from the highest authority." Whether issues brought forth by the Japanese Americans seemed trivial or were indeed of great concern, the

project head should address all concerns with equal care and concern.[97] Whether Embree's document became required reading for all appointed staff in the camps' health sections is unknown.

War Relocation Authority staff were generally white and held all supervisory positions within the camps. Some staff commuted to the camps, but most lived in separate housing areas on the camps. A few senior staff lived in modest houses with their families, while some staff lived in barracks. Individuals living in staff barracks generally had furnished, private rooms with a shared bathroom. A separate mess hall was also provided for WRA staff.[98] In an effort to contain any feelings of animosity that may have occurred due to the superior positions, circumstances, and benefits the white staff enjoyed over the Japanese American incarcerees, the term "Caucasian" initially replaced the term "white," and "evacuee" replaced "Jap" or "Japanese." Believing the term "Caucasian" also emphasized racial differences, the WRA officially banned its use in August 1942, instructing camps to use the term "appointed personnel" instead. The term "appointed personnel" was limited to official documentation, however, as the terms "Caucasian" and "evacuee" became the terms of choice in dialogue among WRA staff and English-speaking Japanese Americans.[99]

Attempts at keeping the language neutral did not compensate for the inequality in pay. Camps needed to be self-sufficient and provide the labor needed for self-sufficiency. Appointed personnel accounted for approximately 1,750 employees at the centers during the peak of operations, while over 30,000 Japanese Americans accounted for the remaining number of workers on the WRA rolls. Appointed personnel received civil-service wages appropriate to the time. Incarcerees received $12, $16, or $19 monthly, depending on skill, plus an average of $3.50 per person per month for each member of the family of the worker. These wages were

purposely set below the $21 minimum monthly wage of a new U.S. service member. A system of sick and annual leave was established for the incarcerated workers that closely resembled the civil-service system. Housing, food, medical care, recreational items, and education were provided free of charge by the U.S. Government.[100] The WRA approximated an average of $1.20 per incarceree to cover daily food, medical care, wage, and associated administrative costs.

Camp Food

Incarcerees were completely dependent on mess hall facilities, which served each block of approximately 300 people their daily breakfast, lunch, and dinner meals. Mess halls were buildings 40 feet by 100 feet in size, with approximately one-third of the space devoted to cooking and preparation of food. The remaining area held enough wooden picnic style tables and benches to accommodate 300 people.[101]

The problem of supplying food to over 100,000 people in 10 different camps across the vast interior western United States would prove to be quite an undertaking, given the wartime food rationing that was already underway across the rest of the nation. Basic kitchen items, such as pots, pans, and utensils, remaining after temporary detention centers had closed were transferred to the incarceration camps. In addition, each camp received an initial 10-day supply of non-perishable foods such as canned goods, smoked meats, beans, flour, and sugar.[102] Providing a variety of fresh food to meet the specific dietary requirements of children and individuals with certain health problems, such as diabetes, was a constant struggle.

The location of the camps determined the growing season and types of crops the camps could reasonably grow. Some of the crops planted at Heart Mountain included beans, broccoli, cabbage, peas, potatoes, and lettuce. Camps reserved hundreds of acres for feed crops such as

alfalfa hay and silage corn. These crops would be used to feed chickens, pigs, and other animals being raised for consumption.[103]

Camp Medical Facilities and Personnel

All camps were to have a group of hospital buildings that contained an administration building, doctors' and nurses' quarters, general patient wards, outpatient clinic, obstetrical ward, surgical space, pediatric ward, mess hall, isolation ward, morgue, laundry, storage space, and a boiler to generate steam needed for heat and sterilization of supplies. The hospitals would range in size from 150-250 beds. Initial equipment was supplied by the U.S. War Department and was to include supplies for meeting the dietary needs of patients, X-ray machines and developing equipment, dental chairs and equipment, laboratory, operating room equipment and supplies such as sterilizers, and morgue supplies to include an autopsy table.[104]

Additional medical staff would be needed to supplement the limited Japanese American medical and nursing personnel. However, licensed and trained medical and nursing staff were difficult to locate and retain. The needs of the war took precedence, with nearly one-third of all practicing physicians in the United States entering military service. Physicians in rural areas migrated to urban areas to replace their counterparts leaving for war. Other physicians migrated to areas where industrial growth related to wartime manufacturing caused surges in population.[105] Physicians available for relocation to these camps were often older males with outdated knowledge, poor bedside manner, and without a comparable job opportunity. It does not appear that black physicians were ever considered as a possibility to help supply vacant positions.[106]

Nurses for the camps were also in short supply, as many were serving in the U.S. Army and Navy at home and abroad. In response to personnel shortages, many civilian hospitals closed wards, as there simply were not enough nurses to care for the patients.[107] The WRA was desperate to hire trained registered nurses, and did manage to hire many nurses as civil service employees at the incarceration camps, although retaining these nurses presented a problem. Some camps also hired black nurses, although desegregation was not standard practice at the time. These black nurses worked especially hard to prove themselves as competent professionals, and in most cases, became valued members of the nursing staff.[108]

As a result of the personnel shortages, the camps initially depended upon Japanese American medically trained personnel to serve their population, while the few available appointed staff would work in administrative and supervisory positions. Although none of the incarcerees were required or forced to work, most medical personnel did work out of a sense of duty to meet the health needs of their fellow people. Most were young, well-trained physicians and nurses holding prestigious positions in public hospitals and Japanese American hospitals in California prior to evacuation.[109] However, with relocation as the goal for *all* incarcerees, it was unclear how the Japanese American medical and nursing staff would be retained in the camps for the long term.

The United States, aware of the drain the war would have on American human resources, established the War Manpower Commission (WMC) within the Office for Emergency Management in April 1942. The WMC was created to "assure the most effective mobilization and utilization of the Nation's manpower for war."[110] The United States Civil Service Commission, which hired nurses for the War Relocation Authority, was required to conform to WMC policies and directives as they related to filling government service positions. In addition,

the WMC also assumed authority over the National Roster of Scientific and Specialized Personnel, as well as the Office of Procurement and Assignment in the Office of Defense Health and Welfare Services.[111]

The WMC added a Women's Advisory Committee in August 1942, to consider and recommend policies as they affected women and women's war contributions. [112] A nurse was not included on the Women's Advisory Committee.[113] Nursing leaders, however, had already acknowledged U.S. government agencies were not actively considering the nation's nursing in the event of war, and organized the Nursing Council for National Defense in early 1940. The council changed its name in July 1942 and incorporated as the National Nursing Council for War Service. An eleven-member board of directors met monthly, and the full council, consisting of representatives from nursing organizations and hospital, medical, and white and black lay groups, met quarterly. Their mission was to ensure a sufficient supply of nurses to the U.S. Army and Navy while meeting the needs of the American public.[114]

The Council soon exhausted their limited resources in recruiting and educating nurses and nursing students regarding their work options and duty to country and community. The Council then approached the Subcommittee on Nursing for assistance in securing a place within the War Manpower Commission.[115] Nursing leaders asserted that a central agency was needed as the WMC did not have a nursing unit to advise on questions and concerns being brought to the War Manpower Commission. In addition, there was an urgent need to ensure that nurses worked only in nursing positions and that inactive nurses regained employment in nursing service. It was not until mid-1943 that the House Appropriations Committee allotted a nursing division within the Procurement and Assignment Service of the WMC. The objectives of the nursing division included creation of a national roster of registered nurses, bringing inactive nurses back to

practice, relocating nurses from areas of relative oversupply to undersupply, and delegating nonprofessional duties to nurse aides, auxiliary workers, and others under the supervision of registered nurses.[116] The incarceration camps would rely heavily on the inexperienced and untrained camp population to supplement nursing care.

Indeed, camps relied on young Nisei women who could be trained to work as nurse aides. These young women delivered most of the hands-on nursing care, such as bathing, feeding, and ambulating patients. Once resettlement out of the incarceration camps was allowed, many aides were recruited to work in civilian hospitals. These positions offered normal wages and a way out of the camps. The nurse aide positions soon became a revolving door of faces, as one class was trained to replace graduates of the previous class.[117] Many Nisei students would leave to continue their nursing education; in fact, a small committee of the National Nursing Council for War Service collaborated with other agencies to aid in the release of these students from the camps and arrange for their acceptance into nursing schools.[118] Nearly 200 young women enlisted in the U.S. Cadet Nurse Corps, a program initiated in 1943 under the Bolton Act to increase the number of nurses in the United States.[119] The staffing situation for nurses would become grimmer as the war and incarceration persisted.

It was in this setting of racism, uncertainty, and manpower shortages that all nurses were called upon to deliver acute and public health nursing care to over 110,000 Japanese American individuals incarcerated by their own country.

Notes: Chapter 2

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Chapter 3

Nursing at the Heart Mountain War Relocation Center, Wyoming

The purpose of this chapter is to describe and analyze the nursing leadership, hospital care, and public health efforts at the Heart Mountain, Wyoming incarceration camp. This chapter seeks to further explain the role of key War Relocation Authority (WRA) nursing and medical leaders in the implementation of WRA policies and procedures through Senior Chief Nurses at Heart Mountain hospital. In it I argue that Margaret Graham, RN, and Anna Van Kirk, RN were the main figures attempting to balance WRA regulations, a lack of organization, tension inherent in the camp, and standard hospital operating procedures with the provision of competent nursing care. I also assert that the lack of administrative support from the Principal Medical Officer constrained the Senior Chief Nurses' ability to effectively function in their roles. Pressure from the Japanese American physicians to defer to expected gender roles further limited the nursing leaders from influencing and developing their nursing staff to its fullest potential.

The War Relocation Authority, Its Policies and Leadership

When President Franklin Delano Roosevelt issued Executive Order 9102 on March 18, 1942 to create the War Relocation Authority, he made provisions to secure housing, food, education, and basic health care for the incarcerated Japanese Americans.[1] The newly founded WRA was left to quickly develop its own instructions, policies, and guidelines for administering its camps, and so developed a comprehensive Administrative Instruction Manual. Although Japanese American and appointed medical personnel began arriving to the incarceration camps as early as June 1942 to establish camp health services, no official WRA instructions or policies

were in place to guide the development of these services. In fact, it was not until August 1942, when hundreds of Japanese Americans began arriving daily to the camps, that guidelines began to be developed for administering the healthcare services in the camps.

To develop healthcare guidelines, a WRA Health Policy Committee met in San Francisco August 13-20, 1942 to develop basic policies essential to the proper functioning of the health program. Committee members included Chairman G.D. Carlyle Thompson, MD, the WRA Chief Physician; Robert Gibson, the WRA Liaison; Elmer L. Shirrell, Tule Lake Project Director; and Joy B. Stuart, RN, the WRA Nursing Consultant. The United States Public Health Service also provided technical guidance to the overall medical program, focusing on organization of the medical program and establishing public health standards for the camps.[2] The official result was Administrative Instruction No. 54, "Health Service in Relocation Centers," dated October 9, 1942. This instruction was broad and administrative in nature. It included a general overview of health services and personnel in the camps, and reviewed allowances and limitations on medical and dental services. Curative services available to the Japanese Americans consisted of "…medical, surgical, dental, and nursing care, medicines, appliances, the services of all professional personnel employed on the medical staff and all hospital facilities necessary for the protection, maintenance and recovery of their health."[3] Elective or highly specialized procedures and medications or procedures that were experimental or unusual were subject to review and approval by the camp's Principal Medical Officer. The Principal Medical Officer (PMO) assumed all responsibility for health services. Other personnel, such as the Chief Steward or Chief Nurse, were expected to carry out the daily operations in their respective departments.[4]

WRA Headquarters, Washington, D.C., Health Section

All matters at Heart Mountain were influenced by the bureaucracy at WRA Headquarters in Washington, D.C. A brief look at the personnel there provides insight into their qualifications and ability to administer a newly formed civilian agency. George Donald Carlyle Thompson, MD, better known as G.D. Carlyle Thompson, was the WRA Chief Medical Officer from its inception in 1942 until he joined the U.S. Army Medical Corps in 1944. Thompson earned his undergraduate and medical degrees from the University of Michigan in 1926 and 1928, respectively. After interning and completing his residency training in Detroit, he became an attending pediatrician at Holtzer Hospital in Gallipolis, Ohio. After a few years of clinical work, he was promoted to positions of greater responsibility as Director of the Idaho Division of Maternal and Child Health and Crippled Children, 1936-1937, then took a similar position in Portland, Oregon, 1937-1940. He was the San Francisco Regional Medical Director for the U.S. Children's Bureau from 1940-1942, before he joined the staff of the War Relocation Authority.[5]

The WRA appointed Joy Barragrey Stuart, RN, and Jean E. Sutherland, RN as Nursing Consultants for WRA Headquarters. They too were well prepared. Stuart graduated from Mills College and the Stanford School of Nursing before earning a masters degree in public health nursing from Teacher's College of Columbia University, New York. Before joining the WRA, Stuart was a consultant nurse of maternal and child health for the Utah State Department of Health.[6] Sutherland graduated from City Hospital School of Nursing, Welfare Island, New York, and continued her education at Teacher's College, Columbia University, receiving her bachelor's of science and master's of arts degrees there. Before her appointment to the WRA, she was a nursing supervisor in New York City, and then a staff nurse with the Henry Street Visiting Nurse Service, 1939-1942. Stuart remained a WRA nursing consultant until late 1943, and was

followed by Sutherland, although there is some overlap in the time they were both employed at the WRA as nurse consultants.[7]

The Heart Mountain Chief Nurse worked in conjunction with the WRA nurse consultants to ensure the nursing service was aligned with WRA policies and guidelines. The WRA nurse consultant oversaw the general nursing care provided at the camps, recruited and vetted nurses to work at the camps, and communicated with the project directors, Chief Medical Officers, and Chief Nurses to coordinate the placement of appointed nurses. The consultants also helped Japanese American nursing students locate suitable schools of nursing where they could continue their education.[8] Both nurses travelled extensively to visit and inspect hospital and nursing conditions at the camps. These two nurse leaders reinforced the WRA expectations of quality nursing care within the incarceration camps.

In Washington, D.C., the WRA Health Section also included Helen K. Shipps, Medical Social Work Consultant.[9] The medical social worker role evolved at the beginning of the 20th century, as the treatment of illness moved away from the home and into the hospital. Family medical practitioners became more focused on disease, and less concerned with how patients' employment, family, and ability to care for themselves might affect their recovery and rehabilitation from illness. The work of the medical social worker generally encompassed helping the physician understand the unique circumstances surrounding the patients and their illnesses, assisting patients in adapting to their illnesses and overcoming barriers to treatment, and working with affected parties, such as families or employers, in understanding how the patients' illnesses might affect them at home or in the workplace.[10] Medical social workers generally held a master's degree in social work from one of the many universities across the nation offering such programs, such as Boston College or the University of California. [11] The

nurses at Heart Mountain would provide expert assessment of the patients, which in turn helped the medical social worker develop a custom plan of care for the patients.

The WRA authorized a medical social worker position to the medical staff in all camps in May 1943. The functions of this position included recognizing and planning for the influence of the population's unique social situation on their medical care.[12] A great deal of coordination was needed to transfer Japanese Americans to outside institutions for care that could not be rendered adequately in the camps. Medical social workers would also be instrumental in transitioning the elderly and infirm into private housing or public institutions as the camps closed.

Heart Mountain, Wyoming Incarceration Camp

Construction of the camp at Heart Mountain began in June 1942, when the WRA ordered the camp to be completed within 60 days. The first train of nearly 300 Japanese Americans arrived from Pomona Assembly Center in California on August 12, 1942. Over the following four weeks, 21 more trainloads of passengers would arrive to Heart Mountain; the smallest trainload from North Portland Assembly Center, in Portland, Oregon, carried only 48 passengers, while most trains from Santa Anita Assembly Center, just outside of Los Angeles, California, carried between 500-600 individuals. The final number of Japanese Americans processed into Heart Mountain camp totaled 10,876.[13] A barbed wire fence formed a perimeter around the camp, with nine guard towers at regular intervals around the fence.[14]

Although Japanese Americans generally complied with the forced removal and incarceration without incident, once there, some took part in actions of resistance. The population of Heart Mountain were especially vocal and demonstrative in their opposition and resentment against the WRA and their unconstitutional incarceration. They were incensed over construction of the barbed wire fence, sending a petition to the project director with 3,000

signatures in protest. Evacuees further protested fence construction by refusing to be hired by the contractor in charge of its construction.[15] Heart Mountain incarcerees also demanded removal of various key administrative figures, almost as soon as the camp opened in August, 1942. Workers not agreeable to conditions set by administrators would threaten to strike or simply walk off the job.[16]

From the start, nurse leaders of Heart Mountain would face challenging situations as the Japanese Americans struggled to adapt to the unjust incarceration. This was particularly true with respect to Japanese American resistance at Heart Mountain. The incarcerees' frustration in their imposed circumstances was evident in their community charter, where they openly acknowledged that true "self-government," as proposed by the WRA, could not exist in the camp. [17] The WRA was well aware of the Japanese American social structure prior to the war, where the Issei generally held positions of authority, respect, and prestige in the community. The WRA feared an Issei-led revolt might occur in the camps, and did everything in their power to usurp Issei influence in the camps. This included forbidding non-citizens (i.e. the Issei) from holding any elective office. Only the young and relatively inexperienced, second generation Nisei would be allowed initially to hold elected positions in the community.

The eventual charter essentially reflected the guidelines in WRA Administrative Instruction No. 34, "Community Evacuee Government," where a Community Council composed of the incarcerees would be formed. This council was authorized to establish committees that would be responsible for the various community structures and systems, such as education, food service, police department, and public health and medical care. The Project Director and WRA regulations had ultimate authority and veto power over the Community Council, and so the

council would essentially function as a liaison group between the incarcerees and the WRA in matters pertaining to their welfare and camp conditions.[18]

Japanese Americans reflected their attitudes towards the WRA and the incarceration in a summary of the Charter Commission's work. Heart Mountain Japanese Americans acknowledged that "…it is far better for the evacuees to leave the final responsibility of the Center management to the WRA Staff, while specifying in written documents evacuees' right to have limited voice in the management."[19] In other words, Japanese Americans wanted the WRA to accept full responsibility for any events occurring as a result of the incarceration, yet still retain their voice in the administration of the camp. This type of tension would be a major factor in the events that precipitated the hospital walkout of June 24, 1943, as well as the overall disregard for the Chief Nurse position.

Heart Mountain Hospital and Physicians

Dr. Keith, a physician on temporary loan to Heart Mountain, served as the first Principal Medical Officer. [20] A visiting consultant, A. B. Carson, MD, Principal Medical Officer (PMO) at Tule Lake War Relocation Center in California, had been detailed to Heart Mountain in August, 1942 for a period of three weeks to assist Keith in developing an effective health service, until a more permanent PMO could be located there. Despite Heart Mountain having one of the largest and best equipped hospitals in the state of Wyoming, Carson perceived potential problems related to Keith's leadership and organization as the Heart Mountain health service was established.[21] Writing to Thompson, his superior, Carson noted:

> Doctor Keith… is sixty-eight years of age. He told me when we made a tour through the hospital this noon that he had no intention of participating in the treatment of patients. He

> further stated that he plans to delegate practically all authority to others. From other sources in this project, I learned that they are already questioning the advisability of having a man of his age as Chief Medical Officer.[22]

Carson went on to describe a lack of organization, writing,

> The organization here seems to be much more loosely knit than it is at Tule Lake. I have difficulty in finding out the simplest type of information. No one seems to know.[23]

Carson was not the only one to notice problems. Japanese American Thomas Oki, of the Heart Mountain Documents Staff, also noted many shortcomings of the hospital in a foreboding and unedited version of the Hospital Report he prepared for Heart Mountain's First Quarterly Report. Although Oki's unofficial report included many personal opinions, this uncensored version most likely painted a more accurate picture of the hospital, than the more upbeat and hopeful report found in the final version of the Quarterly Report submitted to WRA headquarters in Washington, D.C. Besides lack of equipment, which affected all camps, Oki confirmed Carson's view that Heart Mountain hospital lacked a "clear-cut organization plan" with "no clear-cut policy governing the duties of the different departments." Oki further noted,

> Some of the department heads took it on their liberty to extend their power of authority to include the personnel of other departments. Misunderstanding and bickering among the personnel was the imminent result. To sum it up, there were too many bosses.[24]

Keith's hands-off approach to management no doubt gave rise to the many individuals vying for power and authority in the hospital. However, WRA policy dictated that a white physician supervise the health service at each camp, and so the WRA hired Charles E. Irwin, MD as one of Heart Mountain's newest leaders. Irwin arrived at Heart Mountain as Principal Medical Officer (PMO) on August 17, 1942 from Keota, Iowa, after serving six years as

Superintendent of the Iowa Hospital for the Epileptic and Feeble Minded.[25] Community analysts, on site to observe camp behaviors and events, described Irwin as slow moving, slow to speak, and difficult to anger. He appeared unable to handle difficult personalities, a key characteristic needed by any administrator. At one point Irwin was noted to have exclaimed, "If that is the way they [Japanese Americans] want to have this hospital, it is all right with me. After all it is theirs." War Relocation Authority policy did not allow Japanese Americans to be in any administrative positions, and so Irwin could never follow through on these statements. Instead of confronting the consequences of his indecisiveness, Irwin would escape the camp by personally escorting patients for outside medical treatment. Others in administration, most likely Project Director Guy Robertson, finally had to request that Irwin send other personnel to perform this function so he could tend to the problems in his medical staff.[26]

In appointing Irwin as PMO at Heart Mountain, Carson's earlier recommendations that described the desired traits of an effective PMO appeared to go unheeded. Carson stated the PMO should be able to practice medicine as well as supervise staff and the daily operations of a hospital. "It would be a rare exception to find a staff which would respect a Chief Medical Officer not capable in his professional work as well as in administration."[27] This reinforced Embree's guidance in *Dealing with Japanese-Americans*, regarding the importance of a strong and visible camp leader.

Heart Mountain Documents Staff recorder Oki, held Irwin personally responsible for the many failures that plagued the hospital in the first quarter. In addition to suggesting that Irwin lacked much influence on the Japanese American staff, Oki implored hospital administration to demand of Irwin an organizational chart that identified duties associated with the role of each position. Oki also blamed various problems in the dental department to the "very poor judgment"

of the PMO. Finally, Oki blasted the Public Health Department, as well as the PMO, for their "apparent lack of interest" in obtaining whooping cough and diphtheria vaccine.[28]

Nurses would eventually bear the consequences of Irwin's inability to manage his Japanese American physicians. One of the medical staff was Hawaiian-born Wilfred Yoichi Hanaoka, MD, who received a Bachelor of Science (B.S.) degree from the University of Hawaii and a medical degree (M.D.) from the College of Medical Evangelists in Loma Linda, California. He left California in 1935 to further his surgical and obstetrical training at the University of Vienna in Austria, and then returned to Los Angeles to establish private practice and start a family.[29]

Hanaoka had been the Chief Physician at Pomona Assembly Center and was already working to establish the medical service at Heart Mountain when Irwin arrived.[30] As Chief Physician at Pomona, Hanaoka was "…in complete charge of the Center hospital outpatient department, dental clinic, and other medical functions within the Assembly Center." Hanaoka prepared reports and advised the Center Manager on all health-related matters. His authority also "…embraced professional and administrative supervision over other physicians, dentists, opticians, nurses, and hospital personnel."[31] At the Pomona Assembly Center hospital, Hanaoka and other Japanese American physicians had developed a tight bond with one another. Once at Heart Mountain, Hanaoka preferred working and interacting with his fellow Pomona physicians over those arriving from other centers. [32] No doubt Hanaoka expected to lead the Heart Mountain medical staff, as he had done at the Pomona center.

Hanaoka was the opposite of Irwin – aggressive, outspoken, unfriendly, and widely reported to be "anti-Caucasian." He destroyed job applications for those he did not want employed at the hospital, and admitted freely to verbally abusing young Nisei medical secretaries

and threatening fellow staff physicians. Hanaoka secured the loyalty of others, calling them his "gang."[33] Besides the disruption and humiliation brought about by the forced removal and incarceration, there were other reasons why Hanaoka harbored such resentment against the appointed personnel and Japanese Americans who did not agree with his views. Heart Mountain community analysts wrote that Japanese Hawaiians were not subjected to racist attitudes and behaviors until they arrived to the continental United States. Hanaoka, with his impressive education and training, certainly struggled in understanding why he should be the object of racial bigotry. In addition, Heart Mountain Japanese Americans were the objects of hatred and discrimination in Wyoming, especially from the residents of the nearby town of Cody.

Many Wyoming residents resented the Japanese presence in their state from the time Union Pacific began hiring them to work on the railroad and in the coal mines in the early 1900s. The company paid them a third less than what they paid to white workers. Mirroring events in California, white workers in Wyoming feared they would be displaced by the cheaper labor force, and soon resented the Japanese workers. After the Pearl Harbor attack in 1941, Union Pacific fired all its Japanese American employees from work on the railroad, for fear of sabotage to the rail lines. The loss of these jobs meant a loss of their homes, as housing was provided by Union Pacific. Those working in the coal mines, however, were allowed to continue work, as coal was a critical resource needed for the war effort, and would be needed as fuel to heat the cold Heart Mountain barracks.[34]

Wyoming Governor Nels H. Smith led much of the discriminatory practices and inflammatory protestations against Japanese Americans in his state. On December 8, 1941, he ordered all Japan-born individuals to register their presence with the state. The order also prohibited these individuals from moving away from their communities. Later, upon learning of

the proposed redistribution of west coast Japanese Americans to the interior United States, Smith stated, "People in [my] state have a dislike of any Orientals, and simply will not stand for being California's dumping ground."[35] The nearby town of Cody, Wyoming shared Smith's racist views. Irwin witnessed such an event before the Heart Mountain hospital opened when he, Hanaoka, and Ethel Jackson, RN, rushed a pregnant woman to a Cody, Wyoming hospital late one night. A surgeon called in to attend the pregnant woman began to verbally abuse Hanaoka.[36] It is unknown whether Irwin attempted to intervene on behalf of Hanaoka, but Irwin's docile personality and Hanaoka's increasing disdain for the appointed staff suggests this was unlikely.

Despite their differences in character, Irwin and Hanaoka initially developed a good working relationship and came to a common understanding, which was known by all, that Hanaoka was Chief Assistant to the PMO. His duties included requisitioning workers, authorizing surgery, supervision of plant operations and housekeeping – many duties associated with those of the Chief Nurse.[37] Hanaoka would continue to challenge nursing authority while he remained at Heart Mountain.

The professional environment in which the nurses had to work was fraught with tension. Professional jealousies and factionalism between the Japanese American physicians formed along the lines from which assembly centers they had been assigned prior to arriving at Heart Mountain. Physicians challenged their peers by changing medical orders or questioning their surgical techniques. As the Japanese American physicians fought to control more cases and do more surgeries than their peers, Irwin called for trust and teamwork, and declared a minimum of three doctors confirm a diagnosis prior to performing a surgical procedure. Irwin's frustration is clearly evident in the November 1942 Medical Staff Meeting minutes as he reiterated the following to the Japanese American physicians: "OBSERVE MEDICAL ETHICS – OPEN

COMPETITION SHOULD BE ENTIRELY ABOLISHED."[38] By the end of December 1942, Irwin began to distance himself from Hanaoka, as physicians pummeled him with stories of various wrongdoings or inadequacies of the other. Hanaoka slowly lost authority and his position as Irwin's assistant without any formal announcement. The community became well aware of Hanaoka's loss of authority and prestige.[39]

Factionalism and competition among the Japanese American physicians continued to be such a problem that Thompson, WRA Chief Medical Officer, held a special meeting with the Heart Mountain physicians. Thompson emphasized being "…a physician first and at all times and not to be loyal to factions, whether personal or assembly center."[40] Thompson also admonished the Japanese American physicians' treatment toward some of the nurses. Thompson could do little but remind the men they were physicians first, and should comport themselves as such at all times.[41]

It was also at this time, in December 1942, that hospital construction was finally completed and the facility was fully operational. The 150-bed facility, patterned after the U.S. Army style, had a 1,000 foot long corridor from which 17 separate barracks, or wings, were attached. Six wings were used for patient wards, nurses and physicians each had their own wing, one wing housed the administrative offices, another wing held out-patient clinics, the surgical suite was in another wing, the kitchen and mess hall were in another wing, three wings for supplies, and the boiler room and laundry facilities accounted for the two remaining wings. Housed within the ancillary wings were spaces for the pharmacy, laboratory, radiology, ambulance, and morgue. The total cost was nearly $340,000, and the building had a life expectancy of five years.[42]

The 150-bed hospital was divided into separate patient wards. The patient wards were assigned as follows: Ward 9 – Isolation and Mental; Ward 8 – Women's Medical; Ward 7 – Men's Medical; Ward 6 – Surgical; Ward 5 – Children and Soldiers; Ward 4 – Obstetrics and Nursery. Each ward had a nurse's station, diet kitchen, linen closet, and medicine room. The nurse's station held a nursing Cardex, a brief summary of important patient information such as physician orders, treatments, and medications prescribed for each patient. In general, one RN supervised each ward and a number of aides during the day shift, from 0700 – 1500. Only one RN was on duty for the whole hospital on the other two shifts, from 1500 – 2300 and from 2300 – 0700. Nurses on these shifts were extremely busy, especially if the hospital was full and the patients required a high level of care. Nurses checked patient charts for new orders, and to make sure existing orders had been transcribed correctly to the Cardexes. The evening and night nurses also had to pour all the medications and administer all parenteral medications throughout the hospital. Unless a nurse volunteered or requested specifically to work the night shift, this shift was rotated among the nurses in one month intervals.[43]

Nursing and Administrative Control of the Hospital

Martha Partridge, RN, was Heart Mountain Hospital's first Chief Nurse. Partridge remained in this position for only six weeks, from mid-August, 1942 to September 1942. Tension between Partridge and the Japanese American physicians, as well as a lack of harmony with Irwin, forced Partridge's departure. An informant to the Community Analysis Section reported that Partridge and the Japanese American physicians "had some awful scraps sometimes. Their attitude all along has been that they were going to run the place."[44] This sentiment was confirmed by Japanese American physician Suski, who told Irwin he felt the

Japanese Americans should run the whole hospital, as it was there for their benefit.[45] With Partridge's resignation, it appeared as if the physicians might get their wish.

A Chief Nurse had not been appointed to replace Partridge in the fall of 1942, and so medical staff meetings that October and November included only physicians. This was problematic as physicians began to determine nursing needs and take over Chief Nurse functions. Some examples include the physicians determining the number of nurses needed to work in the hospital; one physician wanting to begin a vaccine clinic, using at least two nurses; physicians determining that nurse aides were in need of and would receive ethics lectures, delivered by the physicians.[46] After reviewing all that was needed to be done in the hospital and community, the November 1942 meeting concluded simply with "Doctors and nurses (RN) should meet."[47]

This decision may have been influenced by Stuart's presence at Heart Mountain during that time, as she worked on some nursing issues with Irwin, such as ensuring proper ratios of RNs to orderlies and nurse aides on every shift. A chief theme of their meeting was the lack of registered nurses, especially a Chief Nurse. Stuart recommended promotions for staff nurses Velma Berryman, RN, and Lulu Leonard, RN, perhaps as part of a retention effort, as several Japanese American nurses expressed their desires to relocate outside the camp as soon as possible in order to begin earning standard nursing salaries. Stuart determined the work environment between the appointed personnel and the Japanese Americans as professional and respectful, and felt confident Berryman, who graduated from nursing school only a year before, and Leonard, an experienced World War I nurse, could "carry on together" until a Chief Nurse was appointed.[48] Irwin agreed that "the medical care and treatment of patients are being satisfactorily carried out."[49]

Although Berryman and Leonard performed their nursing duties well, neither was a leader in the hospital. Patients were admitted, cared for, and discharged, per medical routines. Berryman approached each shift with the attitude of a competent staff nurse: receiving report, delegating and supervising tasks to the nurse aides, rounding with physicians, administering medications, and preparing report for the next nursing shift. Although Berryman was genuinely concerned with carrying out her nursing duties efficiently, effectively, and with compassion, she did not look beyond the immediate issues on her assigned shift.[50]

Physicians did not appear to be concerned over the lack of a Chief Nurse. The December 1942 medical staff meeting took place over four hours and again without the presence of a nurse. Physicians offered few solutions to the many problems that a Chief Nurse would normally handle, such as respecting visiting hours, scheduling nurses, and maintaining staff discipline. In fact, a Japanese American medical secretary reported that decisions were never finalized in doctor staff meetings.[51]

Hiro Hishiki, hospital business manager, also warned Irwin of administrative problems in the hospital. In addition to issues related to pricing and timely delivery of supplies to the hospital, Hishiki complained of the lack of communication regarding administrative procedures.

> From time to time changes in the administrative procedures are made without notification of such changes to the divisions or departments or are notified after the procedure is in effect, thereby resulting in confusion and loss of time.[52]

Embree's *Dealing with Japanese-Americans* document had cautioned that new policies should always be introduced by the head administrator to foster trust and decrease anxiety, lest a work disruption should occur. Clearly, problems in organization and administration extended throughout the hospital.

Despite the lack of organization and the absence of nursing leadership, this period between October 1, 1942 and January 1943, where the hospital only had acting Chief Nurses, were the days when workers were happiest, with no authoritarian figure enforcing hospital policies. Conditions quickly changed when Thompson and Stuart appointed Margaret Graham, RN, as Chief Nurse. Graham had begun her WRA work under Carson, as Chief Nurse at Tule Lake camp in California. Her time there had not been easy.

Before Carson left Tule Lake to assist Heart Mountain personnel to establish their hospital, he assigned Graham the responsibility of authorizing requisition requests completed by Japanese American physicians. Carson placed Graham in this position as a check to ensure requests for previously denied medical supplies and equipment were not resubmitted during his absence. Japanese American physicians became insulted that a *nurse* should determine the camp's medical needs. After multiple interpersonal problems, Graham transferred to another camp, most likely Minidoka in Idaho.[53] Now Thompson and Stuart were pulling Graham from her brief work at the Minidoka camp so she could assume the Chief Nurse position at Heart Mountain.[54] Graham's position as Heart Mountain's Chief Nurse, however, would also be short-lived.

Rumors surrounding Graham circulated almost immediately upon her arrival to Heart Mountain. One such rumor was that a Japanese American nurse received a letter detailing Graham's experiences in the Tule Lake and Minidoka camps. This letter allegedly stated that Graham was forced from the other camps due to the objections of the incarcerees at the camps. Perhaps empowered by their previous successful ouster of Partridge, and aware of Graham's problems with the Japanese American physicians at Tule Lake, the hospital staff began a petition against Graham by the end of her first week at Heart Mountain.[55] Undeterred by the rumors,

Graham pushed forward in establishing a nursing service by holding a nursing staff meeting shortly after her arrival in mid-January 1943.

In her first meeting with the nursing staff, Graham addressed some of the same problems that had been discussed in the medical staff meetings, such as hospital employees visiting with each other after hours and lack of professionalism by aides and orderlies. One major difference was that Graham presented some solutions. Graham asked that nursing problems come through her office before going to Irwin, the Principal Medical Officer. She also agreed to write up some rules for the aides and orderlies so they might present themselves in a more professional manner.[56]

At the nurse staff meetings on February 10 and February 16, 1943, nurses reviewed old and new business in an orderly manner. Graham focused on the usual problems of the hospital and determined appropriate solutions and/or follow-up, such as defining the nurse aides' scope of practice, as well as defining the responsibilities of the ward supervisory nurses and the Chief Nurse. The nurses complained of physicians not writing orders for patients admitted to their hospital service, and difficulties in locating physicians in the large hospital when needed. Nurses also noted inefficiencies within the dietary department that affected patients in receiving the proper diet. Graham's attention in correcting these important matters was not well-received by members of the hospital staff, including some of the physicians.[57] In objection to Graham's authority and leadership, Japanese American physicians and 300 other hospital employees signed another petition calling for Graham's immediate dismissal. The petition accused Graham of being

> … antagonistic, abusive and dictatorial beyond reason, that such attitude is of detriment to the morale of the hospital to cause unhappiness and dissatisfaction among the workers,

> and that her conduct, manners and words are unkind, unsympathetic, sarcastic, antagonistic, arrogant and dictatorial as to cause disturbance to peace of mind of the hospital workers so that it is impossible for them to continue work harmoniously as heretofore…[58]

Japanese American physicians handed Graham a copy of the petition shortly after several of them and all the secretaries, all but one of the pharmacists, and all warehouse workers left work to hold a meeting. Although Graham was shocked that a walkout actually occurred, she and other administrative heads, including Irwin, Robertson, and Thompson, were well aware of rumors suggesting a strike might occur. The walkout occurred after Graham moved some of the Japanese American physicians' papers and other items to the floor in order to transfer some desks from the outpatient clinic to other areas in the hospital. Irwin approved of the transfer, but had not alerted the physicians that the transfer would take place.[59] Graham wrote Stuart:

> What we thought was impossible has happened. A strike in the hospital! Dr. Irwin told me he was having the oak tables and desk taken from O.P.D. [outpatient department] to the front office to establish the Chief Nurse's and PHS's [public health nurse] offices. … I went down to the clinic during the moving to make sure that sufficient tables were there to replace the ones being moved. I was accused by two doctors of taking too much responsibility and said they should have been consulted before the change was made.
>
> The medical staff refused to open clinic and the entire OPD staff, seventeen in all, with the exception of Miss Kajii, walked off duty in sympathy with the doctors. Patients were told to go home and the pharmacy put up a sign "ON VACATION."
>
> Dr. Irwin met with the medical staff that afternoon and they agreed to go back to work and give me another two weeks "trial," or until such time as the nursing department

could become better organized. I told Dr. Irwin that since there were other changes to be made the staff would resent, I didn't feel it fair to be on trial, and told him that I didn't care to work under those circumstances. …

I would like to add that the evacuee nurses met with Dr. Irwin Sunday morning and expressed their loyalty to me and their desire that I remain as Chief Nurse. I do feel however, that I have not had sufficient cooperation from Mr. Robertson and Dr. Irwin to carry on any program that would necessitate other changes that would make the hospital staff unhappy….

Even though, in my judgment, the statements set out in the petition are unfounded, I feel that this experience will influence my enthusiasm for any future work with WRA, hence my resignation….

I very sincerely regret that I haven't been able to go ahead with the program as we planned, and I do appreciate the help and guidance you have given me along the way, and shall always be glad of having had the opportunity of knowing you.[60]

Project Director Robertson promptly conducted an investigation of the incident. He presented his conclusions to the physicians and Graham, in which he determined that Irwin, "in the hurry and flurry of hospital work, neglected to make the proper arrangements" for the transfer of the desks. Japanese American physicians believed Graham acted on her own volition by assisting with the transfer of the tables, and so was deemed to have "bad manners." Robertson essentially relieved Irwin and the Japanese American physicians from any responsibility of their actions or inactions.[61] This was now at least the second time that Irwin's lack of communication had caused problems in the functioning of the hospital.

Robertson further concluded that Graham, although competent, capable, and efficient, faced incredible challenges in bringing about discipline and structure in an organization severely lacking in both. His investigation also revealed that some of the employees believed Graham to be "…racially superior to them and had very bad manners in her way of giving orders and in her general conduct and attitude."[62] Robertson explained that because staff were antagonistic towards Graham's disciplinary efforts, Graham returned the feeling, which "was misconstrued to be a racial feeling."[63] Robertson contradicted himself shortly thereafter, when he wrote, "I think Miss Graham is too gruff and expects too much of inexperienced help and that her attitude should be more tolerant but no less firm and that it is her duty to instruct and train her employees."[64] He also blamed the employees for their lack of understanding and cooperation, stating that Graham should have the "…full cooperation of the medical staff and the nursing staff…"[65] Robertson knew the situation was intense, and thought the best way to diffuse the situation was to side with the male physicians, and lay blame on Graham. To Robertson's surprise, this strategy backfired, and Graham, rather than continue in the oppressive work environment, promptly wired her resignation to Thompson. Robertson, trying to regain control of the situation, then wrote WRA director Myer a more malicious view of the events and of Graham.

Robertson smeared Graham several times throughout his letter to Myer, asserting she was "very brusque and determined and has little patience with inefficiency." He stated further that Graham was also "overbearing" while "attacking the problem of organization." He now described the "trivial disagreement" between Graham and the physicians as one where she was "undiplomatic" and "enraged the doctors" as she "unceremoniously" cleared desks and "piled the contents on the floor." After learning of her resignation, Robertson concluded, "I am very happy

to accept her resignation. I do not believe she is the type person who can work smoothly with an evacuee staff."[66]

Robertson's malignment of Graham reflected the feelings of many Americans of the time that women were second-class citizens and did not belong in the workplace. Although the war brought new and important job opportunities to women, the American image of women as housewives and mothers still persisted as a more central one than the woman in the workplace. Men in leadership positions often withheld positions of power and authority from women.[67] Once Robertson realized that Graham refused to submit to him and the other men involved, he escalated the issue by writing to Dillon Myer, director of the WRA. Robertson also changed the tone of his letter by adopting language, such as *overbearing* and *brusque*, often used by men to describe and denigrate powerful women in the workplace.

WRA Chief Medical Officer Thompson, having visited Heart Mountain only a week before the walkout, had a more nuanced perception of the Japanese American physicians' attitudes, as well as an understanding of hospital policy and procedure and Graham's prior work record. Thompson knew of reports of "getting Miss Graham" following the first day of her arrival at Heart Mountain. Hospital staff had drawn up petitions in the beginning of February – weeks before the table incident took place. Thompson called the desk event "silly" and a "small point, but apparently used by the M.D.'s to gain their point – which is to run the hospital including the nursing details."[68]

Thompson admonished Robertson for his lack of support of Graham in the Chief Nurse role. He asserted Graham had been successful in her nursing responsibilities at other camps. She had also gained the loyalty and respect of the Japanese American RNs at Heart Mountain, as no nurse had signed the petition. Not every physician had signed the petition either, which again

demonstrated the factionalism within the hospital. Acknowledging this tension between the physicians, Thompson wrote, "Certain evacuee physicians must accept responsibility for some conditions which if attempted to be maintained will prevent proper hospital operation and will result in continual conflict between the Chief Nurse and staff physicians." He also criticized Irwin in his lack of authority over the Japanese American physicians, and reminded Robertson that Irwin alone had responsibility of the healthcare services at the camp. Thompson underscored this point,

> I think some of our difficulty has been the concept held by the evacuee physicians that they also have such responsibility and accordingly have become involved in administration nursing and other matters when they should not have done so.[69]

Yet this was the struggle between allowing Japanese Americans professional freedom and shared governance in the camp, while remaining loyal to WRA policies and procedures that called on appointed personnel holding ultimate authority and administration in camp matters. Robertson struggled for an adequate interpretation of WRA policy of inclusion and self-governance, whereby the camp attempted "to keep in as close touch as we can with them in administering the center affairs. This does not mean that the evacuees are administering the affairs of the center."[70] Robertson remained indignant towards Thompson, bestowing blame and responsibility on the Chief Nurse position, and stating that any Chief Nurse will receive his support so long as she "is endeavoring to do the job to the satisfaction of the Project Director." Here again Robertson asserted his place and power over women. Before closing the letter and the Heart Mountain Hospital events of February 1943, Robertson disparaged Graham once more, declaring the entire episode "was occasioned almost entirely by her qualifications and personality."[71] The physicians had now successfully ousted another Chief Nurse.

Perhaps finally realizing the importance of a Chief Nurse, Thompson immediately sent for Gertrude Wetzel, RN, Chief Nurse at Manzanar, to return to Heart Mountain as acting Chief Nurse until a permanent replacement could be found. Wetzel, on loan from Manzanar, had been detailed to Heart Mountain in August, 1942, to assist in examining and registering Japanese Americans as they arrived there, and so was familiar with some aspects of the hospital, camp, and personnel.[72] Thompson praised Wetzel's accomplishments and capabilities with the WRA and as the former Director of Nursing and Assistant Hospital Director of Seattle Orthopedic Hospital. He also warned that while Wetzel would be tactful in her role, "…there are sufficient changes required at Heart Mountain to bring about proper hospital service in the interest of the residents that tact alone may not be sufficient."[73]

Mindful of lessons learned from the Graham incident, Irwin invited Wetzel to the next medical staff meeting on February 26, 1943. Irwin introduced Wetzel to staff members, but the absence of her name from the meeting attendance list indicated Wetzel was not a welcome participant in the meeting. Physicians continued to discuss the nursing role in the hospital and camp; there was even talk of assuming physician space in the nurses' room in the clinic – the very space that Graham had been authorized and attempted to clear as office space for the Chief Nurse and Public Health Nurse. Wetzel did not contribute to the nursing aspects of the discussion. In fact, Wetzel's only noted contribution was to borrow a microscope, for physician use, from Manzanar.[74]

The situation appeared more hopeful the following month, however, as Wetzel and Ethel Jackson, RN, attended the physicians' meeting. Jackson, a public health nurse, arrived at Heart Mountain in August, 1942, but was on leave from November until February 1943, and terminated employment only a few weeks after returning. Wetzel was again silent in this

meeting. Jackson, like Wetzel, had not been present during the chaos in the previous months. However, unlike Wetzel, Jackson proposed useful suggestions to ease some of the nurse-physician issues. Although physicians tried to tackle a labor problem involving the Japanese American nurses refusing to work at night, they soon decided to "…let this go for a while and leave the nursing situation entirely up to the Chief Nurse."[75] They would not have to wait much longer for the next Chief Nurse to arrive.

Anna Van Kirk, RN, arrived in March, 1943 to assume the Chief Nurse position at Heart Mountain Hospital. Van Kirk had an impressive resume, and looked to be a perfect fit for the position of Chief Nurse. She had spent 19 years in Japan, arriving there in 1921 as a missionary nurse. She studied and learned to speak Japanese in a Japanese language school in Tokyo during the first 18 months of her time there. After gaining considerable proficiency in the language, Van Kirk moved to Osaka, where she became the nursing director of St. Barnabas hospital, an Episcopal Mission institution, overseeing a staff of 85 nurses. She returned to the United States while escorting a patient from Japan to New York in December 1941. She then worked at a hospital in Carlyle, Pennsylvania, before accepting the Chief Nurse position at Heart Mountain.[76] She kept her knowledge of the Japanese language a secret for several weeks, in order to gain unfiltered information of the goings-on at the hospital. Berryman, RN, thought only good things could come from having Van Kirk as the Chief Nurse; she could speak to the elderly Issei patients and communicate with the Issei employees, hence, Japanese American nurses would be more cooperative in performing their duties.[77]

Despite the administrative turmoil, conditions at the hospital improved. The X-ray department was fully equipped and had enough film to handle the camp's needs. In most cases, hospital beds were in place, although some U.S. Army cots were still in use. Required medical

and surgical supplies purchased by the camp supplemented the supplies and equipment procured from the U.S. Army Supply Depot. Relationships with hospitals in nearby Cody and Powell had improved to the point that some of the physicians in private practice at these facilities lent instruments to the Japanese American physicians at Heart Mountain on occasion. Nurses travelled with patients who were more seriously ill to a larger facility in Billings, Montana, approximately 150 miles away. This facility was equipped to provide X-ray therapy for individuals diagnosed with cancer. Children travelled nearly 250 miles to Casper, Wyoming for paralysis treatment, or as many as 500 miles to Denver, Colorado for cleft palate repair.[78]

Van Kirk dove quickly into her responsibilities, meeting with various hospital departments and the physicians, in an attempt to understand their respective concerns. Physicians agreed the Chief Nurse should see to matters such as disciplining nurse aides and rotating student nurses through different services. Van Kirk also scheduled six nursing staff meetings within the first six weeks of assuming leadership, with weekly or biweekly meetings continuing well into June. Ward nursing supervisors presented concerns affecting their respective wards in the first meeting, with an evaluation of implemented solutions and discussion of new concerns in the subsequent meetings.

Recruiting and maintaining an adequate supply of nursing staff was a constant problem. Japanese American staff nurses had left Heart Mountain hospital by April 1943. The WRA awarded Indefinite Leave status to some Japanese Americans almost as soon as they arrived to Heart Mountain. Many young Nisei transferred to colleges in Midwestern or east coast states to continue their education, while others quickly found permanent employment outside the camp.[79] Of the two remaining student nurses, one left shortly thereafter for employment outside the camp. The Kahler School of Nursing in Rochester, Minnesota, part of the Mayo Clinic, accepted

the last Japanese American nursing student from the camp. Many Japanese American nursing students received rejection letters from smaller schools of nursing, and often had to submit multiple applications before gaining admittance to a nurse training program. Although Nursing Directors of some programs may have been open to the idea of admitting Japanese American students, often it was hospital superintendents and boards of trustees not amenable to accepting these students. Nursing schools in Denver, Philadelphia, Rochester, Minnesota, and Elgin, Illinois who had accepted the Japanese American students sent glowing reviews of their performance once in the schools.[80]

Now within the hospital only nine appointed registered nurses remained. Although the total number of registered nurses remained more or less constant during the first year the hospital was in operation, the turnover in staff was tremendous.[81] Few nurses remained for any length of time. Velma Berryman Kessel, RN, was from Powell, Wyoming, and the Heart Mountain Hospital offered steady employment at a good wage. She lived in the nurses' quarters at the hospital, but on her days off she could seek respite by making the drive to Powell to visit her family.[82] Other nurses remained for as little as three weeks. The reasons for their leaving were varied and were most often cited as personal reasons. Some nurses joined the U.S. Army or Navy, while others were called back home to care for sick family members.[83]

Stuart, the WRA Nursing Consultant, relayed a positive and supportive tone to the nurses at Heart Mountain, yet she was quite anxious regarding the number of nurses at Heart Mountain and other camps. "Personally, I do not relish being responsible for the WRA nursing service when I am unable to send the respective Chief Nurses sufficient staff to render adequate nursing service."[84] Stuart calculated the nurse-patient ratio at Heart Mountain to be 1:36 – only two other camps had higher ratios.[85] Heart Mountain's recent epidemic of upper respiratory tract infections

forced people to remain at home, rather than in hospital beds, due to a shortage of staff to care for them. Stuart felt a serious influenza or other similar epidemic would require the assistance of the Disaster Crew of the American Red Cross. Stuart had recommended increasing the Japanese American nurses' salaries in an effort to retain them at the camps and suggested the WRA request special consideration from the War Manpower Board in recruiting new nurses.[86] All priorities for nursing personnel continued to be directed towards the war effort.

By May 1943, the surgery department was essentially complete. Suture materials and medications were available, and instruments for performing tonsillectomies had arrived. These items were among the few remaining for which the medical staff had been waiting. The most frequent performed major surgeries were appendectomies, although hernioplasties were often completed as well. Minor surgeries were varied, and included cyst and mole removals, biopsies, circumcisions, blood transfusions, and dilation and curettage. The clinical laboratory performed urine analyses, complete blood counts, and blood typing.[87] Despite the physical improvements in the surgical department, the loss of the Japanese American surgical nurse in April 1943 was keenly felt. Two nurse aides and a male orderly were assigned to the surgery department to replace the work of this one nurse. The three were supervised by one of the appointed RNs.

The problems of lack of cooperation from other departments, such as the dietary department and the "X-ray boys," continued to plague hospital operations. Hospital employees held extravagant parties in the mess hall. Multiple hospital patients and their families complained to the Community Council Hospital Committee that off-duty staff ran up and down the long corridor all night, shouting and making so much noise that no one could rest peacefully. Current and former employees visiting with one another had become so out of control, that Van Kirk directed supervisors to call the hospital policeman for assistance in removing them, if

necessary.[88] Van Kirk personally handled many problems of insubordination or inefficiency in other administrative areas of the hospital, including terminating employees who abused equipment, were insubordinate, or whose productivity was lacking. Occasionally a disgruntled employee or supporters of the employee would act out in response.[89]

One such employee was Mitsugi Aiso, a mess hall chief. Aiso did not support the prior walkout against Graham, and became labeled as pro-administration. This ostracism and then lack of administrative support regarding the maintenance of an old dishwasher in the mess hall, restrictions against parties, and current authority of the Chief Nurse, eventually turned Aiso anti-administration. In addition, administrative control of the mess hall had been in disarray from the time the hospital opened – no one knew exactly who was in charge. Although employees assigned to work in the hospital mess hall were responsible for feeding hospital patients and staff, they were administratively assigned to other departments, and so would not respond to suggestions and discipline from the Chief Nurse, claiming they were not technically under her supervision and control. Hanaoka seized the opportunity to exploit the anger and frustration of Aiso and other non-professional staff, to include warehouse workers, some secretaries in the outpatient clinic, and mess hall workers. This disorder aided Hanaoka in assuming leadership over Aiso and the other employees as they prepared to rebel.[90]

Hospital administrators were in the process of sorting out organizational and personnel issues in June 1943. A lead dietician and hospital administrator had been appointed. These employees, along with another newly appointed RN, were white. In addition, some appointed high school teachers, now on summer break, began helping with various clerical duties and warehouse work. Some Japanese Americans perceived these new employees as evidence that the WRA administration was trying to replace Japanese Americans with white personnel in the quest

for control of hospital administration. All of these conditions, combined with a growing unresolved resentment from the Graham incident, set the conditions for the next walkout on June 24, 1943.[91]

Unlike the Graham incident, the June 24, 1943 walkout caught the administration by surprise. Few participants of the walkout claimed to have known much regarding specifics of the walkout until that morning. Under Aiso's direction, Kay Kushino, a secretary in the outpatient department working for Dr. Nakaya, rounded up those clinic aides and secretaries and convinced them to walk out. Other employees in the mess hall, warehouses, ambulance and X-ray departments, and pharmacy joined the walkout. However, no nurses or nurse aides working on the hospital inpatient wards walked out. Several participants claimed to have been threatened directly to participate; some claimed to have walked out because everyone else in their department had already walked out; some clinic aides and secretaries stated they feared Kushino, and so felt compelled to participate. Most employees stated that although they had no personal grievances against Van Kirk, Irwin, or others in administration, they had heard or understood that Van Kirk was the reason for the walkout.[92]

Van Kirk recorded some statements she heard on the day of the walkout. These included, "She is a dictator." "She discharges patients for personal reasons." "She knows Japanese too well and we can't talk freely in the hospital without her understanding." "We wouldn't treat <u>anyone</u> in the chief nurses' position any different, so long as Dr. Irwin remains."[93] An informal meeting between the walkout participants and Community Hospital Committee summed up the reasons for the walkout very simply: "Miss Anna Van Kirk, the Chief Nurse, acted like a Queen and was given too much power to dictate and that Dr. Charles E. Irwin did not have a back bone and

allowed Miss Van Kirk to control everything. This was the unanimous opinion of the people of the four departments" [Mess Hall, Pharmacy, Clinic, and Emergency Telephone departments].[94]

Heart Mountain community analysts proposed several reasons why hospital employees, some educated and experienced in U.S. schools and hospitals and others with relatively little or no hospital or life experience, could not accept Van Kirk, or other women, in the Chief Nurse position. Although Irwin was recognized as having formal authority over the health program, he lacked the informal prestige that would have made his authority effective. Several physicians and employees clearly lacked respect for Irwin; but because he did carry ultimate authority, he could not be an open target for hostility. Instead, the dissatisfied Japanese Americans went after the Chief Nurse position. As one older Issei explained, nurses were not held in high esteem in Japan.[95] Mary Sakaguchi Oda, a Nisei physician, recalled her mother's refusal to allow her to become a nurse, "I don't want you to do work that dirty, that hard."[96]

In Japanese hospitals, physicians gave all orders, and all nurses, including the Chief Nurse, obeyed the physicians. Relative to this, was that Heart Mountain's Chief Nurse was a woman. Japanese culture did not allow for women to give orders to men, except perhaps in the home. Community analysts, trained as professionals in the disciplines of sociology, anthropology, and psychology, noted in the Hospital Walkout report that although many of the Nisei physicians were trained in the United States, they were raised under their Issei parents' values and traditions. Once in camp, it became expedient for them to embrace these cultural attitudes as a form of resistance against the WRA, a U.S. government agency that incarcerated them for their Japanese ethnicity.[97] But Japanese culture was not solely responsible for the views of the Japanese American physicians.

Hospitals in the United States also reinforced the male physician-dominant culture. Nurses, in their socially inferior position as women, were rarely able to negotiate their rightful place within the hospitals and other authority structures that educated or employed nurses.[98] Community analysts agreed the problem was largely one of gender:

> The stereotyping of Miss Van Kirk followed exactly the same pattern as that of Miss Graham and both were due chiefly to the resentment which the Japanese doctors had against the office of the Chief Nurse as defined by the Principal Medical Officer and to the fact that such an office is held by a woman.[99]

Understanding that gender tensions were in large part responsible for the tumultuous environment that led to the walkout, the community analysts proposed methods in which Van Kirk could "recede somewhat into the background." These included having Irwin, the Principal Medical Officer, sign Van Kirk's memos that affected workers other than the nursing staff. Analysts also suggested use of the cultural go-between for Van Kirk and the Japanese physicians to forge a mutual understanding and acceptance of their roles within the health section.[100] Although the WRA had bestowed great power upon the office of the chief nurse through its designation as second in command to the PMO, Japanese American physicians assigned greater meaning to the roles of gender. In doing so, they felt they could attack the office of the Senior Chief Nurse without repercussion.

Another reason the Chief Nurse position came under attack was that Hanaoka and other physicians were not content to be mere hospital employees – they craved a meaningful voice in hospital policy-making and administration, which included a voice in selecting the Chief Nurse. Physicians suddenly had to eat, sleep, and shower with other incarcerees; they earned only $7 more per month than nurse aides, orderlies, and housekeeping staff. A role that came with some

power or authority was the only thing that set them apart in the camp. Physicians no doubt searched for a way to help make up for the loss in status, prestige, and income as a result of their incarceration.

Hospital workers involved in the walkout received termination notices. Of the 346 individuals employed at the hospital during this time, 104 employees walked out. (See Appendix E for hospital departments affected by walkout.) Van Kirk and Irwin conducted interviews with 79 of the individuals wishing to be reinstated. Realizing the importance of his support behind the office of the Chief Nurse, Irwin often concluded the interviews by reciting the Chief Nurse job description and duties to the interviewee, and asking for compliance with the stated responsibilities and duties. Irwin emphasized certain sections of the WRA job description:

> The Chief Nurse, under the supervision of the Principal Medical Officer is in charge of the nursing program and activities of the medical program for a relocation center. She supervises and is responsible for a nursing staff consisting of nurses, nurses aides, attendants, public health nurse aides, home nurses, dietary aides, and the service rendered by them in the hospital,…out-patient department or the public health service; supervises the preparation of necessary reports and service records of the staff, supervises hospital housekeeping, which includes the care and maintenance of supplies and equipment, as well as the maintenance of an adequate stock thereof, reporting deficiencies to the hospital administrator.[101]

Fifty of the seventy-nine employees who were interviewed were eventually reinstated. It is unknown how many of those reinstated to their jobs were clinic aides. Most interviewees were remorseful, wanted their jobs back, and so agreed to accept authority under Irwin and Van Kirk.[102]

During the walkout, individuals in the community and other Heart Mountain agencies lent assistance to keep the hospital running safely. Appointed personnel drove ambulances until individuals employed at the motor pool temporarily assumed those duties. The Police Department handled emergency calls. Boy Scouts patrolled hospital entrances and corridors at night to control access to the hospital. The overall Heart Mountain community reacted negatively towards the walkout participants. A common theme among the community was "they ought to use some other means to settle their problems. The people in the hospital need care."[103]

Aiso and Jack Roku Miyahara, another influential hospital employee recognized as a leader in the walkout, were ultimately blamed for organizing and initiating the walkout. They transferred to Leupp Isolation Center, a WRA prison in use until December 1943, at which point inmates were transferred to Tule Lake Segregation Center in California. Neither Aiso nor Miyahara would implicate Hanaoka or define his role in the walkout, however, community analysts theorized that Hanaoka used Aiso and Miyahara as tools in his lingering resentment against Van Kirk and Irwin.[104] Physicians refused to continue working with Hanoaka, and so the WRA transferred him to Manzanar.

Shortly after the walkout occurred, the WRA appointed Mr. Dearing as hospital administrator. Dearing would oversee non-professional and non-technical functions of the hospital, as well as prepare reports and records connected with all administrative division and maintenance repair.[105] This move allowed Van Kirk to focus more specifically on nursing functions, and provided Japanese American physicians and other male hospital workers a male authority figure to whom they could take their general hospital concerns. Dearing's appointment seemed to have had a positive effect in the hospital. By January 1944, Irwin reported that hospital morale was "excellent."[106]

Emma Thomas, a medical social worker, had also been added to the staff. Van Kirk invited Thomas to a nursing staff meeting, so nurses could understand and distinguish between the similar yet separate roles of the medical social worker and public health nurse.[107] Thomas prepared a document for the Japanese American physicians that outlined the duties of her position and her place within the Medical Service. The document began:

> Miss Emma Thomas has just been added to the staff as Medical Social Worker. Medical Social Work is defined by Administrative Instruction as "a part of Medical Service, giving assistance: to patients…to the medical staff…to community welfare…"[108]

Irwin signed the one-page document, indicating his approval of Thomas' role within the Health Service.[109] This was, no doubt, part of lessons learned from the hospital walkout.

With a hospital administrator and medical social worker now on staff, Van Kirk could turn her attention to developing her staff. Van Kirk valued promptness and ran an orderly nursing service. She developed a booklet for Heart Mountain staff nurses and nurse aides that instructed them to conduct themselves professionally. The first section, titled *Ethics: Your Conduct Toward Patients*, reviewed basic principles that established the relationship between nurses and physicians, and nurses and patients. Some of these included:

> Don't call any patients by their first names or nick names, no matter how well you may know them.
>
> Don't let patients read their thermometer.
>
> Don't tell patient what their temperature is.
>
> Don't argue with a patient.
>
> Stand for all doctors and supervisors and rise when visitors approach to ask information.
>
> Don't argue with doctors or supervisors.[110]

Other rules pertained to the types of problems frequently discussed in the staff meetings: excessive noise, ward cleanliness, economization of supplies, and patient and staff visitation.[111] Van Kirk's booklet identified and promoted essential nursing and hospital practices, and clearly indicated where aides and staff nurses ranked within the hospital hierarchy. Inexperienced nurse aides broke some of the guidelines, such as bringing their knitting projects to the nurses' desk. Velma Berryman Kessel, RN, overlooked these practices, as she recalled that most nurse aides were very conscientious in caring for their patients.[112]

Van Kirk's skills, efficiency, and morale were soon again strenuously tested. The cold Wyoming winter brought over 20 cases of broncho-pneumonia to the hospital in January, and sickened the nursing staff – at times only two RNs were on duty during the day. In addition, the public health nurse terminated her employment. Although Thomas, the medical social worker, accepted a fair portion of public health duties, such as tracking communicable disease cases, Van Kirk assumed more responsibility for public health nursing responsibilities, such as organizing a school health program for children.[113]

The burdens on Van Kirk continued to grow. Only a month later, in February 1944, the chief dietician resigned. Irwin delegated temporary responsibility for the dietetic department to Van Kirk.[114] Soon thereafter, block mess halls began complaining of an overabundance of special diet requests. In her investigation, Van Kirk discovered that outpatient clinic nurse aides had been renewing all special diet requests, without obtaining the proper order from the physician. Van Kirk worked with Irwin to devise a system that was less resistant to abuse. Only a month later, the Community Council appealed to Robertson, the Project Director, to grant Japanese American physicians full discretion over special diet permits.[115] Although the

resolution of this issue is unclear, it illustrates another example of undermining the Chief Nurse position.

Japanese Americans continued to test the hospital rules until Van Kirk stepped down from her position in November 1944. Staff members returned to the hospital on off-duty time to visit and socialize with one another. Friction between the appointed nursing supervisors and ambulance drivers resulted in the drivers acting out by removing blankets from the wards. Physicians placed patients on wards of their choosing, rather than accepting this as an officially designated Chief Nurse responsibility. Nurse aides became careless in signing for materials and equipment on loan from the surgery department, and dietary aides were often unprofessional in carrying out their duties.[116] The November 6, 1944 nurse staff meeting minutes did not indicate Van Kirk had been considering resigning her position.[117] However, the November 1944 Monthly Report noted her resignation and departure from Heart Mountain.[118] As Van Kirk had just received a periodic pay increase that month and the Heart Mountain census numbered 8,137 individuals, the camp remained in great need of her services and her employment seemed secure. Coincidentally, Irwin terminated his employment at Heart Mountain in October 1944 to join the staff at a clinic in Billings, Montana. The WRA appointed T.B. Cracroft, MD, as Heart Mountain's new Principal Medical Officer. [119] Perhaps the new PMO and Van Kirk failed to ignite an effective working relationship. It could be that Van Kirk had finally lost her will to continue fighting.

The last in the long line of Chief Nurses was Margaret Wolford, RN, who had initially arrived to Heart Mountain in March 1943 to assume supervisory duty of hospital wards 7 and 8. She soon started teaching classes to train nurse aides and orderlies. Wolford was orderly and disciplined. She expected precision and detail in charting, and became "annoyed" with "mixed

up doctors' orders."[120] She was eventually promoted to Assistant Chief Nurse, where she appeared to do whatever was asked of her.

Wolford received a promotion to Chief Nurse of Heart Mountain Hospital after Van Kirk's resignation.[121] Having been employed at Heart Mountain for the past 20 months made her well aware of Van Kirk's struggle to gain the respect and authority the position of Chief Nurse demanded. In an effort to establish her presence and authority as Chief Nurse, Wolford held at least four formal staff meetings with her nurses between December 5, 1944 and February 13, 1945. Wolford focused some of her efforts on visitors and visiting hour compliance, as this continued to be a problem noted in the November nurse staff meeting.[122] Understanding that the PMO was recognized as the position of authority, Wolford instructed her nurses to refer any persons wishing to visit outside of visiting hours directly to Cracroft, if he was on duty. She also informed the nurses that patients would assume some of the responsibility for limiting the visitors to only two at a time, otherwise visiting privileges would be suspended for that patient.[123] This strategy was effective, as Wolford noted that "Visitors are conforming to rules better as far as the Supervisors have noticed."[124] Wolford must have been satisfied with the visitor count on February 13, 1945, when 168 individuals[125] braved the cold Wyoming winter to visit the approximately 100 hospital patients[126] between 2:00 and 3:00 p.m., as no further mention of visitors or visiting hour compliance was noted in the remaining staff meeting minutes.[127]

Although Wolford understood and complied with the norms of deferring to the PMO, Japanese American physicians continued to test whoever was in the Chief Nurse position. For example, Wolford reminded her nursing staff that beds were not to be moved about without her approval – this included a crib placed on the women's ward by the Japanese American

pediatrician on staff.[128] Wolford nor her nurses could monitor all physician activity all the time, and so it is likely this behavior continued until the camp closed.

Nursing Work in Heart Mountain Hospital

The types of cases varied in nature and acuity among and within the hospital wards. Children infected with a simple case of the measles or chicken pox were often hospitalized in order to contain the spread of the disease and prevent a large outbreak, as it was impossible to quarantine cases of communicable diseases to the barracks. Incarcerees were constantly exposed to potential diseases due to the use of common mess facilities, shared toilet and wash areas, and open barracks apartments. Physicians and nurses screened Japanese Americans as they arrived at Heart Mountain to determine whether any of them were acutely ill or contagious. In the event a child was determined to be ill, he was taken from his family and immediately transported to the hospital for care. Sometimes a family member would be asked to remain with the child in the pediatrics ward, as a safety precaution. While the hospital waited for cribs to arrive, children slept on U.S. Army cots, as did the adults. Family members helped keep the children safely in the cots.[129]

Some children were more acutely ill and required more specialized care. Most Japanese Americans at Heart Mountain had arrived from the Los Angeles area in California, and so had never been subjected to the extreme cold, ice, and snowy weather that would welcome them as the first winter arrived in 1942-1943. With camps reaching their peak populations during this time, camps also experienced the highest rates of communicable diseases and illnesses. In the first winter, the WRA counted 654 cases of measles, 832 cases of chickenpox, 444 cases of conjunctivitis, and 2,197 cases of influenza across the camps.[130]

The barracks had stoves for heat, but the barracks walls, floors, and ceilings lacked proper insulation to keep the cold and wind out. Children became sick with croup, pneumonia, and sore throats. Penicillin, strictly reserved for wounded servicemen, was not readily available to effectively kill the microorganisms that infected these children, and so nurses relied on other methods, as prescribed by the physicians, to treat the children.

One such remedy was the use of mustard plaster to treat pneumonia. Nurses mixed three tablespoons of flour to one tablespoon of dry mustard, adding a little warm water to make a paste. The paste was spread between cloths and placed on the patients' chests and backs. The patient was carefully monitored, and the plaster removed promptly once the skin began to redden – if the paste was left on the skin for too long, blistering could occur. The reddened skin was covered with a flannel, or pneumonia jacket, and the irritation was thought to help draw out the infection. The treatments were applied several times a day in the acute phase of the illness, along with camphorated oil rubbed into the chest.[131]

Japanese American nurse aides and orderlies did much of the bedside patient care, such as feeding and bathing patients, and taking temperatures. It was difficult, however, to keep a constant supply of trained aides. The administrative turmoil and tense atmosphere no doubt kept some potential employees away. The youngest aides worked only during the summer, while high school was out of session. Other aides left to work in the fields outside the camp in late summer and fall, lured by the higher wages paid by private farmers. Still others took their newly developed skills and left the camp to continue this type of work in a facility that paid them more than the $16 per month they earned at the incarceration camp. Protestant Episcopal Hospital in Philadelphia, Pennsylvania offered room and board plus $60/month to Japanese Americans who

would work as nurse aides.[132] Older Issei women did apply for nurse aide positions in the camp hospital, but were initially turned down because of their limited knowledge of English.[133]

After the hospital walkout of June 1943, attitudes towards employing Issei women as nurse aides began to shift. The hospital and clinic always needed trained nurse aides to carry out nursing care, and so Issei women were slowly accepted into the nurse aide training program. The hospital ran separate classes for Issei and Nisei students. Despite publicizing upcoming nurse aide training classes and loosening requirements for acceptance, interest in the classes waned at times. Van Kirk and hospital administrators implemented Stuart's suggestion of a capping ceremony for nurse aides who successfully completed the training, "…to boost morale and give the hospital some publicity."[134]

Tuberculosis and Mental Illness

Providing nursing care for individuals with tuberculosis was challenging, in part because of the Japanese American stigma towards the disease. Japanese American nurse aides often refused to care for those infected with tuberculosis. The appointed nurses educated Japanese American nurses and nurse aides on the proper methods to protect themselves when caring for individuals infected with tuberculosis. As the appointed staff continued their work in caring for tubercular patients without becoming infected or ill, Japanese American nurses slowly became convinced that they, too, could effectively care for these patients. [135] The essentials of protecting oneself, and other patients, from the spread of tuberculosis were similar to the practices observed in contemporary nursing practice: isolating the patient, strict observance of proper handwashing by all staff coming into contact with the patient, wearing a mask to prevent inhalation of contaminants, covering the uniform with a gown, and proper disposal of infected sputum.[136]

Care of mentally ill patients was also a problem for the nursing staff at Heart Mountain hospital. Like tuberculosis, mental illness carried a stigma among the Japanese American community. Unless mental illness had a physical cause, Japanese culture viewed mental illness as a problem involving willpower or self-control. Japanese culture did not consider mental or behavioral disorders as true physical illnesses, such as cancer, and so often did not seek care. Affected individuals and their families were expected to control the mental illness on their own. Only when the illness progressed to where the family could no longer safely care for the individual did they seek psychiatric care.[137] However, Heart Mountain hospital was not equipped to handle mentally ill individuals who became violent. Irwin wrote:

> Nurse aides, just as the majority of laymen are afraid or loath to assume the responsibility of caring for violent mental cases. Of course, their training has not been sufficient to fit them as attendants to care for mental patients…
>
> In addition to the above enumerated difficulties which we have had in caring for mental cases, the doctor who has been in charge of one or more of these, namely, Dr. Suski, has refused to cooperate with the registered nurses in charge of these cases by not prescribing sedatives when violence occurs stating words to this effect: "I am going to refuse to prescribe sedatives any more for these cases. Let them become violent and raise the dickens and then maybe Dr. Irwin would do something toward getting these patients properly cared for."[138]

Treatment for the mentally ill was essentially limited to institutional care in the first half of the 20th century. At Heart Mountain, the mentally ill were housed on the same ward as the tubercular patients and other individuals with communicable diseases. The staff feared for the safety of all the patients of the ward. After several broken windows, thick wire screens were

placed in front of the glass windows for protection. The hospital requisitioned padding for walls, doors, and metal radiators. The lack of appropriate facilities meant the violent mentally ill would have to be confined with restraints or placed in a strait jacket – neither of which was safe or effective treatment in the long term care of the patient.[139]

The relatively inexperienced nursing staff contributed to the poor care of the mentally ill. Japanese American nurse aides were left without guidance to care for these individuals.

> Because of the inexperience of the majority of the employed, some cases that could be cured or arrested if under proper treatment are not improving, while others are retrogressing. Nurse's aides without any experience in the proper handling of psychopathic cases are for the most part helpless. The more acute cases are being put under the surveillance of evacuee police.[140]

Once contracts were established between Heart Mountain and the state institution for the mentally ill in Evanston, Wyoming, a nurse or the medical social worker would often transport mentally ill individuals in need of further care to the facility in Evanston.[141]

Japanese Americans' Use of Hospital Facilities

The turnover and turmoil that plagued Heart Mountain Hospital administration luckily had little to no direct consequence on the patients that were treated. Although the parties and socialization that took place frequently in the first several months of the hospital did bring forth justified complaints from patients and their families, their overall care did not seem to be negatively effected.[142] Because of the changing census and skewed demographics of the camp, morbidity and mortality rates could not be effectively calculated and compared to national

statistics. However, the mortality rate for the camp in January 1944 was reported at 5.5 per thousand versus a reported 9.5 per thousand for the state of Wyoming.[143]

It is certainly true that few Japanese Americans would have thought of returning to Heart Mountain for medical care, based on the early days of hospital operations. The initial hospital was composed of one barrack building that lacked plumbing facilities, and used army cots, wooden benches, and nail kegs as furniture. Medical supplies and instruments were mostly the property of the Japanese American physicians who had brought their personal belongings with them. Medical instruments were sterilized by use of a Sterno heat can.[144] Nurses filled fire buckets with water and hauled them into the hospital to give baths. Drinking water was kept in a few barrels in the building.[145]

As the hospital facilities improved, so did the demand for health services and quality nursing care. Japanese Americans who had left the camp often applied for "reinduction," based upon their requests for needed medical care that could not be obtained, or was too expensive to obtain, outside of camp.[146] At least two visitors to the camp remained there longer than their intended stay, one to have dentures completed, and another to have her baby delivered. Heart Mountain administration officials, in conjunction with the PMO, devised a method whereby only Japanese Americans incarcerated at Heart Mountain could receive routine hospital care.[147]

Heart Mountain incarcerees also preferred taking up residence in the hospital versus the barracks. One patient, having been recently discharged after spending the prior 13 months in the hospital for an ulcer, presented himself for rehospitalization. The lack of nurses necessitated discharging patients with minor ailments who could easily manage them living in the barracks.[148] The May 1943 Quarterly Report accused other incarcerees of abusing the medical clinic during their first cold winter at Heart Mountain.

> The majority of patients received in the general clinic were sufferers of upper respiratory tract infections; there was very little that the doctors could do for them, aside from swabbing their throat and prescribing rest. Instead of over-taxing the clinic, these patients would have been much better off in bed. Because of free medical care offered, too many persons were abusing their privilege by asking for professional service for every little ailment – they waste too much of the doctors' valuable time, especially when time is such a precious commodity to them. If more doctors should leave the staff, a stricter policy regarding the medical clinic may be instituted by the Principal Medical Officer.[149]

Incarcerees so appreciated the sacrifice of the physicians that the Community Council organized and solicited periodic voluntary monetary donations from the incarcerees and disbursed these funds to the Japanese American physicians. The incarcerees knew the physicians could earn much more money and live more comfortably outside of the camp, and so tried to compensate them in some way for their commitment to the population.[150]

Incarcerees also worried about the lack of nursing personnel, but did not fully understand the work of nurses. They became concerned when hospital wards were closed in an effort to consolidate patients so nurses could adequately supervise the nurse aides. In response to the closure of Wards 5 and 8 in December 1944, the Community Council pointed out that "former nurses' aides and girls who are in a position to serve in the hospital have returned from seasonal work outside the center. Therefore, it is recommended that efforts be made for the reopening of the wards."[151] The Community Council did not understand that nurse aides still had to be under the supervision of registered nurses, and the number of registered nurses had not changed.

Cracroft, consulting with Chief Nurse Wolford, determined that a sufficient number of beds were available to handle the admissions who were truly ill, and the number of staff were not

available in sufficient number to cover opening the closed wards. In fact, he was quite blunt when he responded to the Community Council:

> …no case in need of treatment has been refused admission. …Admissions to the hospital have been sought for many inadequate reasons, some of them quite foolish. Some patients merely want to board in the hospital and be waited upon; others wish admission because the family has been temporarily broken up and they do not wish to live alone. In another instance the man sought admission because his wife was in the hospital and there was no one at home to care for him…
>
> There is no like population I know of that has an equal number of beds available, nor one which makes such generous use of its hospital. There could be no more worthy work undertaken by the Health Committee in the interest of their hospital than to develop a community attitude of respect for the hospital as such, one which would discourage the inclination of some to occupy hospital beds and consume time of doctors and nurses for trivial ailments which in normal life would not attract serious attention.
>
> To summarize: …we have no increase in the number of aides on duty, in fact there has been a 10% decrease; we have a deficiency of nurses....[152]

Cracroft and Wolford did not understand the hardships and inconveniences of living in the incarceree barracks. Individuals who had suffered strokes and other debilitating illnesses, although not in need of skilled nursing care, could not be cared for properly in the barracks. Living in the barracks was not for the frail or infirm – individuals braved snow, rain, mud, and wind to walk to the community latrines at all hours of the day and night. They had to walk to the block mess hall three times a day for their meals. In the hospital, patients could be assisted to use the toilets and sinks on the wards; meals were brought to their bedside. Hence, these individuals,

and the families who would be caring for these individuals, resisted discharge from the hospital as long as possible.[153]

The hospital continued closing wards soon after learning the camps would close. In early January 1945, Dillon Meyer, WRA Director in Washington, D.C., sent a message to the Japanese Americans still remaining in the incarceration camps. The U.S. Army Western Defense Command had recently rescinded several of the exclusion orders that were in part responsible for the Japanese American mass forced removal to the camps. The Japanese Americans would now be allowed to relocate anywhere in the United States, including their original homes or hometowns on the west coast. Camps would remain open through the next six to twelve months, but all were targeted to close before the end of 1945. Schools would remain open until the end of the traditional school year, but would not reopen in September 1945. Only essential services, such as housing, medical care, and mess operations would be continued until the camp closed, although crops would no longer be farmed.[154]

The medical social worker noted that upon learning of this information, incarcerees began flooding the medical department with final requests for elective surgeries (mostly tonsillectomies), eyeglasses, hearing aids, and artificial limbs, and other medical requisitions that would be difficult or expensive to obtain outside the camp.[155] Requests for elective surgeries had become so overwhelming, the WRA issued directives to the camps in efforts to curtail them.[156] Myer confirmed the WRA's plans to close the camps when he visited Heart Mountain camp in February 1945. Japanese Americans continued to press the Social Welfare staff to complete their requests for medical services.[157] By August 1945, Heart Mountain's last Chief Nurse Wolford frequently supplemented the ward nursing staff due to the reduced number of nursing personnel remaining on staff.[158]

Heart Mountain Public Health Nursing

The United States Public Health Service (USPHS) recommended two public health nurses per 10,000 individuals. Most camps, including Heart Mountain, were fortunate if they could retain at least one at all times.[159] Graham had expressed her anxiety over the lack of a public health nurse while establishing the nursing service at Tule Lake.[160] At Heart Mountain, Irwin noted the "organization is weak in the Public Health Nursing Department because of the very limited number of registered nurses we have been able to employ."[161]

Ethel Jackson, RN, the camp's first public health nurse, had initiated and suggested several strategies to improve the public health at Heart Mountain. She remained on staff for only a few months, however, and so some of these strategies never materialized or simply fell apart after she left. In the first few months of outpatient clinic operation, hundreds of Japanese Americans visited the medical clinic every week. The medical staff contemplated opening smaller "district clinics" throughout the camp, where incarcerees could quickly visit for minor ailments, relieving some of the pressure at the medical clinic at the hospital. This idea was abandoned, but a new idea to provide "roving public health nurse's aides" was considered in its place.[162] This plan never materialized, either. Jackson proposed a system of identifying and training "block nurses" that would see to minor cases of illness. Jackson would make daily rounds with all block mothers and document necessary information for follow up by the physicians.[163] There is no evidence that this type of program flourished.

Jackson's attempt at delegating other responsibilities to the blocks also met with resistance. The lack of running water in the barracks apartments meant that an organized system of dispensing infant formula had to be established. Jackson trained young Japanese American women, or formula girls, to prepare baby bottles in a designated area in each block's mess hall.

Conflict grew between the block kitchen chefs and the formula girls, and so a centralized kitchen with a dedicated staff was established in the hospital to prepare the formula for the entire camp. The procedure was again decentralized in 1944 to the block system, where a designated "Block Mother" prepared the formula. A dietician from the Health Section oversaw the final procedure.[164] During the peak period of population at Heart Mountain, over 9,300 bottles of fresh milk and formula were distributed every week.[165]

Maintaining and nourishing children's health was an important goal of all public health nurses of the time. Communicable disease was a serious threat to the survival of vulnerable infants and otherwise healthy individuals, and a critical threat to any person with a weakened immune system or other illness. Fortunately, Heart Mountain incarcerees were not subjected to an overwhelming outbreak of any communicable disease. This was due in part to the immunization efforts that began in the temporary detention centers, and carried through at Heart Mountain. [166]

Even with the lack of trained public health nurses, basic strategies for protecting the health of the population were soon put in place. A census of all children five years of age and younger was conducted in order to plan an effective immunization program.[167] Within the first 4 months of the incarcerees' arrival to Heart Mountain, the nursing staff had been able to assist in vaccinating the Japanese Americans against diphtheria, approximately 2,500 school children received physical examinations, and a relationship was developed with the Wyoming Department for Crippled Children. Affected children were examined and two were sent outside the camp for further care.[168] Over time, all incarcerees received vaccination against diphtheria, typhoid, and small pox.[169] Nurses also vaccinated Japanese American agriculture workers, Girl Scouts, and others venturing deep into potentially infected areas against the tick-borne Rocky

Mountain Spotted Fever. As this disease carried up to a 30% mortality rate, additional educational bulletins and lectures were delivered to the incarcerees, so they might be better prepared to protect themselves against the disease.[170]

One of the largest projects involving the public health nurse was the transfer of incarcerees to and from Tule Lake camp in California. The Tule Lake incarceration camp became a segregation center where all "disloyal" Japanese Americans from the nine outlying camps would be sent. Japanese Americans incarcerated at Tule Lake who were determined to be "loyal" would be disbursed throughout the remaining nine camps. The determination of loyal versus disloyal was based upon a registration survey implemented by the War Department and the WRA to investigate an individual's acceptability for military service or indefinite leave from the camps.[171] This incident had far-reaching implications, including the Renunciation Act of 1944, and the deportation of hundreds of Japanese Americans to Japan after the war.[172]

Nurses had to prepare medical records for incarcerees preparing for transfer to Tule Lake camp. Incarcerees arriving from Tule Lake began arriving at Heart Mountain in late September 1943. The induction process would be similar to the process all incarcerees went through upon initial processing into the camp. Teams consisting of a physician, RN, and secretary would examine individuals as they entered the camp. But even prior to arrival at the camp, the public health nurse boarded the trains carrying the incarcerees to "consult with the Army medical officer and Army nurses concerning various cases to determine whether there are any contagious diseases or patients ill enough to be transported directly to the Center Hospital upon the arrival of the train, or be prepared to have any contagious disease isolated immediately should such cases be found upon the arrival of the train."[173] The public health nurse or medical social worker would notify the PMO or Chief Nurse of any individuals in need of special medical attention.

The Chief Nurse was also responsible for assigning staff to the medical teams and ensuring adequate examination supplies were available for the exams.

After examinations of the incoming incarcerees was complete, the nurses and members of the examination teams were transported to the high school, where Heart Mountain incarcerees awaiting transfer to Tule Lake needed to be examined. These incarcerees would board the now empty trains that just delivered the group from Tule Lake. These individuals would also require examinations before they left, and if found to be infected with a communicable disease, would be held back until medically cleared. In addition, the nurses were responsible for consulting with the train doctor on all individuals requiring special care on the trip back to Tule Lake. Because entire families would be transferred, nurses also had to ensure that enough milk and milk formula were provided for infants and children.[174]

Although the incarceration camps were federally-run facilities, they did their best to comply with state educational and health regulations. For example, Wyoming required physical examinations of all school children.[175] The high-school health room was used to complete examinations of approximately 40 children per day over the 1944 summer break. Examinations consisted of a brief medical history, including information regarding tuberculosis exposure in the family. Thomas, the medical social worker, followed up with families with possible tuberculosis exposure or infection.[176] The state epidemiologist also recommended a tuberculosis survey be completed of the entire Heart Mountain population, as new cases continued to be identified nearly two years into the camp's existence.[177] The June 1944 tuberculosis survey of summer school children identified 43 of 416 elementary school age children reacted positively to the Vollmer Patch Test, and 55 of 385 high-school age children and 34 of 136 school personnel reacted positively to the Mantoux test. Of the 172 individuals with a positive skin test, five

showed on X-ray examination a tuberculosis infiltration, but none were active cases in need of hospital treatment.[178]

The nursing shortage affected the public health department's ability to carry on some of its planned programs: "…examination of the food handlers has not been undertaken due to the lack of nurses and a dwindling medical staff. The periodical tubercular check-up of the project's residents has been held up on account of the same handicap."[179] Dolores Keese, RN replaced Jackson in mid-1943 as the public health nurse but left before the end of the year. The medical social worker absorbed some of the duties of this office. All tuberculosis and venereal disease cases would be followed by the medical social worker. Many of the individuals affected by these diseases required care outside the camp, and part of the public health nurse's duty was to transport them by government car to their appointments in Billings, Montana. Upon receiving an official medical diagnosis and recommendations for treatment, the medical social worker would often be involved in interpreting the medical information to the patients and their families. The only real change in procedure, then, would be that the medical social worker would now also be responsible for transporting the patients by car, except in cases where patients were deemed sufficiently ill to travel without a nurse. In these cases an appointed RN would drive or ride in accompaniment.[180] The absence of a registered nurse removed from hospital duty to accompany these patients was surely felt.

The work of nurses was aided by the medical social worker. Finding an institution to accept individuals in need of complex care or intense psychiatric care relieved hospital nurses of the burden of caring for those individuals.[181] A very special case of an orphaned baby girl highlights the nurses' compassion and collaboration. The baby was the product of a brief relationship between a young man and woman shortly after their arrival to Pomona Assembly

Center. Both were transferred to Heart Mountain. The woman became pregnant. Instead, of marrying the father, private funds covered the cost for the woman to receive prenatal and postnatal care at a Salvation Army Home in Denver. When the woman and her infant returned to Heart Mountain, the woman's parents would not allow the infant to be raised by the family in the barracks.[182] The young woman, succumbing to the shame of bearing an illegitimate child, was found naked and alone on a cold winter night by one of the soldiers on guard duty. He immediately brought her to the hospital, where she remained for a few days until transfer to the mental institution in Evanston, Wyoming could be secured.[183]

The infant girl, named Baby Virgil after the Social Service worker, came to live in the hospital nursery. Nurses and nurse aides cared for the infant. "She soon became the staff's darling. Off duty nurses took her over to the nurses' quarters and played with her, giving her tender loving care."[184] Baby Virgil remained in the custody of the hospital nurses for approximately six months. White couples and Japanese American families applied for consideration in Baby Virgil's adoption. The Social Service Department finally awarded custody to a Japanese American family.[185]

Filling the Gap in Public Health Nursing

The medical social worker (MSW), while excelling at her work, was not a nurse, and could not take on the role of a public health nurse. Katherine M. Scott, one of two medical social workers who had been detailed to Heart Mountain wrote, "We feel the lack of a public health nurse here; in her absence I am doing the best I can."[186] Even with the problem of tuberculosis a constant one in the camp, no health education efforts had ever been initiated. The Community Council approached the MSW in March 1944 with a request for an educational program for the

camp regarding tuberculosis. Fortunately, the MSW had made some contacts with the Wyoming State Tuberculosis Nursing Staff, and would look to them as well as the Wyoming State Department of Health and Tuberculosis Association for guidance.[187]

Public health nursing services from the county were also utilized to help fill the gap. A public health nurse from Park County, Wyoming visited the camp to follow up on some of the crippled children's conditions. Two children with cerebral palsy who were sent to Casper, Wyoming for week-long physical therapy sessions in June, 1945, were sent again for a final checkup before leaving the camp for good. This public health nurse, in conjunction with Heart Mountain's medical social worker, also arranged for affected Japanese American children to attend a Crippled Children's Clinic in Worland, Wyoming, approximately 100 miles away. Arrangements would be made for affected children to receive needed services there.[188] Unfortunately, not all Wyoming agencies were as cooperative.

The medical social worker referred a patient with a tuberculosis of the hip to the Wyoming State Division of Rehabilitation. The agency responded to the request for services:

> First, our State Plan states that a person must be a citizen of the State of Wyoming before service can be rendered. Second, an outlet for employment must be in view. This man, therefore, cannot qualify even though he has a physical disability which would otherwise classify him as one who is eligible for the service from this Division.[189]

As other camp services began slowing down in the last months of Heart Mountain's existence, the medical social worker's increased exponentially, as she prepared Japanese Americans in their move out of the camp. Collaboration between the nurses and the medical social worker at this point was infrequent – the medical social worker interviewed most individuals in the outpatient clinic or visited them in their barracks. Medical information was

sought mostly from the physicians. Most of the information collected by the medical social worker made its way into reports and letters to arrange for institutionalization and/or transport from the camp. Many Japanese Americans with chronic disease and disability remained at Heart Mountain as long as they could, in order to continue receiving the free medical care to which they had grown accustomed.[190] Pregnant women departing the camp also became concerned about meeting the expenses of prenatal care and delivery outside the camp.[191]

Elderly bachelors who had been living contently in the Heart Mountain Hostel also resisted leaving the relative comforts and ease of living in the camp. The hostel was constructed in the spring of 1944 to accommodate chronically ill and/or frail, elderly Japanese American men who had been taking up residence in the hospital, but were not in need of skilled nursing care.[192] Originally considered to be a function of the Social Welfare Department, the hostel was mandated by WRA headquarters to fall under the Health Section. A physician examined new residents to the facility, while the medical social worker kept abreast of the men's social welfare needs.[193] Some men had to wait until living accommodations could be secured in their hometowns of Los Angeles and Fresno before they were transferred there from Heart Mountain. The medical social worker did her best to provide reassurance and information regarding potential sources of financial aid to these gentlemen and other anxious individuals.[194] Heart Mountain War Relocation Center closed on November 10, 1945, five days ahead of its scheduled closing date.[195]

Conclusion

Clearly, Heart Mountain hospital leadership was a failure in many aspects. The failure began at the outset of the camp, when the WRA did not produce a timely administrative manual whereby the Chief Nurse duties were clearly identified and accepted by all members of the medical staff. The Chief Nurses also lacked support from the Principal Medical Officer. Without the support of the PMO, the office of the Chief Nurse was under constant attack. Turnovers and shortages in personnel made it difficult to initiate effective health programs. The nursing and medical staff at Poston faced similar challenges in personnel turnover and shortages, but their unique organizational structure would produce an alternative sequence of events.

Notes: Chapter 3

[1] War Relocation Authority, First Quarterly Report, March 18 to June 30, 1942, Box 1: National Administration, Series I: Poston, Japanese-American Relocation Centers Records (JARCR), #3830, Division of Rare and Manuscript Collections, Cornell University Library.

[2] Ibid.

[3] War Relocation Authority, Administration Manual, Administrative Instruction No. 54, Box 1: National Administration, Series I: Poston, JARCR, #3830, Division of Rare and Manuscript Collections, Cornell University Library.

[4] Ibid.

[5] "Death: G.D. Carlyle Thompson," *Desert News*, March 2, 1997, http://www.deseretnews.com/article/546299/DEATH--GD-CARLYLE-THOMPSON.html?pg=all

[6] "New Appointments to the Staff of the Children's Bureau," *American Journal of Nursing* 43, no. 9 (1943): 869.

[7] "About People You Know," *American Journal of Nursing* 43, no 10 (1943): 958.

[8] Various memos, Entry 16, Box 373, RG 210, NAB.

[9] War Relocation Authority, Information Digest, No. 33., January 23, 1943, Box 1: National Administration, Series I: Poston, JARCR, #3830, Division of Rare and Manuscript Collections, Cornell University Library.

[10] Emma L. Kotz, "What is Medical Social Service?" *American Journal of Nursing* 36, no. 3 (1936): 245-251.

[11] Ernst P. Boas, "The Contribution of Medical Social Work to Medical Care," *Social Service Review* 13, no. 4 (1939): 626-633; Bess H. Medary, "Medical Social Work as a Career," *Bios* 16, no. 2, (1945): 60-64.

[12] War Relocation Authority, Administrative Manual, Administrative Instruction No. 54, Supplement 1, May 22, 1943. Box 1: National Administration, Series I: Poston, JARCR, #3830, Division of Rare and Manuscript Collections, Cornell University Library.

[13] Reports Division, First Quarterly Report, November 1942 (NA Microfilm C0053, Roll 57), RG 210, NAB.

[14] Douglas W. Nelson, *Heart Mountain: The History of an American Concentration Camp* (University of Wisconsin: State Historical Society for the Department of History, 1976).

[15] Heart Mountain Weekly Report, November 21, 1942, Entry 16, Box 206, RG 210, NAB.

[16] Heart Mountain Relocation Center Community Analysis Section, The Heart Mountain Hospital Walkout: June 24, 1943 (Hospital Walkout), p. 66, (NA Microfilm M1342), RG 210, NAB.

[17] Heart Mountain Charter Commission, Summary of the Charter Commission Work, 1943 (NA Microfilm C0053, Roll 56), RG 210, NAB.

[18] War Relocation Authority, Administrative Manual, Administrative Instruction No. 34, August 24, 1942, Box 1: National Administration, Series I: Poston, JARCR, #3830, Division of Rare and Manuscript Collections, Cornell University.

[19] Heart Mountain Charter Commission, Summary of the Charter Commission Work, 1943, (NA Microfilm C0053, Roll 56), RG 210, NAB.

[20] T.B. Cracroft, Heart Mountain Relocation Center Health Section Final Report, 1945, (NA Microfilm C0053, Roll 63), RG 210, NAB.

[21] Reports Division, First Quarterly Report, November 1942, (NA Microfilm C0053, Roll 57), RG 210, NAB.

[22] Memorandum to E.R. Fryer and G.D. Carlyle Thompson from A.B. Carson. Date unavailable, Entry 16, Box 369, File 62.010, RG 210, NAB.

[23] Ibid.

[24] Thomas Oki, Hospital Report for First Quarterly Report (unedited), 1942, Hospital Walkout, Appendix A, (NA Microfilm M1342), RG 210, NAB.

[25] Letter from E.R. Coffey, WRA Medical Consultant to C.C. Applewhite, USPHS District Supervisor, July 28, 1942, Entry 16, Box 369, File 62.010, RG 210, NAB.

[26] Hospital Walkout, 1943, pp. 9-10, (NA Microfilm M1342), RG 210, NAB.

[27] Memorandum from A.B. Carson to Philip W. Barber, August 15, 1942, Entry 48, Box 159, RG 210, NAB.

[28] Thomas Oki, Hospital Report for First Quarterly Report (unedited), 1942, Hospital Walkout, Appendix A, (NA Microfilm M1342), RG 210, NAB.

[29] "This Week's Heroes," *Heart Mountain Sentinel*, March 13, 1943, 8.

[30] Hospital Walkout, 1943, pp. 9-10, (NA Microfilm M1342), RG 210, NAB.

[31] John L. DeWitt, *Final Report, Japanese Evacuation from the West Coast, 1942* (Washington, DC: United States Government Printing Office, 1943), 190-191.

[32] Hospital Walkout, 1943, pp. 9-10, (NA Microfilm M1342), RG 210, NAB.

[33] Ibid., p. 16.

[34] A. Dudley Gardner, "World War II and the Japanese of Southwest Wyoming," *Wyoming History Journal* 68, no. 2 (1996): 22-32.

[35] Nelson, *Heart Mountain: The History of an American Concentration Camp*, 10.

[36] C.E. Irwin, Narrative Report, Hospital Walkout, (NA Microfilm M1342), RG 210, NAB.

[37] Hospital Walkout, 1943, p. 16, (NA Microfilm M1342), RG 210, NAB.

[38] Medical Staff Meeting, November 20, 1942, Entry 48, Box 159, RG 210, NAB. The quote was typed in all uppercase letters, suggesting Irwin's desperation to end the quarreling amongst the Japanese American physicians.

[39] Hospital Walkout, 1943, p, 17, (NA Microfilm M1342), RG 210, NAB.

[40] Special meeting of medical staff, February 7, 1943, Entry 48, Box 159, RG 210, NAB.

[41] Ibid.

[42] "1000-Foot Building Guards Center Health," *Heart Mountain Sentinel*, August 12, 1944, 20.

[43] Velma Berryman Kessel, *Behind Barbed Wire: Diary of a Registered Nurse During the Heart Mountain Relocation Period* (Powell, WY: V.B. Kessel, 1992).

[44] Hospital Walkout, 1943, p. 4, (NA Microfilm M1342), RG 210, NAB.

[45] Ibid., p. 9.

[46] The Hospital Walkout Report states original hospital plans called for 18-20 appointed nurses; this was never achieved.

[47] Medical Staff Meeting, November 20, 1942, Entry 48, Box 159, RG 210, NAB.

[48] Letter from Joy Barragrey Stuart to C.E. Irwin, November 21, 1942; Memo from J.B. Stuart to Christopher E. Rachford and Charles E. Irwin, November 30, 1942, Entry 48, Box 159, RG 210, NAB; Berryman Kessel, *Behind Barbed Wire*.

[49] Heart Mountain Monthly Report, December 1942, National Archives, RG 210, Entry 16, Box 205

[50] Berryman Kessel, *Behind Barbed Wire.* Velma Kessel interview, Susan McKay Papers, Collection Number 400036, American Heritage Center, University of Wyoming.

[51] Heart Mountain Walkout, 1943, p. 11, (NA Microfilm M1342), RG 210, NAB.

[52] Memorandum from Hiro Hishiki to C.E. Irwin, January 18, 1943, Entry 48, Box 159, RG 210, NAB.

[53] Shotaro Frank Miyamoto, Part II. The Social Organization of the Tule Lake Relocation Center, chapter IX, June 18, 1945, Japanese American Evacuation and Resettlement Records, BANC VISS 67/14c, The Bancroft Library, University of California, Berkeley.

[54] Letter from Guy Robertson to Dillon S. Myer, February 18, 1943, Entry 16, Box 369, File 62.010, RG 210, NAB.

[55] Memorandum from C.E. Irwin to Guy Robertson, March 1, 1943, Entry 48, Box 159, RG 210, NAB.

[56] Graduate Staff Meeting, January 25, 1943, Entry 48, Box 159, RG 210, NAB.

[57] Graduate Staff Meeting, February 10, 1943; Graduate Staff Meeting, February 16, 1943, both from Entry 48, Box 159, RG 210, NAB.

[58] Petition, February 13, 1943, Entry 16, Box 369, File 62.010, RG 210, NAB.

[59] Letter from Guy Robertson to Dillon S. Myer, February 18, 1943; Letter from Margaret Graham to Miss Stuart, undated; Memorandum from Guy Robertson to Dr. C. E. Irwin, February 16, 1943, all from Entry 16, Box 369, File 62.010, RG 210, NAB.

[60] Letter from Margaret Graham to Miss Stuart, undated, Entry 16, Box 369, File 62.010, RG 210, NAB.

[61] Memorandum from Guy Robertson to Dr. C. E. Irwin, February 16, 1943, Entry 16, Box 369, File 62.010, RG 210, NAB.

[62] Ibid.

[63] Ibid.

[64] Ibid.

[65] Ibid.

[66] Letter from Guy Robertson to Dillon S. Myer, February 18, 1943, Entry 16, Box 369, File 62.010, RG 210, NAB.

[67] Karen Anderson, *Wartime Women: Sex Roles, Family Relations, and the Status of Women during World War II* (Westport, CT: Greenwood Press, 1981); Alice Kessler-Harris, *Out to Work: A History of Wage-Earning Women in the U.S.* (New York: Oxford University Press, 1982).

[68] Letter from Guy Robertson to Dillon S. Myer, February 18, 1943, Entry 16, Box 369, File 62.010, RG 210, NAB.

[69] Letter from G. D. Carlyle Thompson to Guy Robertson, February 23, 1943, Entry 16, Box 369, File 62.010, RG 210, NAB.

[70] Letter from Guy Robertson to G.D. Carlyle Thompson, February 27, 1943, Entry 16, Box 369, File 62.010, RG 210, NAB.

[71] Ibid.

[72] Memorandum from A.B. Carson to E.R. Fryer and G.D. Carlyle Thompson, date unavailable, Entry 16, Box 369, File 62.010, RG 210, NAB.

[73] Letter to from G.D. Carlyle Thompson Guy Robertson, February 23, 1943, Entry 16, Box 369, File 62.010, RG 210, NAB.

[74] Minutes of Medical Staff Meeting, February 26, 1943, Entry 48, Box 159, RG 210, NAB.

[75] Medical Staff Meeting, March 11, 1943, Entry 48, Box 159, RG 210, NAB.

[76] "Chief Nurse Here was in Japan for Nineteen Years," *Heart Mountain Sentinel*, March 27, 1943, 5; Anna S. Van Kirk, "St. Barnabas' Hospital, Osaka: An Instructor Needed in Public Health Nursing," *American Journal of Nursing* 28, no. 2 (1928): 120.

[77] Berryman Kessel, *Behind Barbed Wire*.

[78] Federal Bureau of Investigation, FBI Survey of Japanese Relocation Centers, Part 2, March 1943, Entry 17, Box 1, RG 210, NAB.

[79] Heart Mountain Weekly Report, October 30, 1942, Entry 16, Box 206, RG 210, NAB.

[80] See various letters between Joy B. Stuart and schools of nursing, May and June 1943, Entry 16, Box 373, RG 210, NAB.

[81] Heart Mountain Quarterly Report, August 1943, (NA Microfilm C0053, Roll 58), RG 210, NAB.

[82] Berryman Kessel, *Behind Barbed Wire.*

[83] Heart Mountain Quarterly Report, August 1943, (NA Microfilm C0053, Roll 58), RG 210, NAB; Monthly Reports, Entry 16, Boxes 205 and 206, RG 210, NAB.

[84] Memorandum from Joy B. Stuart to G.D. Carlyle Thompson, May 10, 1943, Entry 16, Box 373, RG 210, NAB.

[85] Ibid. Minidoka in Idaho nurse to patient ratio was 1:48 and Topaz in Utah was 1:47.

[86] Ibid.

[87] Heart Mountain Quarterly Report, May 1943, (NA Microfilm C0053, Roll 58), RG 210, NAB.

[88] See Graduate Staff Meeting minutes of March 16, March 25, March 30, April 6, April 20, and April 27, 1943, all found in Entry 48, Box 159, RG 210, NAB; Hospital Walkout, 1943, (NA Microfilm M1342), RG 210, NAB.

[89] Hospital Walkout, 1943, (NA Microfilm M1342), RG 210, NAB.

[90] Ibid.

[91] Ibid.

[92] Ibid.

[93] Ibid., p. 73.

[94] Letter from Minokichi Tsunokai to Mr. Provinse, July 20, 1943, (NA Microfilm, M1342), RG 210, NAB.

[95] Hospital Walkout, 1943, (NA Microfilm M1342), RG 210, NAB.

[96] Naomi Hirahara and Gwenn M. Jensen, *Silent Scars of Healing Hands: Oral Histories of Japanese American Doctors in World War II Detention Camps* (Center for Oral and Public History at California State University, Fullerton, 2004), 28.

[97] Hospital Walkout, 1943, (NA Microfilm M1342), RG 210, NAB.

[98] Christine Hallett and Gerard M. Fealy, "Guest Editorial: Nursing History and the Articulation of Power," *Journal of Clinical Nursing* 18 (2009), 2681-2682.

[99] Hospital Walkout, 1943, pp. 98-99, (NA Microfilm M1342), RG 210, NAB.

[100] Hospital Walkout, 1943, p. 99, (NA Microfilm M1342), RG 210, NAB.

[101] Interview of Jimmy Nakano by Dr. C.E. Irwin, Principal Medical Officer, and Miss Anna Van Kirk, Chief Nurse, on July 6, 1943, pp. 5-6, Hospital Walkout, 1943, (NA Microfilm M1342), RG 210, NAB.

[102] Hospital Walkout, 1943, (NA Microfilm M1342), RG 210, NAB.

[103] Ibid., p. 72.

[104] Hospital Walkout, 1943, (NA Microfilm M1342), RG 210, NAB. Little is known of Miyahara's employment at the hospital. A memorandum by Project Attorney Lechliter describes the grounds for Miyahara's transfer to Leupp (page 93 of Hospital Walkout).

[105] Medical Staff Meeting Minutes, July 21, 1943, Entry 48, Box 159, RG 210, NAB.

[106] Memo "Notice of dissatisfaction and Demand #2, signed by Kiyoshi Okamoto," from C.E. Irwin to M. Anderson, January 15, 1944, Entry 48, Box 159, RG 210, NAB.

[107] Heart Mountain Monthly Report, September 1943, Entry 16, Box 205, RG 210, NAB.

[108] Ibid.

[109] Ibid.

[110] A.S. Van Kirk, Memo, Box 2, Folder 17, Susan McKay Papers, Collection Number 400036, American Heritage Center, University of Wyoming.

[111] Ibid.

[112] Berryman Kessel, *Behind Barbed Wire*, 46.

[113] Heart Mountain Monthly Report, January 1944, Entry 16, Box 205, RG 210, NAB.

[114] Heart Mountain Monthly Report, February 1944, Entry 16, Box 205, RG 210, NAB.

[115] Heart Mountain Monthly Report, April 1944, Entry 16, Box 205, RG 210, NAB.

[116] See Nurse Staff Meeting Minutes, 1944, Entry 48, Box 159, RG 210, NAB.

[117] Staff Meeting, November 6, 1944, Entry 48, Box 159, RG 210, NAB.

[118] Heart Mountain Monthly Report, November 1944, Entry 16, Box 206, RG 210, NAB.

[119] Heart Mountain Monthly Report, October 1944, Entry 16, Box 206, RG 210, NAB.

[120] Graduate Staff Meeting, March 23, 1944; Staff Meeting, September 1944, both from Entry 48, Box 159, RG 210, NAB.

[121] Heart Mountain Monthly Reports, November and December 1944, Entry 16, Box 206, RG 210, NAB.

[122] Staff Meeting, November 6, 1944, Entry 48, Box 159, RG 210, NAB.

[123] Staff Meeting, December 28, 1944, Entry 48, Box 159, RG 210, NAB.

[124] Staff Meeting, January 23, 1945, Entry 48, Box 159, RG 210, NAB.

[125] Nurse's Staff Meeting, February 13, 1945, Entry 48, Box 159, RG 210, NAB.

[126] Heart Mountain Monthly Report, February 1945, Entry 16, Box 206, RG 210, NAB.

[127] See Nurse Staff Meeting Minutes, May 22, 1945 and July 23, 1945, Entry 48, Box 159, RG 210, NAB.

[128] Nurse's Staff Meeting, February 13, 1945, Entry 48, Box 159, RG 210, NAB.

[129] Berryman Kessel, *Behind Barbed Wire*; Ada Endo interview, Box 1, Folder 14, Susan McKay Papers, Collection Number 400036, American Heritage Center, University of Wyoming.

[130] War Relocation Authority. *The Evacuated People: A Quantitative Description*. Washington, DC: United States Department of the Interior, 1946. There are discrepancies in the statistical data of communicable diseases based on weekly, monthly, and quarterly reports and the WRA's final statistics. Data are incomplete and some reports are missing. Some numbers sometimes are simply not plausible, based on comparisons of the camp reports and WRA reports.

However, the statistics do give some indication of the number and types of illnesses that occurred at the camps.

[131] Berryman Kessel, *Behind Barbed Wire*; Gladys E. Willett, "A Private Duty Experience," *The American Journal of Nursing* 36, no. 10 (1936): 934-935.

[132] Teletype from Robert Dolins to Giles Zimmerman, Entry 16, Box 373, RG 210, NAB.

[133] Heart Mountain Quarterly Report, May 1943 and August 1943, (NA Microfilm C0053, Roll 58), RG 210, NAB.

[134] Letter from Guy Robertson to Jean Sutherland, August 10, 1943, Entry 16, Box 373, RG 210, NAB.

[135] FBI Survey of Japanese Relocation Centers, Part 2, March 1943, Entry 17, Box 1, RG 210, NAB.

[136] Alice L. Spellman and Katherine G. Amberson, "Preventing Tuberculosis: In the General Hospital," *American Journal of Nursing* 41, no. 4 (1941): 447-451.

[137] Tsunetsugu Munakata, "Japanese Attitudes toward Mental Illness and Mental Health Care." In Japanese Culture and Behavior, edited by Takie Sugiyama Lebra and William P. Lebra (Honolulu, Hawaii: University of Hawaii Press, 1986), 369-370.

[138] Memorandum from C.E. Irwin to M.O. Anderson, August 11, 1943, Entry 48, Box 159, RG 210, NAB.

[139] Ibid.

[140] Heart Mountain Quarterly Report, May 1943, (NA Microfilm C0053, Roll 58), RG 210, NAB.

[141] Ibid.

[142] Memo "Notice of dissatisfaction and Demand #2, signed by Kiyoshi Okamoto," from C.E. Irwin to M. Anderson, January 15, 1944, Entry 48, Box 159, RG 210, NAB.

[143] Memo "Analysis and justification for proposed evacuee personnel on health staff," from C.E. Irwin to Guy Robertson, Jan. 20, 1944, Entry 48, Box 159, RG 210, NAB.

[144] "1000-Foot Building Guards Center Health," *Heart Mountain Sentinel*, August 12, 1944, p. 20.

[145] Hospital Walkout, 1943, (NA Microfilm M1342), RG 210, NAB.

[146] Memo "Notice of dissatisfaction and Demand #2, signed by Kiyoshi Okamoto," from C.E. Irwin to M. Anderson, January 15, 1944, Entry 48, Box 159, RG 210, NAB.

[147] T.B. Cracroft, Hospital Treatment of Others than Bonafide Evacuees of the Center, January 15, 1945, Entry 48, Box 159, RG 210, NAB.

[148] Medical Staff Meeting, December 8, 1944, Entry 48, Box 159, RG 210, NAB.

[149] Heart Mountain Quarterly Report, May 1943, (NA Microfilm C0053, Roll 58), RG 210, NAB.

[150] T.B. Cracroft, Heart Mountain Relocation Center, Hospital Section, Final Report, 1945, (NA Microfilm C0053, Roll 63), RG 210, NAB.

[151] Memorandum from M. Hayashida to M.O. Anderson, December 4, 1944, Entry 48, Box 159, RG 210, NAB.

[152] T.B. Cracroft, Memorandum, December 9, 1944, Entry 48, Box 159, RG 210, NAB.

[153] Heart Mountain Monthly Report, April 1945, Entry 16, Box 206, RG 210, NAB; Berryman Kessel, *Behind Barbed Wire*.

[154] Dillon S. Myer, A Message from the director of the War Relocation Authority, January 1945, [Electronic Record], Dillon S. Myer Papers, Truman Library.

[155] Heart Mountain Monthly Reports, December 1944, January 1945, February 1945, March 1945, Entry 16, Box 206, RG 210, NAB.

[156] Heart Mountain Monthly Report, June 1945, Entry 16, Box 206, RG 210, NAB.

[157] Heart Mountain Monthly Report, February 1945, March 1945, June 1945, Entry 16, Box 206, RG 210, NAB.

[158] Heart Mountain Monthly Report, August 1945, Entry 16, Box 206, RG 210, NAB.

[159] WRA Manual for Medical Services, August 14, 1942, Entry 16, Box 374, RG 210, NAB.

[160] Memorandum from A.B. Carson to G.D. Carlyle Thompson, August 5, 1942, Entry 16, Box 369, File 62.010, RG 210, NAB.

[161] Memorandum, January 14, 1943, Entry 48, Box 159, RG 210, NAB.

[162] Heart Mountain Quarterly Report, August 1943, (NA Microfilm C0053, Roll 58), RG 210, NAB.

[163] Medical Staff Meeting, March 11, 1943, Entry 48, Box 159, RG 210, NAB.

[164] T.B. Cracroft, Heart Mountain Relocation Center, Hospital Section, Final Report, 1945, (NA Microfilm C0053, Roll 63), RG 210, NAB.

[165] Heart Mountain Weekly Report, December 19, 1942, Entry 16, Box 206, RG 210, NAB.

[166] Heart Mountain Monthly Report, August 1943, Entry 16, Box 205, RG 210, NAB.

[167] Heart Mountain Weekly Report, November 21, 1942, Entry 16, Box 206, RG 210, NAB.

[168] Memorandum, January 14, 1943, Entry 48, Box 159, RG 210, NAB.

[169] Heart Mountain Monthly Report, August 1943, Entry 16, Box 205, RG 210, NAB.

[170] Heart Mountain Quarterly Report, May 1943, (NA Microfilm C0053, Roll 58), RG 210, NAB.

[171] War Relocation Authority, *Semi Annual Report: January 1 to June 30, 1944* (Washington, DC: Department of the Interior, War Relocation Authority, 1944); Cherstin M. Lyon, "Loyalty Questionnaire," *Densho Encyclopedia* http://encyclopedia.densho.org/Loyalty%20questionnaire/ (accessed January 25, 2016); Michi Weglyn, *Years of Infamy: The Untold Story of America's Concentration Camps* (New York: Morrow Quill, 1976). Further details of this complex and extended incident are available in this WRA report, *Densho Encyclopedia*, and other secondary sources. Events leading up to this incident began on June 17, 1942, when the War Department refused to accept any more Japanese Americans for military service. In early 1943, the War Department and Office of Naval Intelligence designed Selective Service Form 304A to ascertain the loyalty of Nisei men to the United States, should they be called upon to serve in the war. The WRA administered the same survey to *all* Nisei and Issei in the camps in an effort to quicken the camp clearance process. Survey questions 27 and 28 became the noted points of contention for many Japanese Americans, leading to the eventual segregation of those who were "loyal" and "disloyal."

[172] Cherstin M. Lyon, "Segregation," *Densho Encyclopedia* http://encyclopedia.densho.org/Segregation (accessed January 25, 2016).

[173] Memorandum, C.E. Irwin, September 15, 1943, Entry 48, Box 159, RG 210, NAB.

[174] Ibid.

[175] Heart Mountain Monthly Report, July 1944, Entry 16, Box 206, RG 210, NAB.

[176] Ibid.

[177] Heart Mountain Monthly Reports, May 1944 and April 1944, Entry 16, Box 205, RG 210, NAB.

[178] Letter from T.B. Cracroft to Donnell Boardman, September 25, 1945; Letter from Katherine M. Scott to Madelyn Seabright, January 16, 1945, both from Entry 48, Box 159, RG 210, NAB.

[179] Heart Mountain Quarterly Report, May 1943, (NA Microfilm C0053, Roll 58), RG 210, NAB.

[180] Memorandum "Report of Medical Social Service Department for the Month of December, 1943," from Emma E. Thomas to C.E. Irwin, January 7, 1944, Entry 16, Box 205, RG 210, NAB.

[181] Heart Mountain Monthly Report, November 1943, Entry 16, Box 205, RG 210, NAB.

[182] Virgil Payne, Monthly Report, January 4, 1944, Entry 16, Box 205, RG 210, NAB.

[183] Berryman Kessel, *Behind Barbed Wire*.

[184] Ibid.

[185] Virgil Payne, Monthly Report, January 4, 1944, Entry 16, Box 205, RG 210, NAB.

[186] Letter from Katherine M. Scott to Madelyn Seabright, January 16, 1945, Entry 48, Box 159, RG 210, NAB.

[187] Heart Mountain Monthly Report, March 1944, Entry 16, Box 205, RG 210, NAB.

[188] Heart Mountain Monthly Report, August 1945, Entry 16, Box 206, RG 210, NAB; Heart Mountain Monthly Report, May 1944, Entry 16, Box 205, RG 210, NAB.

[189] Heart Mountain Monthly Report, May 1944, Entry 16, Box 205, RG 210, NAB.

[190] See Heart Mountain Monthly Reports, January thru September, 1945, Entry 16, Box 206, RG 210, NAB.

[191] Heart Mountain Monthly Report, August 1945, Entry 16, Box 206, RG 210, NAB.

[192] Memo from L.T. Main to V. J. Ryan, March 18, 1944, Entry 48, Box, 159, RG 210, NAB.

[193] Heart Mountain Monthly Report, May 1944, Entry 16, Box 205, RG 210, NAB.

[194] Heart Mountain Monthly Reports, September 1945 and August 1945, Entry 16, Box 206, RG 210, NAB.

[195] War Relocation Authority, *Administrative Highlights of the WRA Program* (Washington, DC: United States Department of the Interior, 1946), 75.

Chapter 4

Nursing at the Colorado River (Poston) War Relocation Center, Arizona

While physicians and nurses struggled for power in Wyoming at Heart Mountain, an entirely different scenario was occurring in Poston, Arizona. In fact, context would play an important role in the differences. Poston, embedded in the Bureau of Indian Affairs organization and leadership, would provide for a less hostile environment where nurse-physician collaboration could occur. The purpose of this chapter is to describe and analyze the nursing leadership, hospital care, and public health efforts at the Poston, Arizona incarceration camp. This chapter seeks to further explain the role of the Bureau of Indian Affairs in the administration of the Poston incarceration camp, within the context of WRA policies and procedures. In this chapter I argue that the Bureau of Indian Affairs provided an organizational structure and guidelines that supported nurse leaders in their efforts to develop an effective nursing service.

Bureau of Indian Affairs

The camp at Poston in Yuma County, Arizona, was the largest of the incarceration camps with 72,000 gross acres in an unoccupied area of the Colorado River Indian Reservation.[1] The nearest town, Parker, was approximately 12 miles north of the camp. Officially known as the Colorado River Relocation Center, the camp was also known as Poston for Charles Debrille Poston, the first Superintendent for Indian Affairs in Arizona.[2] John Collier, then Commissioner of the Bureau of Indian Affairs, would play a major part in the development and administration of the Poston War Relocation Center. A brief background of Collier and the Bureau of Indian Affairs is needed to understand Collier's perspective and influence upon the Poston camp.[3]

The Bureau of Indian Affairs (BIA) is one of the nation's oldest bureaus, administratively established by Secretary of War John C. Calhoun in 1824, but with roots reaching back to Benjamin Franklin's creation of a Committee on Indian Affairs as part of the 1775 Continental Congress. Original Federal policies were designed to subjugate and strip American Indians of their culture, but a shift in culture and policy gave way to Indian self-determination as a result of a report prepared by Lewis Meriam in 1928, called "The Problem of Indian Administration," also known as the Meriam Report. [4] This study reviewed the health, economic, and social conditions among select Indian jurisdictions, including reservations, hospitals, sanatoria, and schools. The report also reviewed the educational, industrial, health, and medical activities of the BIA. Overall conclusions of the report were that most Indians lived in poverty and suffered a higher rate of disease morbidity and mortality than white America. The report further deemed the medical and health work of the BIA as inadequate and ineffective. [5]

The Meriam Report also criticized the effects of the Dawes Act of 1887, also known as the General Allotment Act. Prior to the Dawes Act, Indian lands were held in common. The Dawes Act divided reservation land into individual allotments, designed to assimilate the Indians into a Euro-American agricultural lifestyle. Indians accepting an allotment would become land-owning U.S. citizens, and, hopefully, forgo their traditional culture and customs. [6] Yet much of the allotted land was unsuitable for farming, and Indians had no knowledge of farming methods. In addition, many Indians simply did not want to become part of white civilization.[7]

It is in the midst of this debate and confusion that John Collier began his life's work advocating for American Indians. Collier became executive secretary of and soon began lobbying for the American Indian Defense Association in 1923. Collier proposed the preservation of Indian culture and opposed the Dawes Act of 1887, where Indians lost millions

of acres of their land. He requested reorganization of the BIA and supported cooperation with other agencies, such as the U.S. Public Health Service for assistance in medical matters.[8]

John Collier's ten years as executive secretary of the Indian Defense Association and relentless enthusiasm for Indian reform earned him appointment as Commissioner of Indian Affairs under President Roosevelt in 1933. Congress passed The Indian Reorganization Act (IRA) of 1934 with the approval of a majority of Indian tribes. Although practical application of the IRA was often criticized, Collier realized significant gains by the end of his first four years in office. These included land conservation, BIA employment of Indians, stoppage of Indian land losses, and a shift in goals from white assimilation to respect of traditional Indian culture and values. Gains in restoring traditional tribal communities continued steadily until 1942, when the United States went to war. At this point, the BIA was temporarily moved to Chicago, where distance and loss of qualified personnel and funding amounted to increased difficulties in securing support for BIA programs and policies.[9]

Collier and the BIA would soon face additional challenges. Vice-President Henry Wallace and Secretary of the Interior Harold Ickes recommended Collier as director of the War Relocation Authority, due to his extensive experience with displaced minority persons. Instead, Milton Eisenhower was offered the position, and Collier was to administer only the Poston camp on the Colorado River Indian reservation.[10]

The Colorado River Indian Reservation Tribal Council opposed the use of their land as an incarceration camp; they did not to be a part of another minority population's subjugation. Nevertheless, their opinion was overruled by the U.S. Army and BIA. The BIA took advantage of the large Japanese American labor pool and military funds to irrigate the desert land for agricultural use.[11]

Collier supported adult educational programs and activities based on Japanese culture, and initiated the development of self-government, recreation facilities, consumer cooperatives, and a community credit union.[12] The Community Analysis Section (CAS) developed for other incarceration camps was largely based on the program that Collier established at Poston. Collier had long utilized cultural anthropologists and other social scientists to better understand the needs of the American Indians for whom he was responsible. Plans for data collection and analysis began as soon as Collier learned the BIA would be responsible for the administration of Poston. Goals of the research would be to help the Poston administration understand the attitudes and responses of the Japanese Americans to policies, procedures, and administrative actions and inactions.

Collier's vision of the camp clashed fundamentally with the WRA's policy of relocation. In a speech delivered to approximately 7,500 Japanese Americans, Collier described Poston as a "colony" and "great social experiment," where he predicted a protracted stay of four to six years.[13] The WRA's goal had always focused on relocation and resettlement.

Bureau of Indian Affairs District Medical Director

Ralph B. Snavely, District Medical Director for the BIA office in Albuquerque, New Mexico, had an integral role in the formation of Poston's Health Section. Snavely began his involvement with the WRA in March 1942, when he was tasked in the role of arranging medical care for the incarcerated Japanese Americans at Poston. Snavely waited patiently for clear lines of authority to be established within the WRA before he proceeded in his work.[14] Snavely's responsibilities at Poston were consultative and advisory to all aspects of the medical, nursing and public health services at Poston.[15]

Bureau of Indian Affairs Nurse Leader

The nursing leadership of Poston would be critical to the running of the camp hospital and clinics. Sallie Marshall Jeffries began her career with the BIA in 1929, first as assistant supervisor of nurses, then as associate consultant in hospital nursing, followed by her current position since 1940 as Director of Nursing for Indian Health Services. Jeffries would temporarily deploy her experienced BIA nurses to Poston to establish a logical and cohesive nursing service. These nurses remained for various periods of time, until other nurses could be appointed from the civilian sector or recruited from within the camp.[16]

Jeffries held certain expectations of her nurses, and especially of her head nurses that included their social status. Male superintendents of BIA agencies, as a rule, specifically requested single nurses be assigned to Head Nurse vacancies. Jeffries supported their reasons in believing that married head nurses did not exhibit the same amount of interest in the morale and welfare of her staff nurses as a single head nurse might. The head nurse was expected to assume some responsibility in the social development of young staff nurses, and this meant involvement and supervision on the wards as well as in the activities in the nurses' quarters. The War Manpower Commission had not yet begun to affect or deplete the number of nurses available for employment, and so Jeffries was adamant that a single nurse be selected for these positions.[17]

Poston, Arizona Incarceration Camp

Weather and location would play an important part in the running of the camp. This desert area had summer temperatures as high as 120 degrees and winter temperatures as low as nine degrees, with three inches of annual rainfall.[18] Poston was divided into three camps, spaced north to south at three-mile intervals. Incarcerees unofficially dubbed Poston camps I, II, and III

as Roasten, Toasten, and Dustin – a reflection of the heat, misery, and dust that surrounded them.[19]

Construction at Poston began on March 27, 1942 with 5,000 employees working double shifts. Under this frenetic pace, workers completed construction of most of Poston I in only three weeks. Like other camps, barbed wire fence enclosed the three Poston camps. Unlike other camps, guard towers were not erected, due to Poston's remote desert location.[20] The camp had a peak population of nearly 18,000 individuals, with capacity to house 20,000. Poston I housed up to 10,000 individuals; Poston II and III each housed up to 5,000 persons. This organization facilitated administration of the camps as well as worker accessibility to the sprawling farmland.[21] The same block organization, barracks living and communal access to mess halls, latrines, and laundry facilities found at Heart Mountain were also found at Poston.

The camp opened on May 8, 1942. The agreement between the War Relocation Authority and the Secretary of Interior, through Commissioner Collier of the Bureau of Indian Affairs, called for administration of the Poston incarceration camp to be "…in conformity with policies and procedures to be established by the War Relocation Authority…"[22] The WRA anticipated needing four nurses and six physicians for early arrival to Poston to facilitate the physical exams required of all incoming incarcerees.[23] Although the WRA assigned a liaison officer, project attorney, and other necessary liaison staff, Collier was responsible for appointing all other staff, including medical personnel.[24] Lists of Japanese American healthcare personnel, that included physicians, nurses, dentists, lab technicians, pharmacists, bacteriologists, hospital administrators, and other professions associated with health and sanitation services had been compiled and revised for several weeks prior to assigning personnel to the various camps.[25] An even distribution of the limited human resources had to be ensured.

Incarcerees arrived at Poston in large numbers through May and June 1942. Collier addressed the Poston population on June 27, 1942 as "Fellow citizens and fellow Americans." Collier at once empathized with their "bitter and shocking ordeal" while he also claimed the forced removal was a "practical necessity" and "inevitable thing." The speech touched on many topics, such as democracy and communal living, but also detailed the overall organization whereby the BIA would administer the camp within rules and regulations of the WRA.[26] This straightforward approach would be seen with other Poston administrative leaders.

Although Collier attempted to set a collegial tone at the outset, Poston, like Heart Mountain, was not immune to acts of resistance. One unpopular young male incarceree had been suspected of being an informant to the WRA, and on November 14, 1942, a group of incarcerees beat him into unconsciousness. Two of the suspects were arrested. A committee of Japanese Americans met with the Project Director, asking for the suspects' release. Although the appointed administration had little substantial evidence against the suspects, they did not release them, for fear of appearing weak or inferior to the Japanese Americans. Once the larger community learned of this, approximately 1,000 Japanese Americans gathered at the camp jail in protest, and ordered a strike for all but the most essential services.[27] Hospital personnel did not participate in the strike.

Administrators initially considered activating the U.S. Army troops and placing the camp under martial law. Cooler heads fortunately prevailed, and one of the suspects was released. Prior to releasing the second suspect, administrators conferred with Collier and the Secretary of the Interior, who agreed the second suspect should also be released. By November 23, 1942, administrators and an emergency committee representing the Japanese Americans met and brought the matter to a close. The period of nine days over which this incident occurred was

tense, but no further violence or vandalism had occurred. Community analysts agreed the incident "…provided a healthy release of pent-up emotions and…generally agreed that Poston emerged as a stronger and more stable community."[28]

Poston Hospital, Clinics, and Physicians

Nurses would be needed to work in the temporary 10-bed hospital opened on Poston I on May 17, 1942. Indeed, every person who could work was needed – only two weeks later the camp population swelled to approximately 5,500 individuals. Two BIA nurses, three Japanese American nurses, and five American Red Cross nurses would work with the Principal Medical Officer, six Japanese American physicians and two medical students.[29] The needs of the camp quickly outgrew the temporary hospital, and so a 25-bed hospital annex, located directly behind the temporary hospital was constructed. This annex had been erected to accommodate the unexpected influx of incarcerees arriving to Poston with measles and other medical conditions that needed immediate medical care.[30]

Nurses would have a difficult time in meeting the immediate health needs of the Japanese Americans as they arrived at Poston. Although the WCCA and USPHS had guidelines for exempting certain individuals from being transported to the incarceration camps due to disease or disability, many Japanese Americans were sent on long journeys in poor physical condition. Nearly 500 of the approximately 5,500 Japanese Americans that had arrived at Poston by the end of May 1942, had some degree of disability noted in their medical record. The PMO felt 96 of the 500 should not have been transported until the hospital was in a more ready state to receive them. A brittle diabetic patient required hospitalization for insulin shock after arriving to Poston; nine individuals had to be hospitalized immediately as they presented with measles; a young

mother had been transported only days after giving birth; two individuals with serious and active cases of suspected tuberculosis arrived. The lack of physical space, supplies, and nursing personnel meant that not all cases could be hospitalized for assessment and treatment.[31]

Colonel Karl Bendetsen of the WCCA blamed the USPHS for these events: "These reports indicate a laxity on the part of the Public Health Service in carrying out their functions in connection with the evacuation program."[32] Public health officials responded strongly, claiming that individuals sent to Poston met the criteria for transfer when initially examined. In addition, certain individuals that had been offered institutionalization, rather than incarceration, declined these offers, desiring instead to keep their families intact.[33] While true that some of these individuals may have been in fair and stable condition at the WCCA stations prior to their arrival at Poston, the PMO believed heat exhaustion and stress acquired en route to Poston led to the unnecessary demise of one Japanese American, a chronic invalid, only a day after her arrival at Poston.[34]

On June 18, 1942, the nurses at Poston transferred patients and the limited supplies from the temporary hospital buildings to the main hospital, even though construction workers had not completed its construction and critical equipment had not yet arrived.[35] Nurses boiled operating room instruments on the kitchen stove and sent supplies that needed sterilization to a local American Indian hospital until a proper sterilizer arrived. Laundry facilities were not completed until January 4, 1943. Until then, a facility approximately 175 miles away in Banning, California, laundered the soiled hospital linens. The distance did not facilitate a regular transportation schedule; hospital linens would not return for weeks, causing a shortage in linen supply. A small hand laundry across the street from the Nurses' Quarters washed the nurses' uniforms, a service usually provided by hospitals at this time.[36] Initial large shipments of hospital

supplies came in early June from the closure of two nearby temporary detention centers in Arizona, followed by a large drug shipment from the Phoenix Indian Sanatorium and Phoenix Indian Hospital in early July 1942. The U.S. Army shipment of supplies and equipment finally arrived early August, 1942.[37]

Nurses would have to improvise to deal with other shortages. By this time the hospital had been open for two months, and although the hospital had capacity for 250 beds, 24 cribs, and 20 bassinets, the actual availability was 78 beds, 6 cribs, and 11 bassinets. Three wards were open, with the fourth scheduled to open shortly. These were: Ward 4, a 30-bed ward for tubercular and chronically ill patients; Ward 5, a 30-bed medical-surgical ward; and Ward 6, a 20-bed obstetrical ward with 5 cribs and space allotted for 20 bassinets. With 12 newborns and only 11 bassinets available, nurses improvised using boxes until more bassinets arrived.[38] By mid-September, 1942 a fourth ward had opened, and the hospital maintained an average daily census of 100 patients.[39]

One RN, one Japan-trained nurse, and two nurse aides worked alongside two physicians, four orderlies, two secretaries and two pharmacists in the outpatient clinics that were located on Poston II and III. Their goal was to address the routine health needs of Japanese Americans living at those camps. They were responsible for Poston II's population of 5,000 Japanese Americans. The clinic was open for two hours in the morning and two hours in the afternoon, Monday through Friday. The clinic was open on Saturdays for morning hours only. An ambulance delivered any serious cases to the clinic or hospital in Poston I. Specialty clinics ran as needs and staffing dictated; initially, a prenatal clinic ran on Wednesday mornings and a well-baby clinic ran on Fridays. Although Poston II incarcerees desired an infirmary, Snavely and

clinic physicians thought it wiser to transport individuals in need of minor surgeries and hospital care to the hospital in Poston I.[40]

Nurses working at the clinic at Poston III had similar experiences to those working at the clinic at Poston II. A temporary clinic had opened on Poston III in early August, 1942, prior to the opening of the permanent clinic on December 13, 1942. Personnel shortages were anticipated as employees relocated for jobs or education outside of camp.[41] Early public health efforts on Poston III focused on completing vaccination series for typhoid, diphtheria, and small pox. Many individuals had either begun or completed some of these vaccinations at the temporary detention centers, and so nurses completed this work relatively quickly.[42]

Collaboration between nurses and physicians would be imperative for the health section to provide sound nursing and medical care. Leo Schnur, MD, was the first Director of Health and Sanitation, or Principal Medical Officer, at Poston. Snavely tasked Schnur, a BIA physician who had lived and worked on a number of Indian reservations, to establish the health section at Poston. Schnur remained at Poston only until the end of July 1942, when he was called onto active military service. In this short time, Schnur set the tone and expectations of the medical staff straightforwardly:

> We must learn to work as an organization. It is not our doing that we are here, and we must make the most of it. …Let us be reasonable. Do not expect to have everything done in the manner you have been accustomed to.
>
> If there are complaints to be made or some requests wanted, please come to me first.
>
> There has been some agitation from our division. It will not be tolerated. Such agitation is disturbing the community and will have to be stopped. We are going to be here and so accept it and be the kind of leaders that are expected of this unit.[43]

The cause and degree of the medical staff's agitation and discontent at this time are unknown, but seem to have been related to the chaotic west coast exclusion, and lack of adequately equipped health care facilities at Poston. Schnur's short speech no doubt quickly captured the Japanese American physicians' attention. Schnur's words lacked empathy, but his goal was to appeal to their sense of duty as physicians and leaders in the community. Schnur also reminded the physicians that the white health staff were at Poston to help the incarcerees provide sound health services – not to be their guardians or keepers. Schnur left Poston to join the Army August 1, 1942. Little is known of A. Pressman, MD, who arrived two weeks later to become Poston's next Principal Medical Officer. [44]

The First Nursing Leaders at Poston: Hosmer and Brouillet

Gertrude Hosmer, BIA District Supervisory Nurse, was the first nurse to arrive at the Poston camp in early April 1942, to help receive and process incarcerees and establish the hospital and nursing service. (See Appendix F for a photo of Hosmer as she examines incoming incarcerees) Hosmer was detail-oriented, took her nursing responsibilities seriously, and respected the chain of command within the BIA. She frequently contacted Jeffries, her superior, to advise her of routine matters as well as to seek input to improve upon her performance.[45] She remained committed to establishing an excellent nursing service at Poston, writing to Jeffries that she should plan for her to remain on site for some time, until a "chief or head nurse arrives and is well established. The date cannot be predicted at this time."[46]

Cora A. Brouillet, RN, also of the BIA, was Poston's first chief nurse. Brouillet, a graduate of Providence Hospital in Holyoke, Massachusetts, served as an American Red Cross nurse prior to her appointment with the BIA. At the time of her appointment to Poston, Brouillet

had more than 20 years of nursing experience, including faculty appointment at the Haitian General Hospital School of Nursing in Haiti.[47] Brouillet was joined at Poston by some Japanese American nurses who volunteered their services and arrived early to assist in establishing the hospital. American Red Cross (ARC) nurses from Los Angeles and Phoenix also volunteered their services in the first few weeks and months of the hospital's opening, until permanent personnel arrived and the needs of the camp were ascertained.[48]

Among these ARC nurses was Yasuko Kobayashi, a Japanese American nurse who was registered as a First Reserve ARC nurse in her home community in California. Kobayashi arrived with other Japanese American incarcerees, but had been contacted for possible service at Poston by the Chairman of the local Red Cross prior to her arrival. Although hopeful that she would work and receive remuneration as an ARC nurse, Project Director Wade Head and Principal Medical Officer Schnur confirmed that she was an incarceree and would be recognized and paid as such. Head and Schnur also informed Kobayashi that she would work under the direction of Poston's chief nurse, and not the ARC.[49] Although the outcome was not ideal for Kobayashi, these actions conformed to WRA policies and provided clear guidance of the hospital organizational structure from the outset. Kobayashi had little choice but to accept these terms and built upon her five years of obstetrical training to become supervisor of Poston's obstetrics ward and delivery room until she left the camp in mid-1943.[50]

Nurses worked hard to establish a functioning nursing service at Poston. Although Schnur complained about the lack of progress in securing supplies and equipment for the hospital, he was pleased with the nurses' work. As soon as the temporary hospital opened, a nurse aide training program had begun with 12 Japanese American young women enrolled in the class.[51] The program continued to develop the next month as an ARC nurse led the class that

now included a total of 33 Japanese American women.[52] The training course followed a curriculum that Schnur had developed in his work for the BIA.[53] This serves as one example where Poston utilized established BIA procedures as foundational protocols in building and administering an organized health service.

In spite of a shortage of nursing personnel that persisted from the time the camp opened, administrative leaders refused to tolerate unprofessional behaviors from the nurses. Administrators terminated nurses who displayed unethical behavior or poor attitudes, or whose work ethic did not adhere to professional standards. One ARC nurse who responded defensively and in a "brusque manner" to the spouse of a maternity patient, was terminated after barely three days of work. Another ARC nurse was put on notice for her "inability to work hard."[54] All hospital staff would be expected to conform to high ethical standards at all times.

The Arrival of Elizabeth Vickers, Senior Chief Nurse

Permanent nursing personnel slowly began replacing the temporary BIA and ARC nurses. One of these nurses was Elizabeth Vickers, who arrived at Poston in June 1942. Schnur was especially pleased with Vickers as she assumed responsibility for the nurse aide training program. Given the shortage of nurses and nurse aides, the training program required Vickers' full attention in order to ensure that a constant supply of nurse aides were ready to work. Vickers began this work by sorting through approximately fifty applications from Japanese American women who wanted to begin the program.[55]

Elizabeth Vickers, RN arrived at Poston not as Senior Chief Nurse as she had expected, but to work under Brouillet. Highly recommended by another BIA nurse, Vickers was almost detailed to another WRA hospital to assume her promised role as Senior Chief Nurse. But the

BIA needed Brouillet to return to her work with them. In addition, Poston's dust aggravated Brouillet's breathing, which had been compromised from a past tuberculosis infection.[56] Vickers eventually secured the role of Senior Chief Nurse, and retained this position until September 24, 1945, just two months prior to the closure of the hospital and camp.[57] She obtained her nursing education at Union Memorial Hospital in Baltimore, Maryland, and earned a Bachelor of Science degree from Columbia Teacher's College in New York. She was director of the school of nursing and of nursing services at Greenville General Hospital in South Carolina prior to arriving at Poston.[58] Vickers' leadership and dedication to her responsibilities and staff, along with her relationship with the BIA and WRA while employed at Poston, all combined to establish Vickers as a respected authoritative figure.

Several inspections took place during the early weeks and months under Vickers' leadership. Hosmer, BIA District Supervisory Nurse, was already familiar with Poston when she returned at the end of July 1942 to evaluate the rendering of nursing services, and to give assistance or advice as needed. At this time, Vickers was responsible for nine appointed nurses, five Japanese American nurses, five Japanese American student nurses, and 84 other various employees. The additional employees included nurse aides, orderlies, dietary staff, janitors and housekeepers.[59] Kitchen services and supervision were clearly established early in the development of Poston. The Chief Steward was responsible for securing food supplies to the hospital kitchen and mess hall. Hospital kitchen employees and all other aspects of kitchen work would be under Vickers' supervision.[60] The clearly defined organizational structure left no doubt on the part of kitchen workers as to whom they would report. This lies in sharp contrast to the disorganization and difficulties that Heart Mountain experienced in determining who had authority over this division.

Supervision of nurses assigned to the outpatient clinics fell initially under the direction of the physician in charge of that particular clinic.[61] This division of organizational structure surely caused some frustration and confusion for everyone involved. Vickers expressed concerns to Snavely early in her service at Poston that indicated problems with this administrative structure. Vickers required authority over all nurses if she was to deliver a successful nursing program. Snavely had been "quite pleased" with Vickers' efforts in organizing the hospital and nursing service, and so directed Project Director Wade Head to provide Vickers with written instructions that she was to "…assume charge of all nursing activities in the hospital, the out-patient department and the dispensaries."[62] Snavely understood that such a document would provide Vickers with the proper authority to effectively organize and administer the Poston nursing service.[63]

Early Problems in Poston's Nursing Service

Following Hosmer's review of the Poston nursing service in July 1942, she noted the following problems:

1. Unwillingness of graduate nurses trained in Japan to work with graduate Japanese nurses trained in the United States.
2. Training and supervision of nurse aides.
3. Delay in receiving supplies and equipment both for the hospital and the quarters.
4. Need of Caucasian nurses.
5. More supervision for the nursing service in the wards both night and day.[64]

Hosmer had faith in Vickers' ability to lead the nursing service despite these problems, some of which, such as receipt of supplies and equipment, were beyond her control. The problem of getting Issei and Nisei to work together was a problem that extended to other departments of the health service. There were language barriers and cultural differences that both groups struggled to understand in one another. Vickers acknowledged the differences existed, and did seek to understand the Issei and Nisei perspectives, especially within the extraordinary context that surrounded them. Vickers was much more empathetic than Schnur as she reflected in writing:

> There are many customs and attitudes among the Japanese that are strange to us just as many of our ways seem incomprehensible to them. … We have had to keep ourselves reminded that we have a group of people brought here against the will of most of them and under no circumstances should we expect them to abandon their way of life to adopt ours overnight nor can we expect them to accept the changes that evacuation has brought without marked reactions of one kind or another.[65]

Hosmer's report had noted that the Issei and Nisei nursing staff refused to work together. Vickers needed to make full use of whatever nursing staff was available, and so responded to this situation by assigning Issei nurses to the out-patient clinics while the Nisei nurses were assigned hospital duty, thus minimizing their contact with one another. This philosophy would prove to be a key difference between the management style of Vickers and the chief nurses of Heart Mountain, Wyoming. Whereas Heart Mountain chief nurses were rather rigid in their interpretation of WRA policies and procedures, Vickers accepted the casual attitude of the Japanese American hospital workers, whether it was that they preferred working in groups, visited each other often while working, or took frequent breaks to enjoy some refreshment

together. [66] Vickers realized that the events of the incarceration and camp living were traumatic and restrictive enough without her adding unnecessary stress to the incarcerees' lives. Japanese Americans appeared to respect Vickers and the hospital environment, as no evidence of their abusing her trust could be found.

Although incarceration violated the constitutional and civil rights of the Japanese Americans, it did offer some unexpected opportunities for some Issei women. Once at the camps, many Issei women participated in clubs that celebrated traditional Japanese culture, learned English, and went to work in jobs that interested them or ones in which they had prior experience. One Issei woman, Mrs. Minoli Mukaeda, graduated in 1915 from a hospital nursing school in Los Angeles. She married soon after and left nursing. At Poston, Mukaeda, then a personnel barracks housekeeper, became friendly with Vickers. Mukaeda revealed her nursing background, and slowly eased back into nursing, first by becoming a "…hospital housekeeper, arbitrator in labor relations at the hospital, housemother in the nurses' home, and diplomatic advisor to Dr. Pressman and (Vickers) on many occasions in administrative affairs having to do with personnel."[67] Vickers also entrusted Mukaeda with presenting the Report on Hospital Housekeeping, Supplies and Laundry in a February 1943 meeting that included Snavely and all major and minor leaders in the Health Section.[68]

Mukaeda, as an Issei, would have been ineligible for registration as a nurse as she lacked U.S. citizenship.[69] Regardless of licensure status, Mukaeda soon felt confident to enter nursing service again, quickly becoming the hospital nursing supervisor from 4:00 PM to Midnight.[70] Surely Vickers would not have given this enormous responsibility had she doubted Mukaeda's abilities. After only two months in this role, Mukaeda left Poston in September 1943 to accept a nursing position at Methodist Sanatorium, a small church-operated facility in Albuquerque, New

Mexico.[71] In a letter to Snavely, Vickers recalled Mukaeda's contributions to Poston's nursing service:

> Mrs. Mukaeda did a splendid piece of work here from the time she arrived in Poston until the day before she left for good. I feel that we are very much indebted to her in a great many ways and that our hospital organization would not have functioned nearly so well without her contributions.[72]

Vickers often spoke highly of her staff in personal reports, letters to others, and during the frequent hospital inspections.[73] Vickers was clearly proud of Mukaeda's accomplishments, especially the fact that she was able to secure a successful position outside camp. Mukaeda likewise, held Vickers in high regard.[74] Vickers also appreciated the nurse aides, particularly considering the hospital could not operate without them. A total of 141 young women received training in the first 18 months of the Poston nurse aide program. The time to program completion varied from a few months to a year. Nurse aides trained in the hospital and the clinics in Camps II and III to gain a variety of experiences. The nurse aides had become so proficient in their work that eighty of these women had eventually qualified for permanent positions or further education outside the camp. The University of Michigan Hospital hired 12, followed by 7 or 8 in Cleveland, 6 or 7 in Philadelphia, and five enrolled in nursing schools. Vickers encouraged young Japanese American women to enter nursing and secure nursing education, and implored all Poston RNs to promote the nursing profession as a rewarding career.[75] Vickers stated:

> We are very much pleased with the aides as they have been able to fit nicely into most of the services considering them from the standpoint of their training and length of time they have been here. The aides are making a splendid contribution to their community and are also making a good showing on the outside. Fairly large numbers have gone into some

> sort of hospital work and others directly into nursing schools. Of the 84 evacuee girls admitted to various nursing schools, 1/5 went from Poston.[76]

In the first several months of hospital operation, Vickers saw 16 registered nurses, most of whom were white, come and go as staff at Poston Hospital. It was at this point that Vickers "felt justified in assuming that the strength and stability of our nursing service must be built largely around our nurse aide program."[77] The nurse aide training program was planned with a higher level of theory and practical experience than most nurse aide programs, given that many aides would soon be performing nursing duties, such as medication administration. Vickers also felt that the additional learning and responsibility would keep the women interested and stimulate efficiency in their work.[78] In order to successfully complete the course, students were required to attend all lectures and pass final examinations. In the first group of 12 graduates, however, only three had met all the technical requirements to pass the course and receive a certificate of completion. After some deliberation with the physicians who assisted in giving lectures, Vickers decided that the nurse aides' commitment to the nursing service over the past year far exceeded their ability to complete final examinations. "Those twelve have been with us faithfully during the twelve months. They were with us through difficult times."[79]

Vickers' dedication and commitment to developing the nurse aides did not go unnoticed by them. Kimiye Okuno Takeuchi Ariga recalled that Vickers granted her special permission to enter the nurse aide class so she could be near her chronically ill mother who lived in the hospital nearly the entire time they were incarcerated at Poston. Ariga remembered,

> Naturally with (mother's) constant heart attacks, I had to be closer with her. The Nurse Supervisor, Ms. Vickers allowed me as a special case. I was very fortunate to be taken under her kind wing. She helped me a lot in more ways than one. We had our classes to

> attend. One day a year later, we were the first group in all the internment camp to graduate. We got our caps and diploma, just like high school graduation. Then we worked hard and also helped train the next group of nurse's aides. By the way, Ms. Vickers tried real hard for us to get a special nurse's certificate, but it didn't clear through the bureaucrats. Anyway, she really tried for all of us and I highly respect her.[80]

Developing the Nursing Staff

Vickers had a strong work ethic and expected the same from others. After completing her daytime administrative duties as Chief Nurse, she taught the nurse aide classes at night until assistant chief nurse Augusta Kirchner arrived in early December 1942 to take on this duty.[81] Because the hospital laundry service was not in operation during the first six months, Poston laundry workers, nurse aides, graduate nurses, and at times Vickers, filled the gaps in service from the California laundry service by laundering hospital linens in the camps' three Maytag washers and clothes line located near the temporary hospital building. During this time, Vickers and her staff also laundered their own uniforms, a service usually covered by most hospitals during this time. [82]

Vickers held her first nursing staff meeting soon after administrators formally appointed her as Poston's Senior Chief Nurse Staff meetings, and she essentially continued these on a monthly basis. Vickers addressed sensitive topics, such as nursing discontent, in a straightforward manner, by encouraging nurses and student nurses to voice the sources of their discontent and frustration. Both Japanese American nurses and white nurses conveyed feelings of happiness and commitment to the camp, while nurses from both groups also discussed the

difficulty in living in such a harsh environment. Japanese American nurses were eager to leave to earn better salaries. [83]

After listening to the nurses' concerns, Vickers offered practical solutions to combat their feelings of loneliness and address the lack of recreational opportunities at Poston. Vickers suggested forming a "Poston Nurses' Society." All nurses, including those trained in Japan, would be invited to join. Two Japanese American nurses were charged with contacting the nurses and organizing the first meeting. The purpose of the group was to be determined in the first meeting.[84] To further boost morale, Vickers also involved a committee of Japanese American nurses to select furniture for the new living room in the nurses' quarters.[85]

Despite Vickers' good intentions, a rumor began circulating that Vickers was blocking the release of nurses.[86] Vickers, seemingly aware of this rumor, announced at her March 1, 1943 nursing staff meeting that relocation was indeed the desired goal for all Japanese Americans in the Health Section, and every effort to accommodate requests for relocation would be made, so long as applicants comported themselves in a professional and respectful manner, including refraining from "petty prejudices, jealousies, and in circulation of rumors…"[87] Vickers announced that plans for outside employment and indefinite leave from the camp could commence in March 1943. Vickers dangled the opportunity to leave as reward to encourage good behavior from the now restless group of nurses who desired to leave.

> …outside employment was very much favored in the Health Division as a logical means for the nursing group to become re-established in civilian life, that it must be recognized that leave clearance would be granted only when the individual applying for it was felt to be a representative member of the Japanese group…The nurses were reminded that recently unsatisfactory attitudes in some of their members had been noticed…They were

> reminded as a group that … they must conduct themselves in a professional manner showing the proper respect for the doctors, their co-workers, and themselves.[88]

This could have been interpreted by some of the Japanese American nurses as an attempt by Vickers to prevent the Japanese American nursing staff from leaving camp. However, her efforts to build up the nurse aide staff indicate she accepted a permanent shortage of nurses would exist. She was also quite proud of the staff who were able to secure positions outside of camp. A more plausible explanation for her comments is that Vickers did not want behaviors of others, once outside the camp, to hinder the chances of those still within the camp of finding suitable employment.

Vickers realized much of the American public still hated the Japanese Americans, and so it was critical that Japanese Americans leaving camp become exemplary citizens. One nursing school in Phoenix, Arizona, accepted only one student from Poston, only because she had been there prior to the war. Although the nursing staff and school thought little about her continued presence after the Japanese bombed Pearl Harbor, patients at the hospital were cruel. Even some physicians berated her, as well as the nursing faculty, for keeping her in the school. The student was eventually incarcerated at Poston. As soon as the school learned that incarcerated students could begin relocating, they contacted Poston and asked for her release. This was not done lightly, however, as people were still quite discriminatory against Japanese Americans in Arizona. State officials, the Farmers of Arizona, and the Phoenix Chamber of Commerce publicly denounced the population.[89]

Vickers allowed an open discussion following her comments where the nurses could voice the reasons for some of their unprofessional behavior. Two Japanese American nurses decided they were no longer interested in working. They felt they had been unfairly blamed in

participating in gossip and the breakdown in professional attitudes of the nursing staff. [90] The unprofessional attitudes continued, and Vickers was forced to take a firmer stand. Nurses continued gossiping and demanding their own schedules and ward rotations. In fact, physicians commented the less experienced and educated nurse aides had been far more professional than the nurses and student nurses. Vickers noted,

> …there cannot be individual favoritism or prejudice shown among the Japanese or Caucasian nurses…the service is not going to be interrupted by those few who continue to do the bickering and quibbling – they will just be asked to leave the service at once. If the case should arise that only two or three will remain on duty, it was still perfectly alright…[91]

Vickers held the same expectations for all nurses and nurse aides under her direction. When a polio outbreak hit Poston in 1943, a technician experienced in the Kenny Method of treatment was sent to train nurses, nurse aides, and public health visitors in this highly specialized form of care. Snavely arranged for some BIA field nurses to visit Poston and receive this training for implementation in their assignments at various Indian Service agencies. One of the BIA nurses attending the training refused to do the hands-on learning, and "…openly expressed anti-Japanese attitudes and ideas in the presence of Japanese patients and nurse aides."[92] The nurse's unprofessional behavior prompted Vickers to submit a formal written report of her conduct. The report was not included with other documents discussing this situation, but Vickers' indignation is clearly communicated through other letters.[93]

Because of the constant turnover in staff, Vickers frequently reviewed nursing policies of routine procedures with her nurses. These included overall shift responsibilities and supervision of nurse aides, and more specific procedures such as collection of sputum, insulin administration,

and admission and discharge procedures. The nurses tried to be diligent in their work, and participated actively in the staff meetings.[94] Vickers also encouraged the nurses to explore other areas outside their ward work. Hammond, Vance, and Terry, three black nurses, were the only nurses who took advantage of the opportunity to gain additional work experience. Hammond and Vance desired public health training, and so public health nurses made plans to introduce them to public health record keeping. Terry expressed interest in teaching, and so plans were made for her to help instruct in the Child Care Teaching Program, where mothers learned about child diets and other basics of child care. In addition, all three nurses would be rotated to special clinics, hospital staffing permitting.[95]

Securing Nurses for Poston

Poston's unique affiliation with the BIA meant that the BIA was also in charge of securing nursing personnel. Jeffries began her investigation into required staffing levels in mid-February, 1943. The base salary for a staff nurse was $1800 yearly, with payment for overtime. Most nurses worked 44-48 hours per week, and so could earn on average an extra 21% of their base salary, or nearly $400 extra per year.[96] Jeffries worked with Snavely, Vickers, and Poston Project Director Head to determine the number and type of nurses that would be needed and able to cope with the austere living conditions at the camp. As Japanese American nurses began expressing interest in relocation outside the camp, preparations had to be initiated in finding their replacements. Jeffries considered transferring some BIA nurses to Poston for extended periods.[97]

Another method to increase the number of nurses at Poston was to provide a place where the student nurses could complete their schooling and graduate. Jeffries contacted the Arizona State Board of Nurse Examiners, on behalf of Vickers, to request that student nurses be able to

complete their nursing curriculum at Poston hospital. Jeffries hoped the board would grant student credit for their work at Poston so they would be eligible to sit for the Arizona licensing exam.[98] Although an official program to complete nursing school requirements at Poston never materialized, Fresno General Hospital Nursing School in California granted credit to one student nurse for completing the last part of her training based on her work at Poston.[99]

By the end of April 1943, Snavely informed Head that they had been unsuccessful at locating any registered nurses. It was at this time that the use of black nurses had been discussed. The BIA had already been using the skills of at least one black nurse, and Snavely would attempt to persuade her to work at Poston if Head was so inclined. In addition, Jeffries had contacted a black nurse on the Civil Service Register, who accepted a Poston assignment. The nurse, unable to persuade another black nurse to join her at Poston, decided to decline the position, as she did not wish to be the sole black nurse on staff at Poston.[100] Appendix F reveals the grim statistics of the number of medical personnel distributed throughout all ten WRA camps.

By June 1943, all the camp hospitals were in dire need of nurses. Many appointed nurses were leaving for employment elsewhere or to join the Army or Navy. Most of the Japanese American student nurses had been accepted as students in nursing schools in the Midwest and East. Nurse aides were offered and accepted positions at facilities outside of the camp. Thompson, Chief Medical Officer for the WRA, could only proclaim his sympathy with the camps' incessant requests for nurses. He did grant permission for Vickers and Jeffries to contact Mrs. Frances Gaines, President of the National Association of Colored Graduate Nurses, to obtain black nurses for work at Poston. The Gila River camp, also in Arizona, had already successfully employed two black nurses at this time.[101]

Poston finally welcomed its first black nurse, Lydia Vance, in July 1943. Jeffries' contact from Chicago arrived soon after. Vickers thought the black nurses would make a solid contribution to the Poston hospital nursing service, and they did.[102] These nurses were among the few that stayed at Poston until well into 1945. The black nurses worked well amongst the incarcerees. When asked how Japanese Americans felt about the presence of the black nurses, one Issei administrative worker noted:

> Mostly, the people here don't think about the fact that some of the nurses are Negroes. They like them if they do a good job. A person or two (who are not representative) don't like them; I heard about a patient who complained about the nurses; mental difficulties could cause this. The Japanese sympathize with the Negroes as another minority group.[103]

Nursing Work in Poston Hospital

Hospital nurses cared for individuals suffering from illnesses such as cancer, heart disease, and stroke. Tuberculosis and pregnancy were two of the most frequent types of hospital admissions at Poston. In an effort to begin identifying individuals infected with tuberculosis, the medical staff implemented routine chest X-rays for all patients admitted to the hospital beginning in November 1942.[104] Tuberculosis treatment depended on how far advanced the disease presented itself, but rest, nutrition, and fresh air were always major elements of treatment. Physicians performed pneumothorax and pneumothorax refills for the tuberculosis patients.[105] These treatments involved collapsing the lung by introducing air or gas into the plural cavity. The goal of this treatment was to reduce movement of the diseased lung, thereby allowing it to rest and heal.[106]

The nurse's role in preparing and caring for individuals receiving pneumothorax treatment was extensive. The equipment had to be sterilized, assembled, and arranged in proper working order. Patients also had to be carefully monitored for complications, as a collapsed lung under ordinary conditions is often fatal.[107] Care of individuals with tuberculosis followed special guidelines. Metal cups held paper inserts for patients to expectorate – the paper cups were wrapped and placed in a separate container for burning. Soiled linen coming from the tuberculosis ward was separated from other soiled hospital linens. Patient trays were sent to the kitchen and immersed in a disinfectant solution and washed separately. Nurses wore gowns over their uniforms and masks to cover their mouth and nose.[108] These tuberculosis nursing care procedures conformed to nursing texts of the time and were similar to how care was delivered in the Phoenix Indian Sanatorium.[109]

The BIA owned and operated the Phoenix Indian Sanatorium, a 150-bed facility that cared for tubercular patients only. [110] A preliminary tuberculosis survey at Poston had identified at least 131 individuals with tuberculosis, with 35 of those cases requiring hospitalization. The beds in the tuberculosis wards quickly filled and a lack of nursing personnel prevented additional hospital admissions. Pressman, Poston's Principal Medical Officer, looked to Snavely to determine whether the Phoenix Indian Sanatorium might accommodate an overflow of Poston's patients. The sanatorium superintendent agreed that if the WRA paid the standard daily rate of $3.75 per patient, the sanatorium could provide for the additional patients.[111]

The number and availability of nursing staff determined the number of wards and beds that remained open to care for patients. Individuals hospitalized at Poston or institutionalized at the Phoenix Indian Sanatorium varied over the years, however, tubercular patients usually comprised roughly half of those hospitalized at Poston. At a January 1944 nursing staff meeting,

Vickers stated that 20 Japanese Americans were institutionalized at Phoenix Indian Sanatorium, and 48 of the 90 patients in the hospital were tubercular cases. Additional space was reserved on Ward 3 for an additional 33 tubercular patients, if needed. At this time, Poston's tuberculosis rate was estimated to be roughly equivalent to the rate across the rest of the country. So while many Japanese Americans were diagnosed with tuberculosis while at Poston, the number did not appear to be in excess of normal. Causes of death seemed to support this, as the main cause of death in Poston was due to cardiac failure, then carcinoma, followed third by tuberculosis. The birth rate was four times the death rate, indicating a growing population.[112]

The large population of young Nisei at the camp meant that obstetrical care was of primary importance in the camp. Within the first three months of the camp's opening, 27 babies had already been born.[113] Premature births were of special concern during this time at Poston. The oppressive temperatures in the hospital nursery reached 130-140 degrees Fahrenheit. The excessive heat was blamed for the death of two premature infants who died while in the nursery. The events sent the Japanese Americans into an uproar as they demanded better conditions for vulnerable individuals under hospital care. The hospital quickly secured "coolers," and installed them throughout the hospital, including the nursery and nurses' quarters.[114] Nurses developed a 2-page information sheet that instructed mothers in special care considerations for these special babies.[115]

Poston averaged 20-25 births per month. Despite the availability of pre-natal clinics, Vickers could not estimate the number of deliveries that were expected each month, as some women did not attend these clinics. At the clinic on Poston I, some women were advised not to come for pre-natal care if they were otherwise feeling well, due to the physician shortage. It is unclear whether physicians or nurses discouraged attendance. However, it was clear that more

work had to be done to encourage regular attendance. A Japanese American midwife ran the pre-natal clinic at Poston II, and was doing a "splendid piece of work" there.[116]

Japanese Americans introduced the role of midwives at Poston early in the camp's development. A representative of the Block Managers indicated the incarcerees desired midwifery services. One Issei physician felt midwives could be of valuable assistance to the physicians at Poston. However, all medical staff were aware that midwives would not be performing deliveries in the barracks or in the hospital. The WRA officially banned employing Japan-trained midwives to deliver babies in the camps, but their role in Poston's health service was yet to be determined.[117]

Midwives trained in Japan were known as *sanba*. After the Meiji Period (1868-1912) was ushered in, providing education for women and adopting western medicine became part of Japan's modernization efforts. The German medical model was especially appealing to Japan, and heavily influenced Japanese medical and midwifery reform, training, and licensing. Elements of traditional Japanese medicine, or *kanpō*, remained to develop the unique role of the *sanba*, the modern, licensed midwife.[118]

Many Japanese *sanba* arrived as "picture brides" to Japanese men already in America. Those who settled in rural California, Oregon, and Washington essentially gave up their professional practice to do agricultural work alongside their farmer husbands. Rural *sanba* practiced informally, delivering their fellow Issei, as well as some Mexican Americans. Many *sanba* who settled in urban areas, such as Seattle or Los Angeles, built lucrative careers delivering Issei babies. Life as a *sanba* afforded ambitious, entrepreneurial Japanese American women a career that fostered independence and self-sufficiency. It also provided emotional and social support to the childbearing Issei who left their extended families in Japan, as well as a

cultural connection to the Japanese way of birthing. By the 1930s to early 1940s, Nisei women wanted modern, hospital deliveries. Whether the incarceration had come or not come, the Americanization of the Nisei, the advancement and acceptance of science, and the aging and declining number of Issei and *sanba* signaled the demise of the *sanba* in the United States. [119]

As the number of physicians at Poston dwindled over time, the idea of midwives practicing in the hospital was proposed again by one of the Japanese American physicians. The proposal was for midwives to practice in the hospital or outside the hospital, under the supervision of Vickers or Pressman, and a physician would only be called in per the midwife's request. The other Japanese American physicians were against the proposal, stating that midwives, although possessing licensure in California, did not meet with the government's definition of meeting medical standards of care. Physicians believed only other physicians were capable of providing adequate medical care per their interpretation of the U.S. government's expectations of providing adequate care. Physicians were "definitely opposed to opening the hospital for midwifery;" they were more accepting of having the nurses deliver babies, rather than allow midwives in the hospital. "Why can't the nurses do that? Why bother with the midwives. Our nurses here…and the appointed nurses here are probably just as capable and just as trained to make deliveries."[120]

Although nurses were in short supply and had to adapt their methods of care through delegation to nurse aides, they were nevertheless expected to adapt to the physician shortage as well. Physicians first decided to delegate history taking, a key component in diagnosis, to a young woman in the Medical Record Library Office. Before long, nurses and various other hospital staff were asked to take patient histories. Nurses expressed their objections over the delegation of patient history taking to Vickers. However, the resolution of this care issue is

unclear.[121] After losing a physician in the Poston II clinic, physicians also determined that registered nurses would be able to care for the "minor" cases that came to the clinic.[122] Only two months earlier this practice had been forbidden.[123]

The Problem of Inadequate Staffing Affects Patients

Nurse staffing came under scrutiny after a 45 year-old woman died in the hospital following a hysterectomy. The Temporary Community Council chairman complained that nurses did nothing extraordinary to help the woman. Medical records clearly indicated the frequency the nurses attended the patient, but the nature of those interactions were not clearly documented. The complaint also alleged that physicians were not readily available to attend the woman. However, the records indicated that a physician saw the patient twice, described her condition, and prescribed medications. Moreover, physicians resided in quarters connected to the hospital and could be easily retrieved whenever needed.[124] The complaint asked whether the patient could not have received special attention or been allowed to have a family member or special nurse at the bedside, given the patient's critical condition. The husband and son also complained about being sent home after visiting hours, despite them having a bad feeling about the patient's condition.[125]

Vickers' investigation into the complaint indicated that she may have been offended by the suggestion that nursing care had been inadequate:

> From our point of view, this patient received both adequate nursing and medical care. We are very sorry if her family was not entirely satisfied with our service. We do sometimes feel justified in reminding people that it is impossible for us to provide deluxe service here just as it is now impossible for most hospitals in the country to provide such a service due to the limitation of trained personnel. Special nurses do not exist in Poston.[126]

Yet the husband insisted the intent of his complaint did not stem from dissatisfaction with the nursing service per se, but to shine light on the inadequate hospital staffing. He stated his wife had prior surgeries in Los Angeles and had not been allowed any water for some time after the surgery, yet after her surgery at Poston, an attendant provided her with water. Two days after the surgery, the woman's abdomen became distended and she complained of pain, with nausea and vomiting.[127] The standard of care for this type of case varied. For postoperative cases involving surgery on the gastrointestinal system, food and fluids were generally held for a minimum of 48 hours, as the husband had observed in his wife's prior surgeries.[128] In other surgeries, the general guidance was to advance oral fluids and feedings after the effects of anesthesia had worn off.[129] There is insufficient detail to know fully what happened in this unfortunate case. The attendant may have followed physician orders in providing water for the patient or, an inexperienced attendant lacked the proper nursing supervision and so erred in providing the water. In either case, the woman's death most likely did not result from drinking water. Clearly, the woman had not been a good risk for surgery. She had a history of prior surgeries and arrived at Poston hospital in such a weakened and anemic condition, that she required blood transfusions and other measures just so she might be able to withstand the surgery. [130]

The Japanese American physicians supported Vickers and the nursing service at Poston in connection with this incident. "Dr. Wakatake announced that Miss Vickers received an uncalled for letter from the Camp #3 Community Council complaining about the treatments at the hospital….Miss Vickers is investigating further into this matter since the statements are exaggerated or false in many instances."[131] Although members of the community council had been to medical staff meetings in the past, no representatives had been present at the meetings in

some time. In an effort to restore trust and communication with the community, Wakatake suggested Community Council representatives from all three camps periodically attend the staff meetings. [132]

The collaborative working relationship at the hospital flourished naturally as a result of the many medical staff meetings held as the hospital was established. These meetings included heads of all major departments, including pharmacy, warehouse, X-ray, dental, dietary, etc. Together this team of twenty or more would discuss processes that were working well or required improvements. Vickers was not the only nurse attending the meetings, either. Eiko Kikuchi, RN, in charge of the operating room, often attended these meetings, as supplies and procedures were quite specific to the successful administration of an operating room.[133]

Three Japanese American nurses remained until August 1945. One of these nurses worked at the outpatient clinic in Poston I for nearly the entire time the camp was open. Although she spoke limited English, she remained the clinic's supervisor and participated regularly in nursing staff meetings.[134] The remaining hospital nursing staff then consisted of four black nurses, three white nurses and 34 nurse aides in training to care for 50 individuals.[135]

Poston Public Health Nursing

Poston health personnel began planning for a public health program in early May 1942, at the same time that thousands of Japanese Americans began arriving at the camp:

> A health service was to be provided for that number of people that would include…as much public health service as seemed indicated. What no one knew at that time was how personnel would be found to carry on these services or what were the general health problems of the Japanese people.[136]

Anticipated elements of the public health program included communicable diseases and preventive service, tuberculosis control, sanitation, maternal and child health, public health nursing, dental health, school health, nutrition, public health education, and vital statistics. [137] The public health nurse would play a vital role in many of these areas. However, a lack of trained and experienced public health nurses contributed to the slow onset of a public health program at Poston.[138]

Some aspects of the public health program, such as sanitation efforts and dental service, were already underway when WRA nursing consultant Stuart visited Poston in August 1942.[139] Stuart met with Snavely to share the WRA's vision of public health nursing activities.[140] At most WRA camps, the general procedure called for the public health nurse to report to the Chief Nurse and also to function as the Assistant Chief Nurse. [141] Inspired by Stuart's visit, Snavely assembled a group of five individuals connected with public health in early September 1942, to plan a public health program that would meet the basic needs of the community. Although Vickers was Senior Chief Nurse of Poston, she was not invited to the meeting. Snavely decided the BIA's tested method of including public health nursing as a division within the larger public health program would be implemented. This meant that Vickers would remain in charge of all nursing activities in the hospital, outpatient department, and clinics in Poston II and III. The public health nursing supervisor would work collaboratively with Vickers, but report directly to the Principal Medical Officer.[142]

Snavely realized the tremendous effort in establishing a public health nursing program overnight for a population of nearly 20,000 Japanese Americans. To carry out a standard public health program, Snavely estimated that a minimum of ten nurses would be required. The only nurse at Poston with any public health nursing training was Japanese American Dorothy

Matsumoto, but she had no practical experience in conceiving and implementing a public health nursing program. Snavely began the search for a qualified public health nurse to work with and develop Matsumoto. The nurse that would plan and implement the public health nursing program would require tact, organizational ability, some knowledge of Japanese culture, and experience in public health nursing administration. Snavely believed Helen P. Olmstead of the BIA to be a good fit, but soon thought better of it after learning her husband had recently been reported as missing in action in the Philippines. Additionally, Olmstead's BIA duties in Oklahoma demanded her full attention. Snavely appreciated the unique experience the BIA nurses had in dealing with a minority population, and hoped to find a nurse with similar qualifications to lead the public health efforts at Poston.[143]

The public health nursing program began informally when Sally Lucas Jean, RN, public health nurse and international health education consultant arrived at Poston in October 1942. Jean's professional career had taken her to China, Japan, and the Philippines. She had also been a health education specialist for the BIA, and so even at the age of 64, she gladly accepted the Health Education Consultant position personally offered to her by Collier, her old friend and former colleague. A public health nurse had not yet been identified and so Jean, although appointed as health education consultant, took on some public health nursing tasks in addition to her position in public health education.[144] Her official health education duties would include planning and implementing a program of health education, planning school health programs, and securing and organizing health information applicable and of interest to the incarcerees.[145] Jean's experience and skills were desperately needed, as Japanese American physicians, although capable, lacked the public health knowledge critical for preventing "the spread of

contagious and infectious diseases as their work in life has been to cure rather than to prevent."[146]

Jean worked with physicians to develop regulations to prevent the spread of chickenpox, measles, and scarlet fever. She also coordinated adult health education classes for parent teacher groups, women's clubs, and block managers. Vickers and several physicians presented information on various health promotion subjects, as requested by Jean. She also published short educational pieces in Poston's newspaper, the *Poston Chronicle*. She secured approximately 6,000 pieces of health literature, free of charge, and distributed it throughout the camp clinics, libraries, and schools. She also coordinated with the Art and Health Committee to have posters and signage made, some examples of which include quarantine signs, educational materials, and visual aids. Jean also secured health-related motion pictures, which were viewed by nearly all in the camps.[147]

Jean regularly engaged with the Japanese Americans and supported their efforts in improving camp facilities. One such improvement took place in a women's latrine where the block carpenter fashioned an additional spigot so the hot and cold water would mix and come out as warm water. This device encouraged the children to wash their hands more often, as the water temperature was comfortable, and neither frigid nor scalding. Jean drafted a memo to encourage the installation of such a device in all latrines.[148] Jean also successfully advocated for a drinking fountain to be installed in the school. Prior to this, children had been putting their mouths on the latrine faucets to quench their thirst against the desert heat.[149] The fountain offered a clean source of water and reduced the risk of spreading disease.

Snavely's visit to Poston in the early part of December 1942, revealed that a formal public health nursing program had still not been developed.[150] At this point, a creative solution

would be required to address the shortage of public health nurses. Helen P. Olmstead was again recommended to assist Poston to establish its public health nursing program.[151] Olmstead, a BIA Field Supervisor Nurse in Oklahoma City, Oklahoma, accepted the assignment and arrived on per diem service at Poston in mid-December 1942, to develop a unique Public Health Visitors (PHV) program. As no permanent public health nurse had yet been identified, Olmstead proposed to Snavely that a PHV service be initiated to accomplish the goals of a public health nursing program.[152] Training lay Japanese American women as public health visitors would prove an innovative method to increase the number of direct care providers.

Olmstead identified key qualities the PHVs would require. The PHVs were required to be female and in good health, have a high school education, speak English and Japanese, work a full-time schedule, and have their own watch with a second hand, fountain pen, and pencil. Planning and recruiting for the PHV class occurred over six weeks, with recruitment flyers posted in public areas and classified ads placed in the *Poston Chronicle*, the camp newspaper. Those with prior First Aid or nurse aide training or schooling answered questions on their applications to assess their knowledge. Some questions were quite specific, such as "What are the points to be remembered when applying Iodine?" to more general, such as "What do you remember when feeding a patient?"[153]

The Poston Red Cross suggested some older Issei women for consideration as PHVs, but these were rejected as they could not speak and write fluent English. Fluency in English was essential for completing the myriad forms and record keeping required in the public health nursing program. Several of these Issei had nurse training in Japan, and their "maturity, judgment, experience and ability" would have been valuable to the program. Olmstead, Matsumoto, and Pressman met to consider ways in which to use their skills, and proposed a

home nursing program to be administered by the Poston Red Cross Chapter. These women would provide basic nursing care to individuals in their barracks apartments as prescribed by the physician. The PHVs would be assigned to visit these cases to ensure care was being properly delivered.[154] The WRA implemented a Home Nursing Course to be delivered by one Japanese American instructor to all the camps. The course was two months long, and the instructor delivered the course separately to Nisei and Issei women. The instruction eventually reached Poston nearly a year after the PHVs had begun their training.[155]

Jean brought to Poston not only her ability and wealth of experience, but also an extensive network of professional contacts. This included accomplished public health nurse Elma Rood, RN, who arrived at Poston on January 24, 1943, the day before the PHV training program began. Jean was influential in recruiting Rood to Poston. After Rood wrote to Jean of her interest in the position, Jean and Olmstead rushed to Pressman's office to recommend her and have him offer her the position officially.[156] Rood would be Poston's public health nursing supervisor, and would oversee the public health nursing program in Poston I, II, and III. Under Rood's supervision and guidance, Matsumoto now felt confident to become Rood's assistant and oversee the PHVs in Poston I, while other Japanese American nurses supervised the PHV training and activities in Poston II and III. [157]

Seventeen young women were present for the first day of PHV instruction.[158] Training consisted of lectures, study of records, supervised home visits with debriefings, and emphasis of confidentiality and privacy when working with the community. Jean was integral in planning the course of instruction for the PHVs, and delivered instruction covering school health exams.[159] Realizing the need for tuberculosis identification and education in the camps, half of the initial 14 hours planned for discussion on communicable diseases focused solely on tuberculosis. Oral

and written exams evaluated the PHVs' knowledge of the course information. PHVs spent most mornings in the classroom while afternoons consisted of on-the-job training, assisting with school physical exams or home visits.[160]

The PHV program would address many needs at Poston. The PHVs would visit pre- and post-natal cases, and provide follow-up care for certain clinic cases. Crippled children living in the barracks received follow-up care as well. Incarcerees with chronic conditions consumed valuable manpower as hospital inpatients. Discharging these individuals to the barracks with follow-up care from a PHV would free beds and precious nursing hours to care for more acute cases. The PHVs assisted physicians with school physicals and any special clinics or surveys that might be conducted. Translation, dissemination, and education of health information necessary for practicing better health habits via home visits or classes was another expected function. Perhaps the most important purpose was to assist in the identification and reporting of communicable diseases, such as chicken-pox, measles, and tuberculosis.[161] The PHVs would essentially become the eyes and ears of the Poston public health department.

The PHV training went well, and Rood soon expressed confidence in the PHVs' ability to assist in health examinations, perform home visits, and establish medical records.[162] The PHVs in Poston I remained busy identifying and referring new crippled children, performing dressing changes, attending post-natal visits, and continuing their education when learning opportunities presented themselves. Rood often accompanied the PHVs on initial home visits for case evaluation and demonstration of special techniques before turning responsibility over to the PHV.

Matsumoto reported that PHVs in Poston III called on families of students absent from school for three days or more, ensured that tubercular patients observed physician orders for diet

and exercise, made follow-up calls on chronic cases and communicable diseases such as chicken-pox, poliomyelitis, and scarlet fever, conducted well-baby clinics, and assumed charge of the whooping cough immunization clinic where they administered 836 injections. Poston III PHVs received continuing education regarding review of first aid, method for obtaining blood pressure readings, and dressing changes. [163]

Poston II had considerably less activity, due in part to the clinic doctor being ill, thereby reducing the number of office cases and subsequent referrals for home visits. Matsumoto also noted the PHVs' declining interest in their work during this period, but was at a loss as to how to keep the young women engaged.[164] Because Poston II was three miles away from either of the other camps, and limited transportation had already tested the ability to run the course at Poston I for the initial three-week training period, the PHV program at Camp II languished somewhat. Poston I also suffered losses of its PHVs. Within the first six months of the program, Poston I had already lost one PHV to acute appendicitis.[165] By the end of the program's first year in existence in December 1943, three PHVs remained on staff at Poston I.[166] Six months later, there would be only one.[167]

Rood was proactive in her work at Poston, and she managed problems that arose with speed and efficiency. As the weather grew warmer, flies became a problem at Poston. She addressed reports from concerned school teachers over the swarms of flies that disrupted class. She also became disgusted with the amount of flies in the hospital dining room. She investigated both cases, and drew up simple suggestions for Pressman to approve, mainly installation of additional window screens.[168]

Rood also worked cooperatively with other Poston administrators. Although children had examinations by a physician in the fall of 1942 prior to starting school, Rood conferred with

elementary school administration to determine a follow-up review in the spring for these children. Parents, teachers, and students would visit with the nurse to review the child's health record and obtain height and weight. Teachers, students, and parents could discuss concerns or questions regarding the child's health. The nurse would provide education or arrange for follow-up care with the physician. Rood secured the services of an interpreter for individuals in need of those services.[169]

In addition to her responsibility as Poston public health nursing supervisor, Rood also maintained responsibility to her profession through attendance at professional meetings, such as the Arizona State Public Health meeting in Phoenix in May 1943. Rood made good use of her time in Phoenix by shopping for uniforms and shoes for the Public Health Visitors and visiting facilities where Poston incarcerees were institutionalized. She visited a baby at the Crippled Children's Home, and sought to secure plastic surgery services for four patients in need. Civilian agencies were not immune to the demands of the war, as no plastic surgeons were to be found in all of Arizona. Rood also visited tubercular patients at the Phoenix Indian Sanatorium, and personally met with their families once back in Poston to relay news of their condition. Noting the apparent restlessness and boredom of individuals at the sanatorium, Rood also consulted with the Poston Red Cross to see if they might supply materials to occupy patients' hands and minds while they recuperated.[170]

Poston Public Health Surveys

The public health program was guided by several surveys conducted by the nurses and PHVs. Nurses referred to the National Organization for Public Health Nursing's 1936 manual whose first principle stated that a survey of community needs and current resources should

precede the rendering of any nursing services.[171] Nurses conducted and assisted with several surveys throughout Poston's history, the most important being the tuberculosis (TB) survey.

Public health nurses prepared a list of all known cases of individuals infected with tuberculosis and the status of their symptoms and infection, identified as moderately or far advanced active, or minimal arrested. Under each name were the individuals in close contact with them, most often family members or fellow bachelors if living in the bachelor quarters.[172] They also plotted these known cases on a map of the camp to identify clusters of disease activity. Nurses would use these epidemiological techniques to anticipate and follow other communicable diseases as well.

The older Issei were not as forthcoming when giving their health histories, the social stigma of TB long ingrained in their culture.[173] Physicians noted *okyu* scars on some of the Issei men presenting with chronic tuberculosis. *Okyu* scars developed after burning small amounts of incense, or moxa, on the skin over the point of distress, or at the base of the nerve supplying the area in pain. Individuals with TB had these scars on the shoulders, at the base of the neck, to the base of the thorax. These scars were soon viewed as evidence that some type of lung disease or illness had afflicted an individual, even when that person denied ever having any TB symptoms. This therapy, known as moxibustion, was not limited to the treatment of TB; scars were noted in the epigastric area on individuals with known peptic ulcers, or on the legs of those with peripheral neuritis.[174] This ancient form of healing was used in Japan to treat a variety of conditions, including leprosy.[175]

Because of the social stigma Japanese Americans associated with TB, trust had to be obtained before the study could be carried out. The needed supplies also had to be requisitioned. Health education films, discussions, and other informal education took place over the course of

the first year of incarceration. During this time, Kazusai Kasuga, MD, a Japanese American physician, was placed in charge of the Chest Clinic, where he led some of the group discussions and lectures, capturing the interest and confidence of the population.[176] He had also been charged with leading the tuberculosis survey, and Poston was fortunate to have him in this position. Prior to incarceration, Kasuga worked on staff at the University of California Medical School and was in charge of tuberculosis patients at the San Francisco Hospital. Although he retained his professional contacts with officials at the California Tuberculosis Association, they could do little in regards to assisting with a survey, as Poston was outside their state jurisdiction.[177] Kasuga left Poston in November 1943 to work briefly for the BIA under Snavely, until his report date for the U.S. Army in January 1944.[178]

To obtain the needed supplies for conducting an in-depth tuberculosis survey, Jean was naturally selected to go on a fact-finding trip to Phoenix where she met with officials from the Arizona Anti-Tuberculosis Association and the Arizona Health Commissioner.[179] From this trip, Jean discovered that some resources from the state, the National Tuberculosis Association, and the USPHS might be available. Jean presented a logical strategy for Pressman to follow that would lead to the eventual X-ray survey of over 5,000 Japanese Americans at the camp.[180] Pressman, as the Principal Medical Officer at Poston, was in the proper position to request assistance from Collier of the BIA, and other high-ranking officials.

Aware of the cultural stigma attached to TB, Jean advised that the Japanese Americans would not simply fall in line and march to the hospital to be X-rayed, and suggested a mobile unit that came to the incarcerees might better facilitate cooperation. The BIA Director of Health in Chicago agreed that everything possible should be done to expose the problem to its fullest extent.[181] The USPHS aided in carrying out the tuberculosis survey at Poston by lending a

special X-ray device and a technician for assistance in using the device.[182] Although not a portable unit, it could be transported to the various block manager's offices to encourage participation by as many as possible in Camp I.[183]

Public health nurses and PHVs educated infected tubercular children and their parents on measures to maintain and protect their health. These included adhering to rest periods, consumption of milk, and regular check-ups to ensure the child was growing and gaining or maintaining a healthy weight. [184] A tuberculosis education booklet, prepared by the California Tuberculosis Association based in San Francisco, was also available to educate the Japanese Americans. The material was easy to read and printed clearly in English and Japanese. Simple diagrams illustrated how the disease is spread from one person to another.[185]

Jean secured educational films through the Arizona Tuberculosis Association entitled, *Cloud in the Sky*, *Behind the Shadow*, and *Another to Conquer*. Rood published an educational piece in the *Poston Chronicle*. This short article reinforced that tuberculosis was "caught" like other diseases, and not inherited.[186] It appears that educational efforts were effective over time. The camp organized a benefit dance for institutionalized tubercular individuals in February 1944:

> In order to help the Poston patients at the Phoenix Indian Sanitarium, the Stardusters will hold a Benefit Ball…This ball is believed to be the first of its kind given by a center organization, all proceeds going to make the stay of local tuberculosis patients in Phoenix as pleasant as possible.[187]

Other surveys took place, including a child tonsil survey, weights of babies and children under three months of age, milk survey of mothers with babies less than 12 months of age, immunization status survey, and survey of mental diseases, to name but a few.[188] One extensive survey was completed at the request of the WRA and the Children's Bureau. Public health nurses

and PHVs assembled information on Japanese Americans of all ages with known physical and/or mental impairments. Included in this survey was information on their current health condition, current or past treatments, and outlook for recovery from that condition. Individuals were grouped by the type of conditions or injuries they sustained, such as disabilities as a result of birth injury, congenital crippling, disabilities associated with tuberculosis, osteomyelitis, or other infections, disabilities associated with polio, crippling associated with various types of accidents, crippling associated with burns, deformities, crippling from loss of limb, crippling associated with mental deficiency, and crippling associated with chronic illness or old age In total, 101 cases of crippling were identified.[189]

These surveys were critical in identifying individuals in need of extra care or assistance, and provided ready information when preparing these individuals for transport, either during the Tule Lake segregation or transfer out of the camp. Many individuals received care that had been long overdue. For example, a teen-aged girl had been wearing the same leg prosthesis since she was nine years old. She was fitted with a desperately needed new limb in April 1943, as a result of appropriate referrals stemming from the survey.[190] Medical social workers worked in conjunction with public health nurses to refer cases of crippled children for care and treatment with the Arizona Crippled Children's Service, and arranged for outside medical care.[191]

Maternal and Child Care

Public health nurses focused considerable attention on the health of Poston's children, from birth through high school. Nurses compiled detailed reports of overall findings from exams and surveys to determine the needs of the population and plan appropriate interventions. The tonsil survey conducted from December 1942 thru February 1943 identified 104 of over 4,000

children in need of tonsillectomy. Nurses consulted with these 104 families and, after gaining their consent, arranged for surgery and follow-up with the physician. Surgeries were completed in the summer months, so as not to interfere with schooling. A special health education information sheet, *Directions for Mothers Whose Children Have had Tonsil Operation*, was prepared and printed in Japanese and English.[192] (See Appendix H for the instruction) PHVs participated in the tonsil survey as part of their training.[193]

Although Vickers claimed that not all expectant mothers attended prenatal clinics, by September 1943, 80 women were receiving prenatal care. Kahn and/or Kline blood tests drawn on the expectant mothers determined the presence of syphilis. All newborn babies received two home visits during the first month after discharge from the hospital. Japanese midwives often conducted the first visit, while a PHV performed the second visit. The home visits stressed the value of cod liver oil and orange juice in the infant diet, maintaining a regular feeding schedule, providing boiled water between feedings, keeping baby in a separate bed, insect protection, afternoon rest for the mother, and reminder of the six-week post-partum check-up by the physician.[194] These measures met the standards of care at the time.

Unless a problem was noted, the babies would only be seen by the physician at two months of age and again on their first birthday. In the meantime, Japanese midwives held well-baby clinics in an area within each residential block. This dramatically reduced the amount of walking that mothers had to do in the heat and dust of Poston. The proximity of these roving clinics also ensured a more regular attendance for check-ups, and reduced the burden on the regular outpatient clinic. During these clinics, midwives and/or PHVs weighed the infants, continued to reinforce age-appropriate infant care measures, and addressed other concerns as presented by the mother.[195]

To increase the number of children completing immunization series, nurses instituted an Immunity Certificate that families would receive once the child completed recommended immunizations. Public health nurses developed a schedule for immunization that all Poston clinics would follow. Pressman's approval was clearly noted at the top of the page.[196] The table in Appendix I shows the recommended immunization schedule for infants and children. The frequency of injections no doubt made compliance difficult, therefore nurses had to be innovative in searching for methods that would increase compliance. The certificates and conveniently located clinics were effective methods in increasing compliance with recommended care.

Pressman took note of the proactive public health program that had been developed at Poston. After a trip to Topaz incarceration camp in Utah in July 1944, Pressman stated:

> In general the essential difference was that Poston has been guided since its inception, toward a health program which had as its main emphasis prevention and reducing the public health hazards of disease without overlooking the remedial aspects of the practice of medicine; whereas in Topaz the emphasis seemed to be on a more individual type of practice primarily remedial in nature with very little attention paid to such problems as tuberculosis control, school health, etc.[197]

Thompson, of WRA headquarters in Washington, DC, also noted the accomplishments of Poston when he commented to another physician that Poston had one of the best health sections of all the camps. [198]

Conclusion

Vickers' goal for the Poston nursing service was the provision of "adequate nursing care to the community."[199] Hosmer placed good faith in Vickers, noting that although Poston was Vickers' first experience in a government hospital, she believed her capable of fulfilling her vision of providing quality nursing care.[200] Nurse Sallie Jeffries along with Drs. Schnur and Snavely repeatedly expressed their satisfaction with Vickers' work and abilities.[201] Vickers alone bore the heavy burden of organizing, administrating, and supervising a hospital in its infancy, for a newly created war agency, under extreme conditions of heat and uncertainty. Experienced BIA medical and nursing leaders supported Vickers in her efforts. Established and effective BIA policies and procedures also provided a sound framework for the expedient development of a functioning nursing service. Vickers remained committed to her nursing staff and her position over the course of the nearly four years the camp remained in use.

The public health nursing service was successful in preventing and controlling major outbreaks of disease, and providing public health education to the Japanese Americans. Nurses customized public health interventions based on careful survey and assessment of the population's health needs. The nurses and public health visitors implemented a proactive plan of care that addressed the unique needs of the population.

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Chapter 5

Conclusion

This study begins to fill a gap in the historical literature that examines nursing work in the Japanese American incarceration camps of World War II. Prior works concluded that there were overall health system failures based on select incidents when the camps were in the earliest stages of development. The published works also include limited personal reflections of physicians, nurses, and individuals seeking health care. These too dwelt on the period of time when the camps were first set up, when supplies were limited and processes were in their infancy. Existing literature on this topic focuses heavily on the larger unconstitutional incarceration and the heavy losses sustained by the Japanese American population. These prior works provide only glimpses into the daily work of nurses at the camps. This study identified, described, and analyzed the work of nurses in the U.S. incarceration camps holding west coast Japanese Americans during World War II, from 1942-1945.

More specifically, this study investigated the nursing personnel and nursing work in two of the ten incarceration camps: Heart Mountain in Wyoming, and Poston in Arizona. The nursing care was examined from the opening to the closing of the camps. The social, political, economic, and cultural context in which the camps emerged provided the setting and defined the limitations in which the nurses were able to provide care. In this dissertation, I argued that (1) Nurses working in camps with established organizational structures in place found administrative support as they developed the nursing service at that camp; (2) Nurses who did not conform to expected gender roles suffered backlash and resentment from the Japanese American physicians, while those who deferred to their place as women received the support of their superiors and the

Japanese American physicians with whom they worked; (3) Nursing leaders who demonstrated cultural sensitivity, nurtured interpersonal relationships, and had a clear vision of the goals they wanted to accomplish, were better equipped to manage and influence hospital personnel and processes.

Organizational Structures of the Camps

The leadership styles of the Chief Nurses at Heart Mountain and Poston incarceration camps were entirely different from one another. An effective organizational system can support developing and accomplished leaders to achieve successfully the goals of the organization. But even the most experienced leader's efforts can become stymied without organizational processes in place. The War Relocation Authority (WRA) carefully selected chief nurses who were also experienced managers and leaders. Lacking clear administrative guidelines or the support of the hospital's Principal Medical Officer (PMO), the chief nurses were destined to fail.

The strong support of a structured organization is something that all healthcare personnel at Heart Mountain lacked. The concept of a War Relocation Authority agency had only been created a few months prior to opening any of the incarceration camps. Key personnel had to be hired before policies and procedures could be drafted. Attorneys for the WRA and other relevant administrators had to approve of the policies before they were put into effect. Although these events occurred at a rapid pace, the need for this guidance outpaced the time when the guidance was actually received.

The WRA did not deliver organizational guidelines concerning activities in the Health Section until October 1942, several months after the first camps began accepting Japanese Americans from the temporary detention centers. Japanese American physicians arriving at Heart

Mountain had been practicing with almost total control over all aspects of the Health Sections at their respective temporary detention centers. Once at Heart Mountain, Wilfred Hanaoka, MD, attempted to retain this power by overshadowing Dr. Keith, temporary PMO, and then permanent Principal Medical Officer Charles Irwin, MD. Keith did little to stop Hanaoka from claiming power over the Health Section. In fact, through his inaction, he encouraged it. Even though Irwin arrived shortly afterwards, Hanaoka had already established himself as the unofficial authority figure in the Health Section.

War Relocation Authority Administrative Instruction No. 54 provided policies and guidance on health care matters in the camps. The instruction was broad and somewhat general in nature, and, just as Hanaoka had taken advantage of the lack of guidance, he now exploited the instruction's ambiguities. A chief nurse was not present during the formative phase of establishing the Health Section to help interpret the instruction, and so nursing's voice within the system was never heard or considered. When Chief Nurses Margaret Graham and Anna Van Kirk attempted to give nursing a voice, Japanese American physicians and other staff were quick to remove that voice in an effort to retain power.[1]

Elizabeth Vickers' experience in a hospital nursing training program prepared her well for developing young women into responsible and professional nurses and nurse aides. Yet had she been at Heart Mountain, it is unclear if she would have been as successful in her accomplishments. Employees at the Bureau of Indian Affairs (BIA), including Commissioner Collier, Ralph Snavely, MD, and Sallie Jeffries, RN, already operated under a long-running healthcare organization that consisted of sanatoriums, hospitals, and public health programs. Unlike the WRA, the Indian Health Service had decades of experience in determining the processes that worked well and those that did not work well. They valued nursing work in their

programs and facilities, and understood the diplomacy required in working with a minority group that had been displaced by the U.S. government. Vickers was well-supported by Jeffries and Snavely – the support of Ralph Snavely, District Medical Director for the BIA, ensured the support of the men at Poston, including the PMO, Project Director, and Japanese American physicians at Poston.

Gender Role Expectations

Nurse training historically socialized nurses to be passive and subservient to physicians.[2] In the 1940s, nurses working at Heart Mountain and Poston incarceration camps were socialized to be submissive. At Heart Mountain, Margaret Graham and Anna Van Kirk fully embraced the authority the WRA bestowed upon them, rather than accept their usual status below the male physicians. Their boldness shocked the camp's Japanese American physicians and created explosive situations.

Project Director Guy Robertson described Margaret Graham as brusque and overbearing after she rejected the terms that would allow her to remain as Chief Nurse. These included an apology and a probationary period for an event where everyone was at least equally at fault, but she would be the only one to pay a price for her role in the events.

Lynne Andersson and Christine Pearson, researchers in workplace and organizational issues, introduced in 1999 the concept of workplace incivility as "low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect."[3] These behaviors can include excluding colleagues from meetings, adopting a condescending attitude towards others, or addressing others in an unprofessional manner.[4] Individuals engage in incivil behaviors when their identity is threatened. Hanaoka's persistence in undermining the

chief nurse position were acts to protect his identity as a male physician with power over female nurses. Nurses exhibited these behaviors, too, in typical "Tit for Tat" fashion that Andersson and Pearson describe.[5] Graham's actions in placing physicians' belongings on the floor was certainly a demonstration of power in an attempt to assert her identity as Chief Nurse.

Van Kirk used the walkout at Heart Mountain that was directed against her to bolster her position as Chief Nurse. Irwin and Van Kirk knew that it would be difficult for Heart Mountain to lose its third Chief Nurse in less than a year if she resigned. Surely other nurses would not volunteer to work in a place where they were abused. Irwin finally had to assert his position in order to support Van Kirk in her position; the entire situation could have easily become a total disaster had Irwin remained silent again. Irwin and Van Kirk presented a united front as they interviewed participants involved in the walkout, and, after Hanaoka was transferred to Manzanar, there was finally some peace at the hospital.

At Poston, Vickers complied with gender expectations and was rewarded for it when she approached Ralph Snavely, District Medical Director for the BIA, to grant her authority over all clinic nurses, rather than have the physicians supervise them. Although the Principal Medical Officer was technically the one to make these types of decisions, Vickers read the situation and understood that Snavely had the power to affect the change that she desired.

These three women negotiated their nursing practices within the social contexts of the time, but only Vickers was truly successful as she negotiated from her proper place within the medical and gender hierarchies.

Leadership

Nursing leaders since Florence Nightingale have largely defined successful leadership as being attentive to one's charges and instilling a trusting relationship between supervisor and employee. More recent evidence also suggests that ethical nursing leadership in a health work environment must be responsive to health care workers and to the contextual system in which both leader and employee work.[6]

Clearly, Heart Mountain chief nurses lacked essential leadership qualities. While they were well-versed in the operation and administration of a hospital, these types of managerial skills did not translate to effective leadership within the context of the camps. An organized nursing service was certainly lacking when Margaret Graham arrived at Heart Mountain in January 1943, as the chief nurse position had been essentially vacant for the prior four months. Graham no doubt became overwhelmed with the amount of work that had to be done, and quickly focused on the work, and not the individuals under her supervision. She did not take the time to assess the group dynamics in the hospital or evaluate the formal and informal power structures that had developed. This was a critical error, especially in this setting where individuals already felt isolated and rejected as citizens of their own country.

Anna Van Kirk, Heart Mountain's third chief nurse, did try to gain an understanding of the dynamics within the hospital, although her method of eavesdropping on conversations in Japanese resulted in an atmosphere of distrust with her staff. After the walkout of June 1943, Van Kirk had little time to do anything but focus on the nursing work that needed to be done. Her instruction booklet for staff nurses and nurse aides identified acceptable work behaviors, but also clearly indicated her position as superior to nurse aides and staff nurses.

Nursing literature of the time focused on efficiency and task completion, but offered little guidance on the "soft skills" that we understand today as essential in running a successful ward or hospital. Sister Mary Cecilian, RN, and director of a school of nursing and of nursing service in South Bend, Indiana, was acutely aware that hospital administrators and directors of nursing service in 1944 had the responsibility of setting a professional example for their nursing staff. Such actions included positively acknowledging the work of professional and non-professional personnel. Cecilian underscored other points: that hospital employees should be considered as individuals and, only with an efficient administrator could the director of nursing be efficient.[7]

Ordway Tead, an organizational theorist and adjunct professor to many nurses studying at Columbia University, also wrote that nursing leaders needed to be attuned to the individuals under their authority:

> But it is important to be explicit about one uniquely necessary attribute for the successful leader. I refer to a total attitude and habit of mind of attentiveness to the reactions of other people, a continuing awareness of their personas and concerns, a sensitiveness to their responses, and because of all this a concern for their reactions which results in a certain basic kindliness – all prompted by the leader's persistent will to work amiably together with people.[8]

The leadership at Poston was in direct contrast to that of Heart Mountain. At Poston, Elizabeth Vickers, Senior Chief Nurse, and Elma Rood, Public Health Nurse Supervisor, both demonstrated cultural sensitivity, nurtured interpersonal relationships, and had a clear vision of the type of nursing service that would best meet the needs of Poston. From the earliest days of the camp, Vickers took note of cultural clashes between Issei and Nisei nurses. Vickers took these tensions into consideration as she prepared their work schedules. She joined the ranks of

her nurses and aides to complete menial yet vital hospital tasks, such as laundering hospital linens and uniforms. Vickers also understood WRA goals of relocation and took immense pride in the fact that so many Japanese Americans at Poston left camp to complete their nursing education or to work in their new careers as nurse aides.

Although hospital directors were more authoritarian in the 1940s than today, analysis of the data suggests that bedside nurses desired a supportive, visible, and responsive leader, just as they do today.[9] Vickers was not only visible among her staff, she was also a supportive and responsive presence. In staff meetings, Vickers encouraged nurses to express their personal feelings and concerns in addition to concerns regarding their work duties. Nurses felt secure in voicing their desires as well as their displeasures in their work and life at Poston, because Vickers had fostered a trusting and supportive environment for them to do so. She was also responsive to their needs when she suggested starting a Poston Nurses Society, securing coolers for the nurses' quarters to enhance their comfort and rest, and including them in the plans to decorate a common living area in the quarters. Surely Vickers was responsive to the many young women who needed a reference in order to secure positions outside the camp, either in school or the workplace.

Rood took time to develop the inexperienced public health nurse, Dorothy Matsumoto, as well as the Public Health Visitors (PHVs) that would be doing much of the public health nursing work amongst the population. Rood accompanied the PHVs on initial visits to ensure they were confident to perform the required follow-up care on their own. Rood's grand vision for the public health nursing service included an educational component and sanitation measures.

The nursing profession has long admired its pioneers and leaders, yet theories of nursing leadership that emphasized personal leadership qualities and the effect of the leader on

organizational functioning and group behavior did not emerge until the early 1990s.[10] Nurses at Heart Mountain and Poston were largely left to implement personal theories of leadership in their roles as chief nurse. With support and guidance from a structured organization and a male authority figure, the nurse was likely to succeed – lacking this support, the nurse would struggle to gain the respect or authority she needed to run an efficient nursing service.

Success or Failure?

In both camps, nurses participated in health promotion activities for Japanese Americans who were acutely or chronically ill, and also promoted wellness activities in the general camp population. Many Japanese American incarcerees received health care services to a greater extent than they had before the war.[11] Prior to incarceration, nearly 50% of the incarcerees worked in the agricultural industry, living on remote farms where access to health care was not easy, readily available, or affordable.

The difference in nursing care between the camps lies within the public health nursing program. The first public health nurse at Heart Mountain was succeeded by a second public health nurse who resigned in late 1943. After her resignation, another public health nurse was never supplied to the camp.[12] Poston's public health nursing program was slow to start, but grew into a robust program once training of Public Health Visitors began and Elma Rood, public health nurse, arrived at Poston to assume responsibility. Programs that were established early in Poston's history, such as the tuberculosis education program initiated under Sally Lucas Jean, Health Education Consultant, were not seen at Heart Mountain until much later. No one had conceived of such a program at Heart Mountain until the Community Council approached Emma Thomas, Medical Social Worker, in mid-1944. In fact, most efforts by Thomas were often

initiated by suggestions and recommendations from the Community Council.[13] These actions highlighted the differences between the proactive role of the public health nurse and the reactive role of the medical social worker.

Despite the larger problems of securing supplies, personnel, and organizational guidance, the provision of nursing care at Heart Mountain and Poston was a success due to informal leaders: the bedside nurses and nurse aides. Their voices are mostly silent, but the results of their actions are not. Japanese American women delivered healthy babies who grew to be healthy toddlers before they left camp. Japanese Americans of all ages recovered from pneumonia, polio, and various surgeries. They were safely transported to mental health facilities and sanatoriums in an effort to secure appropriate treatment. No major communicable disease outbreak occurred. Individuals received pain medication and comfort measures as they died. These successes resulted from the work of nurses and nurse aides who overcame personnel and supply shortages, overlooked petty squabbles and the inefficiency of the WRA, to care for their fellow Americans.

Future Research

It was not until April 1976 that President Gerald Ford rescinded Executive Order 9066. Four years later, President Jimmy Carter created the Commission on Wartime Relocation and Internment of Civilians, a government body that investigated the effects of Executive Order 9066 and the incarceration camps on the Japanese Americans.[14] The commission's report, *Personal Justice Denied*, concluded that military considerations did not inform the exclusion of nearly 120,000 Japanese Americans from the Pacific west coast of the United States; rather, "…these decisions were race prejudice, war hysteria and a failure of political leadership."[15] These events culminated in the passage of Public Law No. 100-383, also known as the Civil Liberties Act.

President Ronald Reagan signed the Civil Liberties Act into law on August 10, 1988. This law mandated Congress to issue a formal apology on behalf of the nation and gave reparations of $20,000 to each of the estimated 60,000 surviving Japanese Americans of the incarceration. The Act also established a public education fund to ensure that incarceration events would never be forgotten or repeated.[16] In the spirit of shedding light on aspects of the incarceration, this dissertation sought to describe and analyze the nursing care within two of the incarceration camps: Heart Mountain in Wyoming, and Poston in Arizona. Although nurses had no control over the U.S. government's decision to forcibly remove loyal and law-abiding Japanese Americans from their homes and incarcerate them in desolate camps in the interior United States, they did have control over their decisions to work in the camps and the type of nursing care they would render.

This study highlights fundamental differences in the way the health sections at two camps were administered and the unique challenges that nurses faced in establishing nursing departments and providing essential nursing services. Future research would extend the scope of the study to examine nursing care at other camps. A beginning research question would be: What type of relationship did Wilfred Hanaoka have with the nurses at Manzanar incarceration camp upon his arrival there? Did the organizational dynamics at Manzanar have an effect on these relationships or Hanaoka's attitude towards nurses?

Another direction for future research would examine other camps using similar research questions that were used to guide this study. The humid, swampy environmental conditions at the Rohwer and Jerome camps in Arkansas certainly put those incarcerees at risk of health hazards unlike those incarcerated in the camps located in desert areas. The Midwest/Southern location may have also influenced how local residents viewed the camps and the Japanese Americans.

The Tule Lake camp was truly unique. In 1943, the Tule Lake camp had been converted into a maximum security segregation facility for "disloyal" Japanese Americans. The camp was home to numerous acts of resistance; one protest had escalated into a situation where the military police took control of the camp from the WRA. The camp remained under martial law for two months.[17] These and other events were certain to have had significant impacts on the recruitment of nurses and the nurses' ability to deliver adequate nursing care.

While historians have examined many aspects of Japanese American incarceration, fewer have examined the smaller U.S. enemy alien internment camps, or the nursing and medical care that was delivered there. The Immigration and Naturalization Service (INS), under the authority of the Department of Justice (DOJ), administered approximately 20 enemy alien internment camps throughout the United States. The camp in Crystal City, Texas was the largest. This camp and other INS camps imprisoned individuals of Axis nationalities – Japanese, Germans, and Italians – and their families. Similar to the Japanese American incarceration camps, these INS camps housed, fed, educated, and provided medical care for the population.[18] The unique points for comparison lie in the fact that the camps held individuals of different ethnicities, they were administered under a different governmental agency, and the population were clearly labeled as prisoners without relocation as a goal. Recruiting and retaining nurses for this population was no doubt equally challenging to recruitment and retention efforts in the Japanese American incarceration camps.

Although chances are unlikely that an incarceration of this magnitude would ever again occur in the United States, many Americans are anxious of their safety at home, especially in light of the most recent domestic terror attacks in San Bernardino, California. Concerns regarding refugees, immigrants, or asylum seekers to the United States are largely based on fear

regarding these individuals' ethnicity and religion. Wherever nurses are needed, there is no doubt they will look past these constructs and remain as committed to the provision of exceptional nursing care as they were over 70 years ago in the Japanese American incarceration camps.

Notes: Chapter 5

[1] Cynthia Formosa, "Understanding Power and Communication Relationships in Health Settings," *British Journal of Healthcare Management* 21, no. 9 (2015), 421.

[2] Karen Tosh, "Nineteenth Century Handmaids or Twenty-First Century Partners?" *Journal of Health Organization and Management* 21, no. 1 (2007), 68-78.

[3] Lynne M. Andersson and Christine M. Pearson, "Tit for tat? The Spiraling Effect of Incivility in the Workplace," *Academy of Management Review* 24, (1999): 457.

[4] Jennifer L. Welbourne, Ashwini Gangadharan, and Ana M. Sariol, "Ethnicity and Cultural Values as Predictors of the Occurrence and Impact of Experienced Workplace Incivility," *Journal of Occupational Health Psychology* 20, no. 2 (2015), 205.

[5] Andersson and Pearson, "Tit for tat?"

[6] Kara Schick Makaroff, Janet Storch, Bernie Pauly, and Lorelei Newton, "Searching for Ethical Leadership in Nursing," *Nursing Ethics* 21, no. 6 (2014), 642-658.

[7] Mary Cecilian, "Hospital Nursing Problems in Wartime," *American Journal of Nursing* 44, no. 8 (1944), 763-764.

[8] Ordway Tead, "The Development of Leadership Power," *American Journal of Nursing* 42, no. 8 (1942), 870.

[9] Kara Schick Makaroff, Janet Storch, Bernie Pauly, and Lorelei Newton, "Searching for Ethical Leadership in Nursing," *Nursing Ethics* 21, no. 6 (2014), 642-658.

[10] Ruth Harris, Janette Bennett, and Fiona Ross, "Leadership and Innovation in Nursing Seen Through a Historical Lens," *Journal of Advanced Nursing* 70, no. 7 (2014), 1629-1638.

[11] FBI Survey of Japanese Relocation Centers, Part 1, March 1943, Entry 17, Box 1, RG 210, NAB.

[12] Heart Mountain Monthly Reports, April 1944, Entry 16, Box 205, RG 210, NAB.

[13] Heart Mountain Monthly Report, November 1943, Entry 16, Box 205, RG 210, NAB.

[14] Anti-Defamation League, *Understanding the Civil Liberties Act of 1988* (New York: Anti-Defamation League, 2013).

[15] The Commission on Wartime Relocation and Internment of Civilians, *Personal Justice Denied, Part 2: Recommendations* (Washington, D.C.: U.S. Government Printing Office, 1983), 5.

[16] Anti-Defamation League, *Understanding the Civil Liberties Act of 1988* (New York: Anti-Defamation League, 2013).

[17] Burton, Jeffrey F. Mary M. Farrell, Florence B. Lord and Richard W. Lord. *Confinement and Ethnicity: An Overview of World War II Japanese American Relocation Sites.* Western Archeological and Conservation Center, National Park Service, U.S. Department of the Interior: Publications in Anthropology 74, 1999.

[18] Jan Jarboe Russell, "Trade Off," *American History* 49, no. 6 (2015), 64-70.

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Appendix A

UNIVERSITY of VIRGINIA

OFFICE OF THE VICE PRESIDENT FOR RESEARCH
INSTITUTIONAL REVIEW BOARD FOR THE SOCIAL AND BEHAVIORAL SCIENCES

In reply, please refer to: Project # 2015-0018-00

January 21, 2015

Rebecca Coffin and Arlene Keeling

Dear Rebecca Coffin and Arlene Keeling:

Thank you for submitting your project entitled: "Nursing in the Japanese American Incarceration Camps, 1942-1945" for review by the Institutional Review Board for the Social & Behavioral Sciences. The Board reviewed your Protocol on January 21, 2015.

The first action that the Board takes with a new project is to decide whether the project is exempt from a more detailed review by the Board because the project may fall into one of the categories of research described as "exempt" in the Code of Federal Regulations. Since the Board, and not individual researchers, is authorized to classify a project as exempt, we requested that you submit the materials describing your project so that we could make this initial decision.

As a result of this request, we have reviewed your project and classified it as exempt from further review by the Board for a period of four years. This means that you may conduct the study as planned and you are not required to submit requests for continuation until the end of the fourth year.

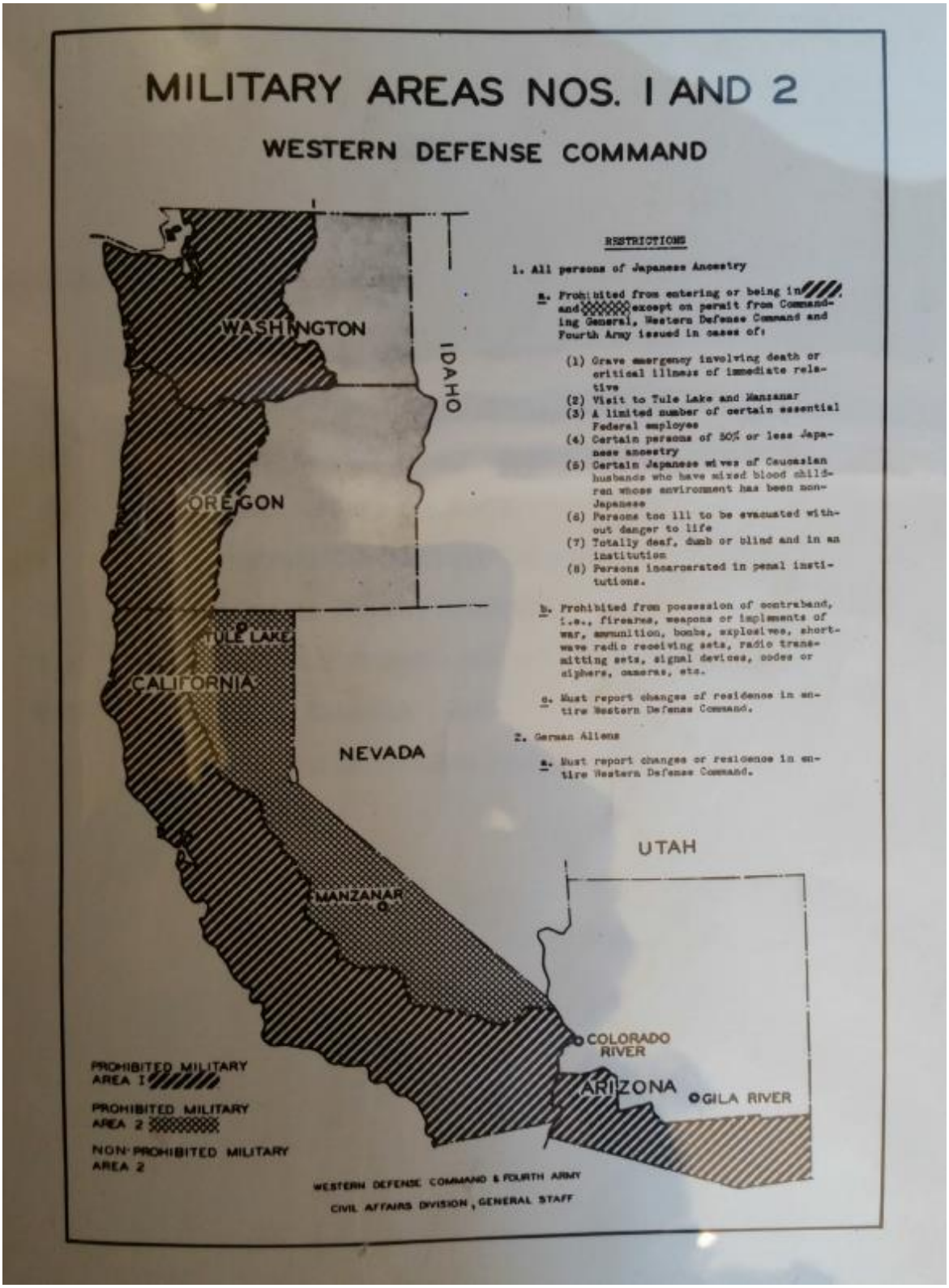
This project # 2015-0018-00 has been exempted for the period January 21, 2015 to January 20, 2019. If the study continues beyond the approval period, you will need to submit a continuation request to the Board. If you make changes in the study, you will need to notify the Board of the changes.

Sincerely,

Tonya R. Moon, Ph.D.
Chair, Institutional Review Board for the Social and Behavioral Sciences

One Morton Drive, Suite 500 • Charlottesville, VA 22903
P.O. Box 800392 • Charlottesville, VA 22908-0392
Phone: 434-924-5999 • Fax: 434-924-1992
www.virginia.edu/vpr/irb/sbs.html

Appendix B



Source: Western Defense Command, *Military Areas Nos. 1 and 2*. Entry 16, Box 242, RG 210, NAB.

Appendix C

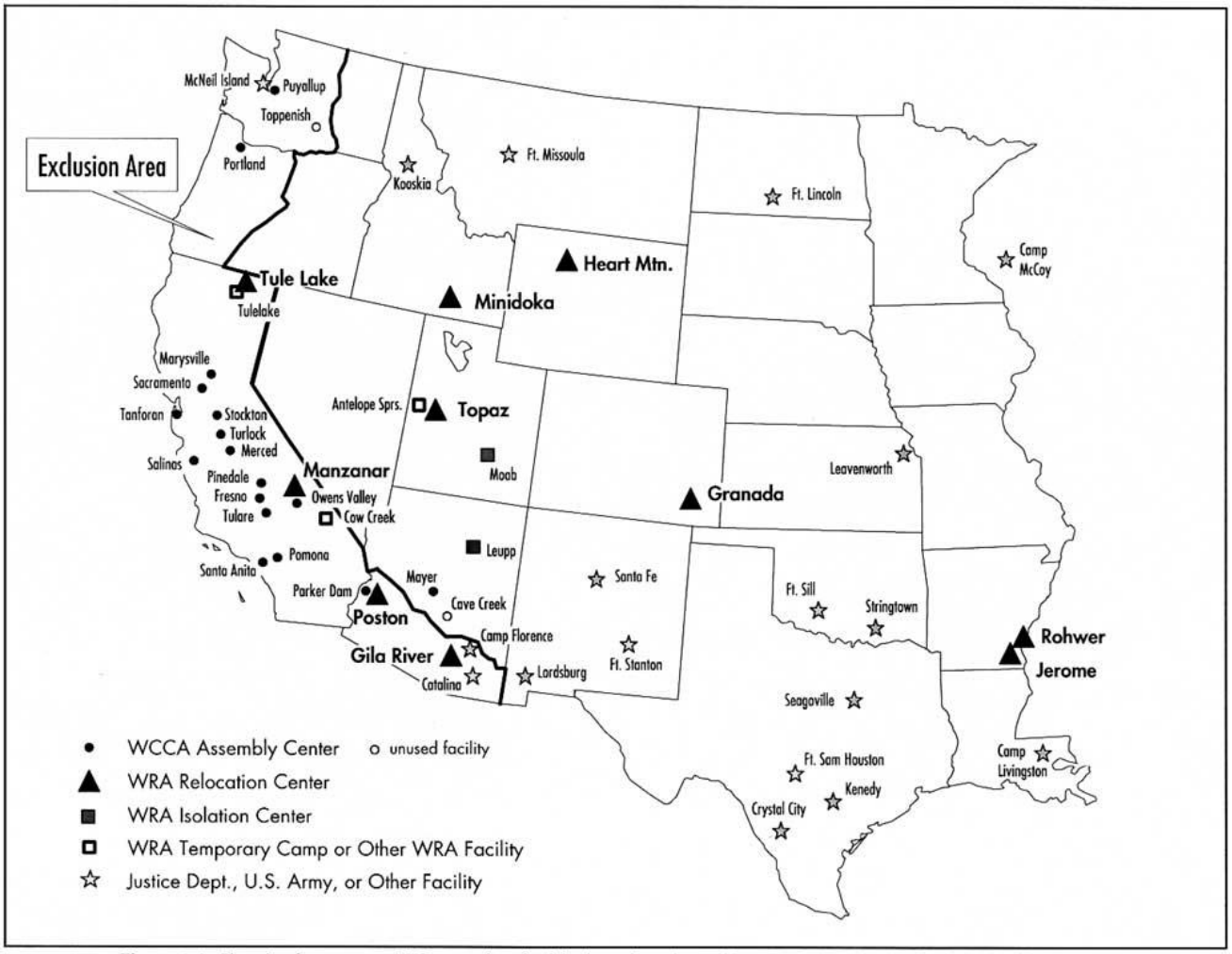
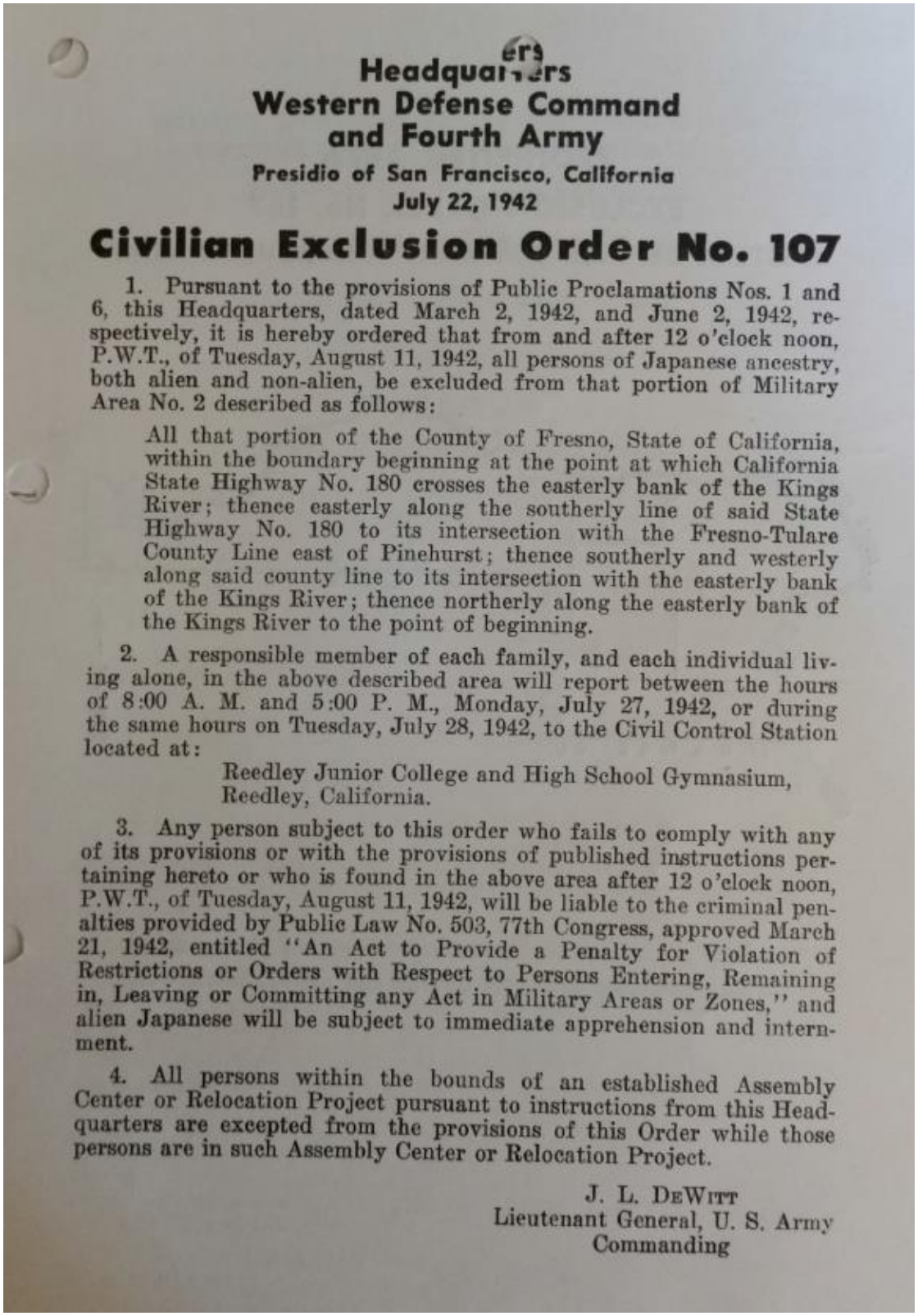


Figure 1.1. Sites in the western U.S. associated with the relocation of Japanese Americans during World War II.

Source: Jeffery F. Burton, Mary M. Farrell, Florence B. Lord and Richard W. Lord, *Confinement and Ethnicity: An Overview of World War II Japanese American Relocation Sites* (Western Archeological and Conservation Center, National Park Service, U.S. Department of the Interior: Publications in Anthropology 74, 1999).

Appendix D



Headquarters
Western Defense Command
and Fourth Army

Presidio of San Francisco, California
July 22, 1942

Civilian Exclusion Order No. 107

1. Pursuant to the provisions of Public Proclamations Nos. 1 and 6, this Headquarters, dated March 2, 1942, and June 2, 1942, respectively, it is hereby ordered that from and after 12 o'clock noon, P.W.T., of Tuesday, August 11, 1942, all persons of Japanese ancestry, both alien and non-alien, be excluded from that portion of Military Area No. 2 described as follows:

> All that portion of the County of Fresno, State of California, within the boundary beginning at the point at which California State Highway No. 180 crosses the easterly bank of the Kings River; thence easterly along the southerly line of said State Highway No. 180 to its intersection with the Fresno-Tulare County Line east of Pinehurst; thence southerly and westerly along said county line to its intersection with the easterly bank of the Kings River; thence northerly along the easterly bank of the Kings River to the point of beginning.

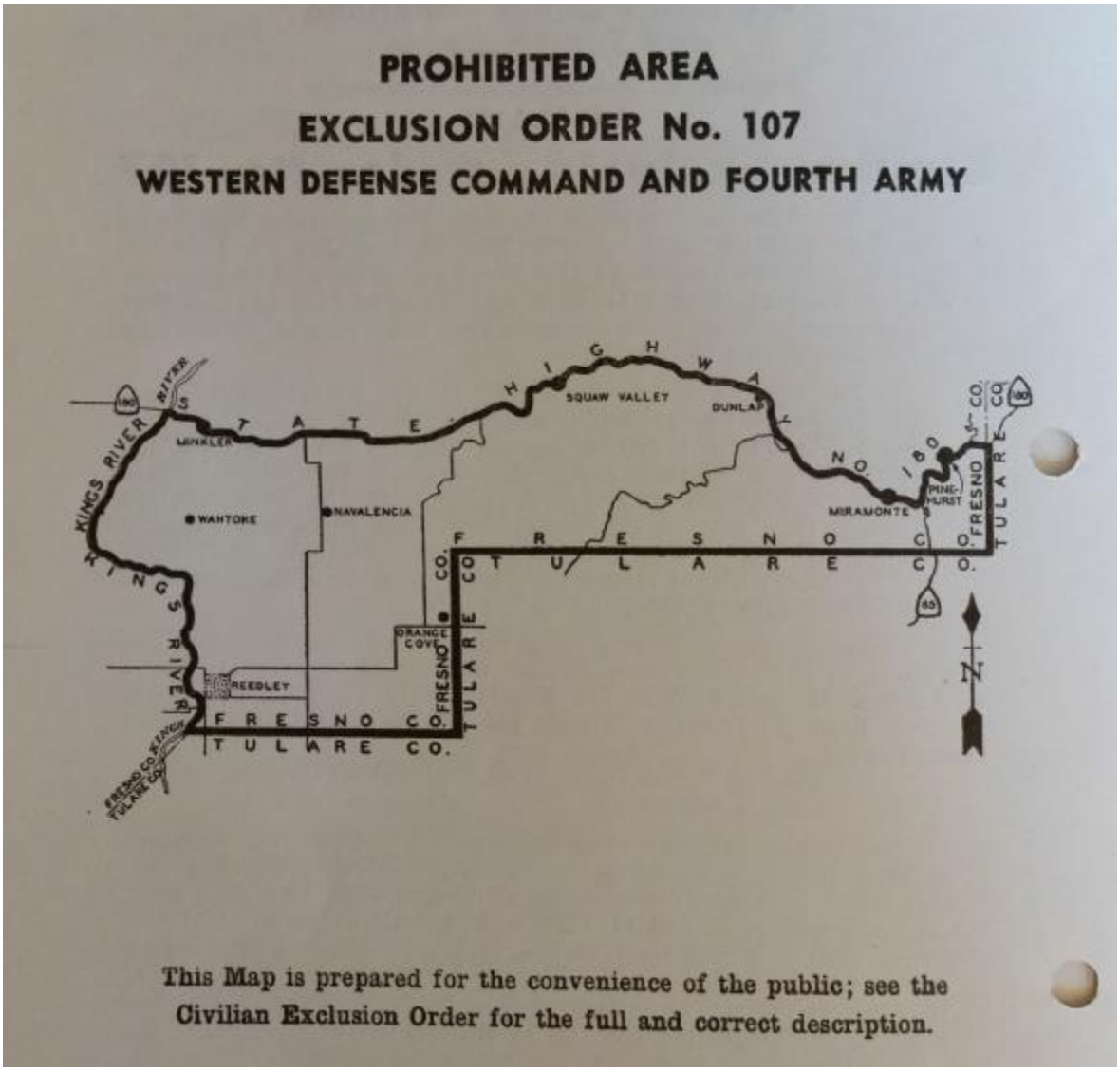
2. A responsible member of each family, and each individual living alone, in the above described area will report between the hours of 8:00 A. M. and 5:00 P. M., Monday, July 27, 1942, or during the same hours on Tuesday, July 28, 1942, to the Civil Control Station located at:

> Reedley Junior College and High School Gymnasium,
> Reedley, California.

3. Any person subject to this order who fails to comply with any of its provisions or with the provisions of published instructions pertaining hereto or who is found in the above area after 12 o'clock noon, P.W.T., of Tuesday, August 11, 1942, will be liable to the criminal penalties provided by Public Law No. 503, 77th Congress, approved March 21, 1942, entitled "An Act to Provide a Penalty for Violation of Restrictions or Orders with Respect to Persons Entering, Remaining in, Leaving or Committing any Act in Military Areas or Zones," and alien Japanese will be subject to immediate apprehension and internment.

4. All persons within the bounds of an established Assembly Center or Relocation Project pursuant to instructions from this Headquarters are excepted from the provisions of this Order while those persons are in such Assembly Center or Relocation Project.

J. L. DeWitt
Lieutenant General, U. S. Army
Commanding


PROHIBITED AREA
EXCLUSION ORDER No. 107
WESTERN DEFENSE COMMAND AND FOURTH ARMY
KINGS RIVER
STATE HIGHWAY NO. 180
SQUAW VALLEY
DUNLAP
WAHTOKE
NAVALENCIA
MIRAMONTE
PINEHURST
ORANGE COVE
REEDLEY
FRESNO CO.
TULARE CO.
FRESNO CO. KINGS CO. TULARE CO.
N
This Map is prepared for the convenience of the public; see the Civilian Exclusion Order for the full and correct description.

C. E. Order 107

WESTERN DEFENSE COMMAND AND FOURTH ARMY
WARTIME CIVIL CONTROL ADMINISTRATION

Presidio of San Francisco, California

INSTRUCTIONS
TO ALL PERSONS OF
JAPANESE
ANCESTRY

LIVING IN THE FOLLOWING AREA:

All that portion of the County of Fresno, State of California, within the boundary beginning at the point at which California State Highway No. 180 crosses the easterly bank of the Kings River; thence easterly along the southerly line of said State Highway No. 180 to its intersection with the Fresno-Tulare County Line east of Pinehurst; thence southerly and westerly along said county line to its intersection with the easterly bank of the Kings River; thence northerly along the easterly bank of the Kings River to the point of beginning.

Pursuant to the provisions of Civilian Exclusion Order No. 107, this Headquarters, dated July 22, 1942, all persons of Japanese ancestry, both alien and non-alien, will be evacuated from the above area by 12 o'clock noon, P.W.T., Tuesday, August 11, 1942.

No Japanese person will be permitted to move into, or out of, the above area after 5:00 A. M., P.W.T., Wednesday, July 22, 1942, without obtaining special permission from the representative of the Commanding General, Northern California Sector, at the Civil Control Station located at:

Reedley Junior College and High School Gymnasium,
Reedley, California.

Such permits will only be granted for the purpose of uniting members of a family, or in cases of grave emergency.

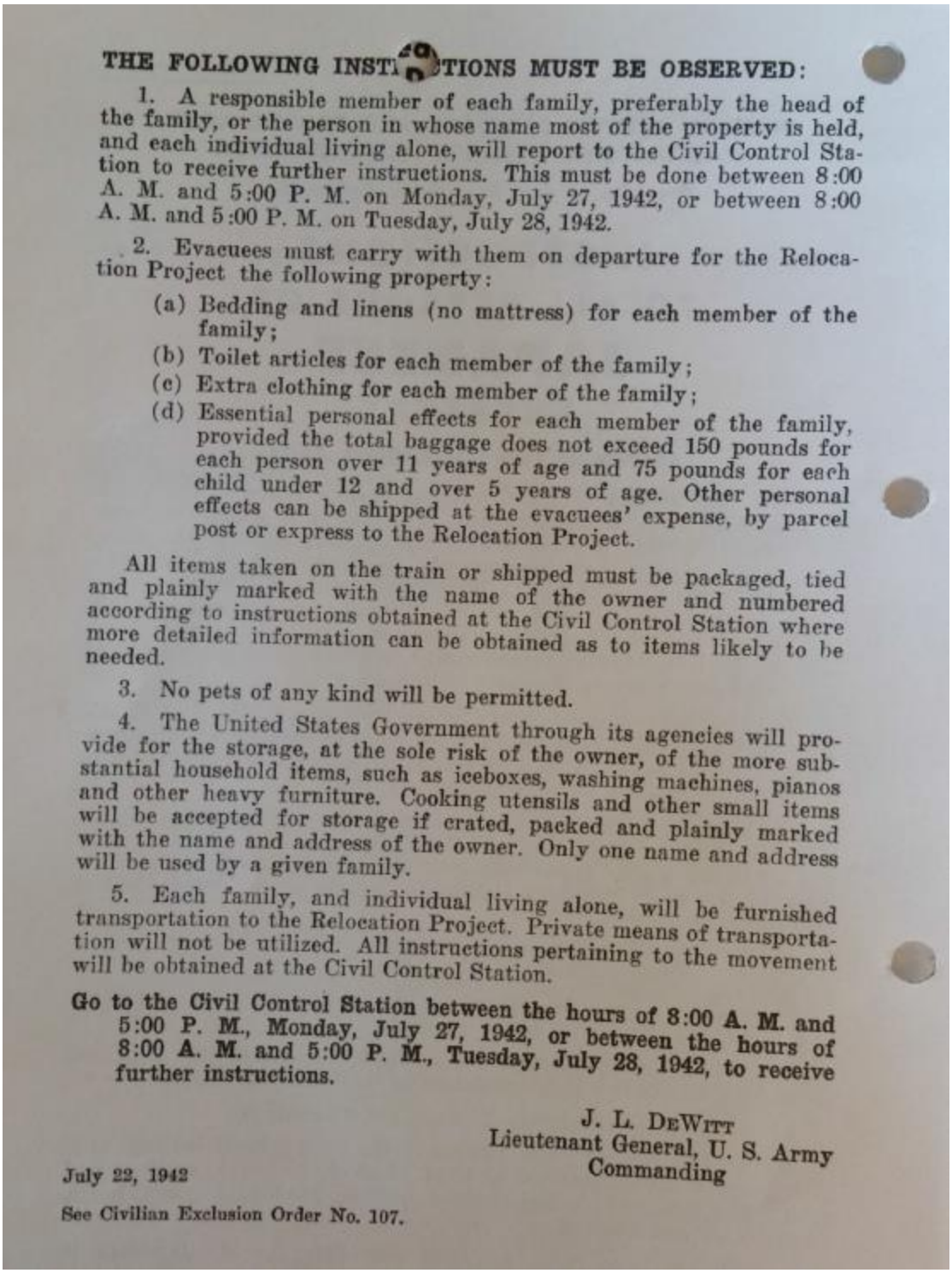
The Civil Control Station is equipped to assist the Japanese population affected by this evacuation in the following ways:

1. Give advice and instructions on the evacuation.

2. Provide services with respect to the management, leasing, sale, storage or other disposition of most kinds of property, such as real estate, business and professional equipment, household goods, boats, automobiles and livestock.

3. Provide temporary residence elsewhere for all Japanese in family groups.

4. Transport persons and a limited amount of clothing and equipment to their new residence.



THE FOLLOWING INSTRUCTIONS MUST BE OBSERVED:

1. A responsible member of each family, preferably the head of the family, or the person in whose name most of the property is held, and each individual living alone, will report to the Civil Control Station to receive further instructions. This must be done between 8:00 A. M. and 5:00 P. M. on Monday, July 27, 1942, or between 8:00 A. M. and 5:00 P. M. on Tuesday, July 28, 1942.

2. Evacuees must carry with them on departure for the Relocation Project the following property:

(a) Bedding and linens (no mattress) for each member of the family;

(b) Toilet articles for each member of the family;

(c) Extra clothing for each member of the family;

(d) Essential personal effects for each member of the family, provided the total baggage does not exceed 150 pounds for each person over 11 years of age and 75 pounds for each child under 12 and over 5 years of age. Other personal effects can be shipped at the evacuees' expense, by parcel post or express to the Relocation Project.

All items taken on the train or shipped must be packaged, tied and plainly marked with the name of the owner and numbered according to instructions obtained at the Civil Control Station where more detailed information can be obtained as to items likely to be needed.

3. No pets of any kind will be permitted.

4. The United States Government through its agencies will provide for the storage, at the sole risk of the owner, of the more substantial household items, such as iceboxes, washing machines, pianos and other heavy furniture. Cooking utensils and other small items will be accepted for storage if crated, packed and plainly marked with the name and address of the owner. Only one name and address will be used by a given family.

5. Each family, and individual living alone, will be furnished transportation to the Relocation Project. Private means of transportation will not be utilized. All instructions pertaining to the movement will be obtained at the Civil Control Station.

Go to the Civil Control Station between the hours of 8:00 A. M. and 5:00 P. M., Monday, July 27, 1942, or between the hours of 8:00 A. M. and 5:00 P. M., Tuesday, July 28, 1942, to receive further instructions.

J. L. DeWitt
Lieutenant General, U. S. Army
Commanding

July 22, 1942

See Civilian Exclusion Order No. 107.

Source: Headquarters Western Defense Command and Fourth Army, *Civilian Exclusion Order No. 107*, National Archives, RG 210, Entry 16, Box 242.

Appendix E

Heart Mountain Hospital Departments Affected by the June 24, 1943 Walkout

Department	Number Employed	Number on Strike	Percentage on Strike
Mess Hall	33	33	100
Pharmacy	10	10	100
Ambulance Drivers	12	12	100
Messengers	1	1	100
Clinic Section and Aides	26	26	100
Sanitation	7	7	100
X-Ray	3	3	100
Telephone Operators	5	5	100
Orderlies	5	1	20
Front Office	20	3	15
Nurse Aides	89	1	1.11

Source: Heart Mountain Relocation Center Community Analysis Section, The Heart Mountain Hospital Walkout: June 24, 1943; p. 70; *Community Analysis Reports and Community Analysis Trend Reports of the War Relocation Authority* (National Archives Microfilm Publication M1342).

Appendix F

The full caption for this photograph reads: Poston, Arizona. Preliminary medical examinations are made by Registered Nurse Hosmer upon arrival of evacuees of Japanese ancestry at this War Relocation Authority center.

Source: Fred Clark, Photographer, National Archives Identifier: 536144, Local Identifier: 210-G-A179, Creator: Department of the Interior. War Relocation Authority. From Series Central Photographic File of the War Relocation Authority, 1942-1945, Record Group 210. https://catalog.archives.gov/id/536144

Appendix G

Health Section Personnel in all Incarceration Camps

Japanese American personnel	**Originally available**	**Working April 1, 1943**	**Working May 1, 1943**	**Required Staff**	**Balance** (including appointed personnel)
Physicians	86	69	55*	86	- 18
Registered Nurses	72	42	30**	273	- 170
Student Nurses	79	45	28		
Nurse Aides or Orderlies		1,000 (approx.)		1,240	-240 (approx.)
Dentists	101	93	74	45	+ 30
Pharmacists	118	91	77	45	+ 32
	* 13 appointed physicians in addition to this number				
	** 73 appointed Registered Nurses in addition to this number				
X-Ray technician	22		4	23	-19
Laboratory technician	44		9	45	-36
Hospital dietician	25		4	14	-10

Source: Adapted from chart in WRA Information Digest, May 15, 1943, War Relocation Authority. Information Digest, No. 44, May 15, 1943, Box 1, National Administration, Series I: Poston, JARCR, #3830, Division of Rare and Manuscript Collections, Cornell University Library.

Appendix H

INSTRUCTIONS FOR PARENTS OF CHILDREN
WHO HAVE HAD TONSIL OPERATIONS

Important - Read Carefully.

1. On coming home from the hospital the child should remain in bed for another two days.
2. The child should be given only liquids for the first day at home, soft foods the next two days, and then the regular diet as he is able to swallow.
3. The child is to be kept in the house for at least one week after leaving the hospital, and during this time he should not run or play hard.
4. Any sign of bleeding, unusual discomfort or signs of a fever should be reported to the doctor. In case of severe bleeding, the child should be brought to the hospital immediately.
5. The child should be brought to the clinic in the camp in which he lives two weeks after the date of operation for an examination by the doctor.

A. Pressman, M.D.
Director of Health & Sanitation
Poston, Arizona

扁桃腺を切開した
子供の両親へ御注意
之は大切です是非御一讀下さい

一、扁桃腺切開後家に帰つてから二日はベッドの中で安靜を守つて下さい

二、家に帰つて最初の日の食物は流動食其へ次きの二日間は柔い食物にして其後は普通食にして下さい

三、退院後少なく共一週間は家の中で安靜守り無理な運動は控へて下さい

四、出血の徴候及発熱或は気持が悪つたらドクターに通知して下さい又出血が甚だしい時は到病院へ連れて来て下さい

五、退院後二週間したら再診を受けち様者の舘府の外来診察所（クリニック）へ行つて下さい

一九四三年七月廿六日
アリゾナ州ポストン セネラル病院
院長 エー、プレッスマン

Source: Instructions for Parents of Children who have had Tonsil Operations, Box 461, RG 75, NARA – Pacific Region (R).

Appendix I

Recommended Immunization Schedule

Agent	Manufacturer	Dosage	Age Recommended
Smallpox Vaccine	Mulford	1 application by prick method covering an area 1/8 inch in diameter	6 – 12 months
Diphtheria Toxoid Refined alum precipitated	Lederle	Give subcutaneously in 2 injections with an interval of 1 month between injections	Begin at 6 months
Whooping Cough "Pertussis Vaccine"	Lederle	Give subcutaneously in 3 injections with an interval of 3 to 7 days between injections	6 months – 3 years
Typhoid Combined Vaccine	Lederle	Give subcutaneously in 3 injections with an interval of 1 week between injections	Begin at 1 ½ years

Source: Adapted from Standard Method of Immunization, August 1943, Box 461, RG 75, NARA – Pacific Region (R).