Not “Lady” but “Worker”: The Changing Role of American National Red Cross Hospital Volunteers after World War II

（リハビリテーションの専門化と女性ボランティア表象の変容： 第二次世界大戦後の退役軍人病院とアメリカ赤十字社）

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SUMMARY IN JAPANESE: 本稿は、第二次世界大戦後にアメリカ赤十字社が実施した退役軍人病院でのボランティア業務に焦点を当て、医療の専門化が生み出したジェンダー規範の変化を考察する。1940 年代末から 1950 年代にかけて全国の退役軍人病院に勤務した赤十字ボランティアの多くは、両大戦間期以前と同様、白人中産階級の女性であった。しかし、戦後におけるリハビリ医療の専門化と医師の権威拡大によって、19 世紀以来、女性ボランティアの美徳とされてきた「共感性」は病院内での地位を低下させた。また、自動車の普及により多数の女性を広域から集めることが可能となったため、地域コミュニティにおける草の根の活動、という従来のボランティア像は修正を迫られた。コミュニティの善意を体現する「慈悲深いレディ」ではなく、男性労働力の再生産を補助する「労働者」であることが、無給で奉仕する病院ボランティアの理想とされていく。こうした新しいボランティア表象は冷戦初期のジェンダー化された女性役割の創出にも貢献した。

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I. Introduction

In 1963, sociologist William A. Glazer found the large number of volunteer workers to be a remarkable aspect of U.S. hospitals which distinguished them from those of western European countries which he had studied. Glazer cited the American class structure as a contributing factor to the robust replenishment of the volunteer workforce, pointing out that volunteers were middle-class people who exerted a spirit of service.[1] However, the perspective of class does not provide a comprehensive explanation. It is said that from the late 1940s, people in American suburbs cherished “home,” seeking a shelter from anxieties about the Cold War and atomic warfare.[2] If so, why did middle-class women, who seemed to embody this homeward-bound culture, go to hospitals for no pay?[3] The perspective of gender is a key to this question, and the story of female volunteers who worked in hospitals of the Veterans Administration (VA), a federal agency in charge of veterans’ benefits, provides an answer. Contrary to the traditional image of benevolent ladies and their grassroots activities, the majority of female volunteers in veterans hospitals enlisted as members of the workforce through the bureaucratized recruiting systems provided by the American National Red Cross (ARC), a nationwide organization having the status of “a federal instrumentality.” Nevertheless, their identities as homemakers in the private sphere and as supplementary workers in the public hospitals had in common the role of reproducing the male workforce. Volunteers did not abandon their identity as self-sacrificing American women but remade it to adjust to the rehabilitation needs of veterans. The national security concerns of the federal government and the new principle of rehabilitation medicine drove this change of identity during and after World War II. With a focus on the labor of nonprofessional middle-class women in veterans hospitals, this essay examines the social and cultural impact of war and medicine which revitalized the foundation of American volunteering in the mid-twentieth century.

Leaving the vigorous associational life of American people untouched,[4] historical research on medical care, welfare, and the legal system in the mid-twentieth century focused on the activities of professionals.[5] Even when welfare history notes that private organizations played a major role in provision of welfare at the state and municipal level, they draw attention

to professional lawyers and social workers as service practitioners.[6] Yet in the shadow of the professionals, amateur volunteers continued to play indispensable roles as a labor force in the postwar social service programs. Public-minded civilians covered the substantial shortfall in labor which arose from the enormous demand placed on military hospitals, veterans hospitals, and communities.[7] Especially in veterans hospitals, the recruitment and training of volunteers reached an unprecedented scale after World War II.

This surge in volunteer activity cannot be described as a spontaneous phenomenon since it was coordinated by the nationwide bureaucratic institutions. Even if women's unpaid work looked like a symbol of time-honored goodwill sourced from local communities, in reality it was part of a semi-governmental mobilization of the civilian workforce. Only cross-regional networks of large private organizations such as ARC could manage it.

The nature of volunteer work inside the hospitals also became different from that of the earlier period in terms of its expertise and discipline. Rehabilitation professionals claimed lay volunteers to be effective and competent laborers who could keep the hospital rules and follow the instructions of medical staff. Their new task was to aid the rebuilding of patients' masculinity, which was defined by workability.

A scrutiny of hospital volunteer activities will show how some cultural assumptions, which historians have seen as characteristic in early Cold War America, emerged from the federal policy related to wars. Recent studies see the 1950s not only as an era of a conservative view that praised suburban homemakers, but also as an era with a norm that women should help men regain their productivity. According to Sonya Michel, the romance of veterans in postwar movies was based on the plot that the devotion of wives and lovers helped veterans readjust to society.[8] As if tracing this plot, hospital volunteers worked to restore the productive bodies of injured soldiers and encouraged their economic independence as national human resources.

Historians point out one more significant change that women faced in mid-century America: the decline of the authority of emphatic middle-aged mothers and the rise of the expectation of well-educated female citizens. According to Rebecca Jo Plant, postwar guidance and articles for young women recommended them to seek the advice of male psychiatrists and doctors on how to treat their returning partners, rather than to ask senior

women.[9] Further, psychologists, writers, and popular culture such as movies portrayed middle-aged “mom” negatively as an obstacle to the independence of veterans. Women who maintained a strong emotional interdependence with their young son became subject to mockery as ignorant and irrational “bad mothers.”[10] The VA facilitated this trend by emphasizing supervision and control of lay women by medical experts in charge of maintaining the quality of volunteers. In this context, qualified volunteers meant those with higher adjacency to medicine, and diverged from the praised image of “clubwomen” —middle-class women active in charity organizations and community affairs or sometimes in reform movements in the nineteenth century.[11] With the hegemony of medical professionals in veterans hospitals, which were not established until World War II, the compassion and sympathy of hospital volunteers for male patients lost its footing.

In bitterer ways, ARC blamed unregulated pampering by amateur “ladies” for preventing patient independence. The VA and ARC were complicit in devaluing the emotional connection between middle-aged volunteers and young men and in undermining the authority of affectionate women. In supplying tens of thousands of female standardized volunteers gathered from wide locations annually (together with a far fewer number of male volunteers), the VA and ARC utilized and strengthened a certain kind of femininity for the purpose of disciplining women working in hospitals without pay.

As soon as they were denied their mother-like roles in hospitals, female volunteers lost their unique contribution to helping male patients return to the workforce. In veterans hospitals after the late 1950s, one of the major purposes of rehabilitation programs was to make chronic patients dischargeable even if they could not be employed outside hospital. Female volunteers’ social significance corresponding to the Cold War culture, which expected women to help men earn, decreased there. Coincidentally, as the VA tried to increase male and teenage volunteers in its hospitals, the singularity of adult female volunteers disappeared.

By analyzing the vast mobilization of volunteers at veterans hospitals, this essay clarifies the broader effect of wars and medical professionalization on the rise and fall of a particular American gender order from the late 1940s.

II. Using Volunteers in Federal Hospitals

Since it was chartered by Congress in 1900, ARC has been obliged to improve the well-being of sick and wounded soldiers in wartime.[12] ARC's hospital volunteer program was in use in the military as soon as the United States entered World War I. At Walter Reed Army Hospital in Washington, D.C., a comprehensive program for rehabilitation of injured soldiers was developed in which orthopedic surgeons, physiotherapists, occupational therapists, nutritionists, and prosthetic engineers gathered to work on restoring the physical mobility of soldiers. In assisting these professional staff, the Hospital Service and Recreation Corps of ARC—nicknamed "Gray Ladies" from their uniform color—played a central role. Their tasks included visiting and decorating wards, being a companion to patients, setting up recreation and providing entertainment. In addition, the Arts and Skills Corps was organized by professional artists and craft workers, which provided patients with opportunities to learn vocational skills. In some cases, they worked for patient distraction and entertainment, or as part of occupational therapy.[13]

However, the utilization of hospital volunteers by the military during World War I remained modest as a whole. This is because there was an idea among doctors in charge of rehabilitation that women's pampering would prevent patients' independence. Army surgeons, being intimidated and bitter about women who were approaching patients driven by wartime curiosity and adoration of servicemen, restricted volunteers' access to hospitals. Doctors also admonished soldiers against associating with hospital volunteer women.[14] In addition, the non-expertise of volunteers was a reason for the military to hesitate to call for them. During the war, the Department of War considered intensive use of ARC nursing assistant volunteers to cope with the shortage of nurses. Yet, this did not come about because the National Association of Nurses and the National Hospital Association were opposed, being afraid that it would undermine the expertise of nursing.[15]

When the size of military mobilization swelled far more during World War II, the labor shortage in military hospitals was so serious that they accepted a huge number of volunteers to aid hospital staff. According to the history of ARC written by Foster Rhea Dulles, about 400,000 volunteers, the majority of them female, worked in Army and Navy hospitals from

1943 to 1944.[16] Although such active utilization of hospital volunteers was unprecedented for the military, surgeons had admitted that exchange and recreation with volunteers had a positive psychological influence on soldiers by this time.[17] This experience in military hospitals would be a model for similar programs in veterans hospitals after the war.

The works of ARC volunteers in military hospitals during World War II varied according to the psychological and life needs of patients, and not all of the contents could be predefined. The volunteer tasks which ARC permitted included helping patients' distraction, providing entertainment, planning parties and picnics, purchasing items desired by patients, giving transportation by car, supplying and managing fresh flowers in wards, managing libraries, reading books for patients, and writing letters on behalf of soldiers.[18] Through these activities, volunteers were expected to improve the treatment effects and mental health of patients in hospitals.

In addition, as female volunteers took care of soldiers, they protected, encouraged, and disciplined patients. At the Army station hospital in Pasadena, California, ARC volunteers were trying to cheer up patients who were not active in the use of prosthetic devices.[19] Sometimes white middle-class female volunteers with their superior racial or class status acted as a matron or supervisor of minority soldiers. A monthly report on the Pasadena Hospital volunteer program submitted to the ARC headquarters in Washington, D.C. recorded the episodes proudly. Volunteers calmed Puerto Rican soldiers with schistosomiasis who were "more emotionally immature than many of the American patients" in bed, relieved the anxiety of black soldiers who had insufficient understanding of the environment inside the hospital, comforted and encouraged a soldier who was ridiculed by other patients because of his illiteracy, and accompanied a Chinese soldier who could not speak English to the station on his way home.[20]

While the armed forces utilized hospital volunteers on a large scale during World War II, the VA, a civilian agency, was hesitant to do so during wartime. Early in 1945, one ARC staff traveled to look around the medical facilities of the VA on the "East Coast"—Washington, D.C., Indiana, Kentucky, Maryland, Ohio, Pennsylvania, Virginia, and West Virginia—and reported problems occurring in volunteer activities. The report said that in some facilities, the guidance of the VA prohibited the use of volunteers. Even if there were some volunteers, many of them were old-timers from

the era of the Great War, who hardly kept pace with the advancements of medical knowledge and technology used in the rehabilitation of World War II veterans. Furthermore, the report noted that there were no differences in task or treatment between ARC volunteers and short-term volunteers sent by veterans organizations or local associations. The ARC staff assumed that the influence of "local politics" was behind the presence of insufficiently trained volunteers in the hospitals, and she lamented that the VA and its hospital staff disregarded the continuity of volunteer training and the volunteer program as a whole.[21]

As well as ARC, high-ranking officials who moved from the army to the VA were concerned about the lack of hospital volunteers. What they feared was the "disappointment" that hospitalized veterans would feel at the absence of volunteers. Veterans who had experienced warm care from volunteers at military hospitals while they were active soldiers noticed the far lower number of volunteers appearing at veterans hospitals to which they moved after being discharged from the military. They complained that American society was losing interest in them.[22] The VA, concerned with this situation, met with ARC officials and decided to expand the acceptance of hospital volunteers. Although the Department of Medicine and Surgery (DMS) of the VA was striving to control the operation of hospitals by delegating administrative powers to medical professionals exclusively, its officers welcomed lay volunteers in the hospitals because they highly valued the positive influence of volunteers on patients' emotions, as will be shown later.

Just after World War II, the VA drew up a nationwide volunteer utilization plan in a short period of time. In April 1946, Omar N. Bradley, the administrator of the VA, ordered the establishment of the Volunteer Service National Advisory Committee that would coordinate the activities of volunteer organizations at the national office in Washington, D.C., in regional offices, and in each veterans hospital. At the committee, twenty-three welfare organizations and veterans groups attended on behalf of about 300 organizations participating in volunteer work at the hospitals. Among them, large-scale organizations, which were obliged to serve veterans under the charter of Congress, regularly discussed volunteer work policies. They included the American Legion, Veterans of Foreign Wars, Disabled American Veterans, United Service Organizations, and ARC.[23] In 1948, about 60,000

people participated in volunteer work at veterans hospitals every month through these organizations, contributing over 310,000 hours of work.[24]

III. Wide Area Volunteer Recruitment

To collect such a vast number of volunteers in veterans hospitals, public relations articles were released in media frequently accessed by middle-class women. Margaret Hickey, in charge of the public affairs section of *Ladies' Home Journal*, wrote a column introducing volunteer activities at veterans hospitals to readers of the magazine in August 1950, shortly after the Korean War began. According to the article, a physician of a veterans hospital praised the work of volunteers, saying that it had caused “more miracles to happen than the newest drugs or medication.” In addition, it quoted the words of Karl Gray, the administrator of the VA, saying that veterans were longing for volunteers in hospital as “a constant and welcome reminder of community life.”[25] Hickey was a celebrity who worked as a lawyer while belonging to various charitable and service organizations such as the Young Women’s Christian Association and ARC. During World War II, she worked at the Women’s Advisory Committee of the War Manpower Commission to come up with the labor force mobilization plan and efficiently utilize the power of women for the total war effort.[26] Hickey herself was not a so-called “homemaker,” since she had a career that is considered as an elite professional. However, from her experience of being involved in long-term unpaid service activities, she talked about grassroots goodwill for national security even after the war.

By contrast, people who gathered at veterans hospitals in response to calls like Hickey’s did not, on the surface, seem to be so different from the image of the conventional volunteer. Although there is no detailed data divided by group or region, the VA’s report made in 1960 describes the average volunteer after World War II. According to the report, 11,000 volunteers worked at veterans hospitals in May 1959. They belonged to more than 5,000 regional organizations and were active in 157 veterans hospitals nationwide. Typical volunteers were as follows: middle-aged women without any paid job, in charge of the same volunteer task for more than three years, doing weekly work totaling twenty-one hours a month. These average

volunteers are said to have not differed significantly across regions and hospitals.[27] The report did not show personal motives for beginning to work in veterans hospitals, but it said that many of the volunteers started after face-to-face recruitment. More than two-thirds of hospital volunteers were invited by other members of volunteer organizations, and nearly thirty percent got information about the volunteer work at veterans hospitals from small town or neighborhood meetings.[28] These descriptions seem to fit the stereotype of female volunteers which existed at that time and persisted for many years in American society.

The female volunteers assigned by ARC, however, had characteristics which distinguished them from volunteers of the previous era and from those of competing associations in the same era. First of all, ARC volunteers were the single largest group among veterans hospital volunteers. In the first five months of 1949, about 20,000 ARC volunteers worked in hospitals nationwide. Furthermore, in terms of gross working hours, ARC personnel bore more than half of the workload in veterans hospitals during this same period.[29] ARC devoted considerable time, money and labor to place a sufficient number of people at appropriate sites. It assigned local staff who would supervise and promote volunteer work at each veterans hospital, and serve as coordinators between ARC and the hospital director. In addition, ARC set up the Veterans Hospital Service as part of its organization and arranged salaried staff to secure volunteers.[30]

ARC had to collect a large number of volunteers from a wide area where their homes were dispersed. Most of their commutes to veterans hospitals took about thirty minutes by car, more than a quarter took about one hour one way, and fourteen percent spent even more than one and a half hours. While about three-quarters of all volunteers used private cars for commuting, only fifteen percent used public transportation, and ten percent were picked up by organizations they belonged to. Long commuting distances, lack of appropriate transportation, and shortage of parking lots could be obstacles in recruiting volunteers.[31] These facts show that many of the volunteers did not live in the vicinity of veterans hospitals, and that the popularization of automobiles enabled middle-class volunteers to go out by themselves. Although recruitment of volunteers required face-to-face persuasion based on a local connection, only cross-regional organizations such as ARC made it possible to network people living away from hospitals. It no longer was a

"grassroots" activity literally.

Changes in the role of veterans hospitals as federal facilities moved them close to suburban, not rural, volunteers after World War II. The number of soldiers who were injured or suffered from illness in World War II came to 670,000, and the figure overwhelmed the capacity of existing veterans hospitals. Therefore, the federal government planned construction of more than seventy new hospitals. Alongside this increase of veterans hospitals, the location of the facilities changed. Until the interwar period, some politicians had used the construction of veterans hospitals as pork-barrel for their constituents and built many hospitals in rural areas far from advanced medical institutions and doctors. These remote hospitals could not secure enough medical staff and became nursing facilities for veterans who were chronic and aged.[32] To convert veterans hospitals into advanced medical complexes, Congress passed Public Law 293 in January 1946. This law allowed the medical director of the VA to appoint doctors and specialized staff directly and gave him the discretionary power necessary to secure talented personnel.[33] The VA had established cooperative relationships with universities throughout the country so that it could secure and train specialized doctors. The medical director asked heads of medical schools adjacent to veterans hospitals to organize "deans' committees," and made them involved in the personnel affairs of the hospitals. In addition, residents enrolled in each medical school could select veterans hospitals as their place for training and research.[34] Inevitably, many of the new facilities were located in cities having universities. It geographically connected suburban volunteers with veterans hospitals.

ARC volunteers were special not only for the quantity but also for the quality of their work. Certified by the American Nurses Association and the American Hospital Association, ARC opened its own nurses aid training program based on the assumption that unless training volunteers by themselves, ARC couldn't maintain the level of service.[35] Another ARC policy was to supervise volunteer recruitment work through national headquarters and regional offices. It was based on a bitter experience that ARC had failed to secure enough competent volunteers when recruitment was entrusted to each local chapter. In 1948, the ARC board of directors reduced the budget for supervisory work in each region and dismissed many local officials. Consequently, paid staff of ARC disappeared from twenty-

five veterans hospitals. Since this caused a visible hindrance to volunteer recruitment work, veterans hospitals, veterans organizations, and ARC local chapters criticized the Red Cross national headquarters.[36] Thus, the staff in Washington, D.C. analyzed the impact of the absence of paid staff and confirmed the occurrence of problems including lack of appropriate guidance to volunteers, duplication of work, and general lack of cooperation among staff. Furthermore, the staff found it almost impossible to secure local volunteers for veterans hospitals and neighboring small ARC chapters located in remote areas without the diligence of paid staff.[37] Learning from these experiences, ARC would adhere to the policy to let regional offices and its paid staff work to maintain the quality and quantity of volunteers.

IV. ARC Volunteers in the New Era

Alongside the numerical and geographical expansion of ARC's recruitment activities, it was a notable development that the direct connection between medical care by hospital staff and work by the organization's volunteers intensified after World War II. In the veterans hospital in Northport, New York, Gray Ladies played music to patients not solely for entertainment purposes, but to improve their mood as well. By doing so, they provided "a setting that favors the wholesome reintegration of personality" after psychiatric patients underwent insulin therapy and electrotherapy. Furthermore, in the psychiatric surgery program at the hospital, Gray Ladies were carrying out a postoperative training program for patients who received leucotomies. This program began with the rebuilding of "elementary speech mechanisms" and progressed to the training of "uses of vocabulary, symbolic constructions, up to the ways of the outside world in everyday life, correct manners, and practices in ethical reasoning."[38] The role of hospital volunteers became more than being companionable for those with light symptoms. To adjust to such a situation, ARC volunteers at veterans hospitals first learned practical care knowledge and skills.[39]

It seems that the expansion of women's middle and higher education that occurred during the interwar period was a precondition for demanding volunteer work. Looking at the statistics from 1910 to 1935, women's high

school graduation rate exceeded sixty percent excluding the South. Also, the number of women who earned bachelor's or first professional degrees increased from less than 17,000 in 1920 to approximately 77,000 in 1940.[40]

As early as its relief activities for continental Europe during World War I, ARC trained civilian women to carry out biomedical and hygienic education campaigns in Italy and France.[41] The inclination of the international Red Cross movement for public health in the early interwar period preceded the medicalization of volunteer activities in the American mainland after World War II.[42] The fresh factor which advanced the change of volunteers' role in the late 1940s was a philosophy of rehabilitation medicine. During the war, Howard A. Rusk, a physician from Missouri who launched the Army's convalescent program from scratch, proposed the concept of "whole-man rehabilitation."[43] In reports addressed to the Army Air Force headquarters, Rusk reviewed the program and explained its basic philosophy. According to him, it was a program for soldiers who would be returned to military service or civilian work that emphasized intermediate processes located between medical treatment and vocational training. By performing non-intensive labor and gymnastics, receiving physical therapy, and taking academic training, soldiers gradually recovered both mentally and physically, Rusk explained. He asserted that through the program, many of the injured and sick soldiers who had been forced to leave the Army in the past could stay in military service. Even if not, they would return to the civilian world as productive members of communities.[44] For the purpose of realizing the idea of whole-man rehabilitation that aimed at giving soldiers independence not only through restoring functional deficits of the mind and body, but also through the overall utilization of existing physical functions, the role of volunteers had to change. Simply keeping hospital life comfortable for patients was no longer enough. Volunteers must teach patients the principle of self-help and stimulate their independence.

Joan Younger of *Ladies' Home Journal* expressed the change in qualities required for hospital volunteers in the magazine by saying that "ladies bountiful" went out and efficient "workers" came in.[45] "Ladies bountiful" is a phrase that social workers had used since the beginning of the twentieth century in promoting their profession. They used it mainly to criticize evangelicals competing with in the field of welfare. By doing so, the social workers distinguished the welfare profession from the faith-based

charity.[46] After World War II, hospital volunteers, who were not themselves professionals, used the phrase to criticize fellow volunteers for being overly empathetic. This semantic change after World War II shows that it was no longer appropriate for middle-class women to express unrestrained sympathy towards hospitalized veterans, and it became the obligation of volunteers to act as one of the staff supporting patient rehabilitation under the direction of medical professionals. In a forum at the ARC National Convention in 1947, the floor expressed a critical opinion against "ladies bountiful." It emphasized refraining from excessive sympathy for patients, helping them regain physical and mental functions, supporting their confidence, and aiding patients' participation in local community activities as the pillars of volunteer discipline.[47]

Throughout the redefinition of hospital volunteers, ARC did not deny femininity as a whole, but only devalued the virtue of compassion. Rather, the volunteers' focus on helping men become breadwinners thus aligned with the ideal of womanhood in the early Cold War period.

V. ARC Volunteers in the Early 1960s

In the latter half of the 1950s when most of the veterans of World War II and the Korean War finished settling back into society, it became a significant part of ARC volunteer activities to promote the discharge of older veteran patients who had chronic illnesses. After suffering budget cuts due to the increase in government spending on the military during the Korean War, the VA attempted to reduce its spending. Consequently, the importance of rehabilitation as a way to facilitate patients' discharge rose because it was expected to relieve the financial and manpower burden of long-term hospitalization.[48] This situation transformed the meaning of men's independence, which VA hospitals were supposed to facilitate, from bread-winning to living outside hospital, and consequently, the gendered call for female volunteers to make men workable weakened.

With the passage of time from the end of World War II, the proportion of patients in the acute cases among the inpatients of veterans hospitals decreased, and in contrast the number of chronic patients with little improvement in symptoms increased. At the same time, the increase of World

War I veteran patients, many of whom entered their old age and received constant medical treatment, had led to a surge of hospitalization. The number of patients that the VA granted hospitalization gradually increased from less than 350,000 in 1946 to over 600,000 in 1963.[49] The increasing number of veterans who entered nursing care facilities became a problem, too. The Council of Chief Consultants (CCC), an advisory body of the DMS, pointed out that there were about 17,000 nursing home residents and 2,000 more on the waiting list in 1950. The CCC recommended enhancing rehabilitation efforts to facilitate the discharge of long-term residents.[50]

Private hospitals had already accelerated the discharge of chronic patients with fixed medical conditions and patients with poor ability to pay, specializing in medical treatment with high profitability.[51] According to the Visiting Nurses Association, by the early 1950s, half of the home patients whom it sent personnel to see were the discharged patients referred from hospitals.[52] The VA followed suit with this trend, and as a result the role of volunteers would change again from facilitating men's entry to the workforce to transferring the care task for veterans with chronic disabilities to communities.

The VA launched the first case of specialized programs in the Los Angeles VA medical center which urged chronic veterans to leave hospital. The staff of the center asserted in a report of 1952 that ninety-one percent of newly hospitalized patients fit rehabilitation, and of those twenty-three percent could be more productive in local communities and nursing homes outside the hospital wards. Based on experiences in this center, the VA set up the Physical Medicine and Rehabilitation Division in 155 veterans hospitals that prescribed physiotherapy, occupational therapy, and physical correction to patients.[53] Since then, the DMS devoted a large part of its work to rehabilitation programs conducted at outpatient clinics, convalescent centers, nursing care homes, sheltered workshops, mental health clinics, vocational training facilities, and patients' homes.

In the late 1950s, for promoting the reintegration of chronic veterans into society, a program began in which VA social workers consulted patients on their life design after discharge. Fifty veterans hospitals introduced this program, which mainly consisted of arrangements for livelihood support from volunteers and outpatient medical care provided by professionals. The name of the program was "Planning for the Patient's Discharge" (hereafter

"discharge planning").[54]

One big difference of discharge planning from the VA's precedent rehabilitation programs was that chronic patients were expected not to work but just be self-sufficient within their family and neighborhood as much as they could.[55] In other words, the independence that the discharge planning requested of the old veterans was to leave the hospital and cooperate to reduce the medical budget of the VA.

A report from the veterans hospital in East Orange, New Jersey, published in the *Journal of American Geriatric Society* in 1963, explained the outcomes of the discharge planning that pushed patients with chronic neuropsychiatric diseases to exit. According to the report, the purpose of rehabilitation for chronic patients was to stabilize patients' emotions and maximize physical functions, thereby returning them "home." To that end, not only the patient himself, but also his family had to understand the purpose and significance of the program. One problem at the beginning of the discharge planning process was that patients who thought they could survive only in the hospital expressed dissatisfaction with being discharged. However, by patiently persuading the veterans and their families and taking careful planning processes to resolve the anxiety, the hospital staff got positive reactions in the end. As a result, in the East Orange Hospital, the number of discharged old patients with neuropsychiatric diseases increased, and the average length of stay was shortened. William Middleton, director of the DMS, considered that maximizing attention to the emotions and needs of patients and their families was the key to letting patients out of hospital.[56]

The VA asked volunteer organizations, especially ARC, to participate in the discharge planning program from its inception.[57] But, assuming that its volunteer department had made a sufficient contribution within existing programs, ARC hesitated to dispatch personnel specializing in discharge planning. Nevertheless, the VA continued to seek Red Cross cooperation because by that time, the activities of the ARC volunteers without pay did more than show the goodwill of local communities symbolically. They became indispensable aides for the smooth execution of the rehabilitation program in veterans hospitals for the purpose of budget reduction.[58] Eventually, in the early 1960s, ARC volunteers became more deeply committed to the DMS rehabilitation program for chronically disabled patients. They newly worked in daycare facilities for veterans with mental

disabilities.[59] Volunteer nursing aides, who received the most specialized training among ARC volunteers, expanded their involvement in the rehabilitation programs for chronically disabled veterans in 1961.[60]

Alongside this shift, a sudden change occurred in the statistics on the hours spent by volunteers. In 1960, volunteers at veterans hospitals spent three million hours on "Recreation," more than 1.2 million hours on "Nursing," and about 450,000 hours on "Phys. Med. & Rehabilitation." However, in the fiscal year 1963, recreation work disappeared from the statistical data, while 3.5 million hours of volunteer work came to be used for "Phys. Med. and Rehabilitation."[61] It is not clear whether these classifications of volunteer hours reflected a change in actual work content, but at the very least it can be pointed out that the VA policy focusing on rehabilitation for chronically disabled veterans had an effect on the appearance of statistical data. Against this backdrop, even when the number of hospitalized veterans of World War II and the Korean War decreased, the workload of volunteers at veterans hospitals increased.

Amidst these changes, veterans gradually acknowledged the identity of ARC volunteers as "workers" to assist rehabilitation. There still persisted a tendency to view volunteers as attendants in wards rather than staff indispensable for rehabilitation but some patients praised the positive effect the volunteers had on their rehabilitation progress.[62] This new volunteer identity, born from the strain placed on hospitals during wartime and the necessity to advance and expand rehabilitation medicine, was carried over into the 1960s through daily activities at veterans hospitals. At this time, however, employment of discharged patients, whom female volunteers (and American women generally) were supposed to work for in the direct aftermath of World War II, was not the only concern of rehabilitation programs. By caring for the growing number of old chronic veterans, women did not necessarily reproduce "productive" male bodies as they did earlier.

Simultaneously, changes in the demography of hospital volunteers made the monolithic identity as adult nonprofessional women less appropriate for them. In the early 1960s, the need for a wide variety of auxiliary workers increased in the VA's medical facilities. Lewis A. Leavitt of Baylor College of Medicine specializing in physical medicine and rehabilitation presented this point at the CCC in 1962. According to him, military, state and private hospitals were actively recruiting volunteers and competing against veterans

hospitals. For Leavitt, this was a desirable phenomenon itself, recalling the fact that the volunteer recruitment and training at state hospitals developed under the guidance of the VA. Ironically, however, the shortage of various types of hospital volunteers got worse, and adult middle-class homemakers alone could not fulfill the volunteer needs of veterans hospitals. Although, as early as World War II, retired men with some professional or semiprofessional skills were popular as valuable personnel who could provide "prevocational rehabilitation" to patients, the VA became more eager to get male volunteers. Moreover, besides the utilization of adult volunteers, the VA's "volunteens" (volunteer-teens) program tried to give vacationing teenagers the experience of "paramedical" work and to give opportunities to consider future career formation in the medical field.[63] The social and cultural idea that volunteers must be adult women seemed antiquated.

VI. Conclusion

Being wary of the lower number of volunteers in veterans hospitals than in the military hospitals, the VA requested ARC to expand its hospital volunteer program after World War II. In advancing smooth demobilization after the war, it was inconceivable for the VA to overlook the veterans' grievance that American society lacked interest in former soldiers compared to active soldiers. Additionally, VA officials expected that the presence of volunteers would increase the veterans' motivation to complete physical rehabilitation.

With a nationwide network of regional offices and local chapters, ARC played crucial roles in gathering volunteer workers from "communities" to veterans hospitals. The longer travel distance distinguished the postwar volunteers from their predecessors. Most volunteers at veterans hospitals commuted by automobiles. This indicates that the word "community" that VA and ARC personnel frequently used was rhetoric in large part. Even when unpaid work in the hospitals was expressed as the manifestation of grassroots goodwill by surrounding communities, each volunteer was incorporated into the mechanism of national security individually through a large bureaucratic organization. In collecting a number of volunteers traveling a long way, the VA depended not on small local associations but on cross-regional or

nationwide organizations including ARC. Inside of the ARC organizational structure, there was close cooperation between national headquarters, regional offices, and local chapters. Wide area activity units covered several cities and municipalities. This system could efficiently respond to requests for large-scale personnel from the federal government.

In the postwar era, ARC stressed the difference in quality between its own volunteers and other organizations’. This was because of the necessity to reform the unstable position of volunteers in charge of non-medical work at veterans hospitals after World War II where specialized medical care increased burdens. When they faced the professional suspicion that amateurs would intervene in the field of medical work or spoil patients indiscriminately, hospital volunteers tried to earn the trust of medical staff by maintaining a strict deference to their authority. As a result, a “worker” properly carrying out duties under the direction of the hospital staff became the ideal character of ARC volunteers, far from a “lady” giving unrestrained mercy on impulse. In order to approach such a figure, volunteers as an auxiliary workforce had to be familiar with the rules in the hospital, and have a positive influence on patients’ struggle for self-reliance.

For hospital volunteers who became part of the rehabilitation policy of the VA, the boundary between non-medical and medical services was always subtle and complicated. Providing patients with distractions and consolation was still an important role for female volunteers after World War II, but this alone was not enough. They had to cheer up patients or discipline them for training, and in some cases assisted them in their recovery from surgery. The average background of a postwar volunteer—a white middle-class homemaker who came to work at a veterans hospital through the invitation of neighbors—was not so very different from that in the interwar period, but the assigned work and expected ethos had changed. They struggled to maintain the self-discipline not to deviate from the scope of proper work, to maintain the rationality and efficiency suited to the objectives of patient rehabilitation, and to possess well-timed ingenuity more than compassion as a component of femininity.

Such a characteristic feature of ARC volunteers after World War II strengthened the dominant gender norm of the era. As with the virtue of white middle-class wives living in the Cold War, it was not considered just enough to create comfortable and relaxing private spheres for men.

Homemaking had to lead to the reproduction of the male workforce. Modeling after their expected roles in households, female hospital volunteers strived to help male patients get discharged and return to civilian society as breadwinners. There was less room for the ideal of motherhood than in the previous era.

From the end of the 1950s, the volunteer work programs in veterans hospitals weakened their connection with Cold War femininity in turn. As the main focus of the hospital activities had shifted to the rehabilitation of unemployable old chronic patients, what "independence" of veterans meant became not employment but living outside the hospital. In connection with this development, hospital volunteers lost their significance as agents helping veterans regain their masculinity as breadwinners. At about the same time, more retired men and teenagers became welcome in volunteer activities at veterans hospitals. The majority of the volunteers were still adult women, but the cultural importance of their age and gender declined.

This essay has analyzed the growing presence of volunteers as a nonprofessional workforce in postwar hospitals, but has said nothing about its collision with the economic interests of nonprofessional employees there. By the end of the 1950s, the use of volunteers as a substitute workforce for non-specialized hospital staff was openly pervasive. In particular, private non-profit hospitals, which had been exempt from negotiating with unions by law, relied on volunteers when their nonprofessional employees struck for union recognition. One philanthropic fund even awarded volunteers in 1959 as they enabled hospital operations during the walkout by members of Local 1199 of the Retail Drug Employees Union in New York City. The fund cited the volunteers for morally accusing the striking black and Puerto Rican hospital workers, including nurses' aides, orderlies, porters, elevator operators, kitchen workers and other "housekeeping" employees. Hospitals created class and racial divisions between volunteers and low-income workers. Examination of the tense relations between American voluntarism and caring labor is the next task.[64]

Notes

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