redoubling efforts to get WAC recruits, and when posts and air bases were contributing additional teams. Recruiters, from a study of the reactions of hesitant prospects, felt that it was difficult enough to secure an enlistment when the applicant could be rushed through processing in her own home town and sworn in before she repented her decision. It was deemed impossible to persuade most applicants to take leave from their jobs and travel several hundred miles for an examination which, if unsuccessful, would leave a woman in the embarrassing position of having publicly announced her intentions and then having been publicly rejected. Therefore, the whole plan of centralized screening was dropped, and the number of enlistment stations was actually increased instead of decreased.

Finally, in March of 1944, a conference of all interested agencies adopted a plan proposed by Director Hobby's representatives. This solution, similar to that which had proved successful in The Surgeon General's Office and in other agencies, called for centralizing responsibility in a WAC specialist. Accordingly, a highly qualified WAC officer was appointed in each service command to improve screening procedures as best she might. She was responsible for giving medical examiners the proper background material for an understanding of Corps jobs, and for obtaining for them such reports on doubtful candidates as would assist their judgment, such as case histories and hospitalization records. If qualified psychiatrists were unavailable locally, she was authorized to pay $2.50 per doubtful applicant to recognized social agencies for a full investigation—a small investment compared to mustering-out pay and veterans' benefits, and one that left the final decision in the hands of military personnel. It was also required that a qualified WAC officer be placed in each recruiting station where WAC enlistments were processed, to render much the same assistance and to assume responsibility for a final review of acceptances.[19]

The Surgeon General called the attention of service command surgeons to these measures and directed that they assist the WAC liaison officer in every possible way. A conference was also called in May of 1944, of one member from each service command, to clarify procedures. In August of 1944, a more forceful directive to recruiting stations reiterated the requirement that the neuropsychiatric examination must be made by a qualified neuropsychiatrist, and that the gynecological examination must not be omitted. It was stated that "experience has shown unequivocally" that there was an undue discharge rate of women accepted by stations where such examinations were "omitted or inferior." Finally, in the fall of 1944, a medical technical bulletin gave an extremely clear statement, in medical language, of the conditions of WAC life that medical officers must consider in approving an applicant.[20]

This last combined effort seemed to be moderately successful. The rejection rate rose markedly and the disability discharge rate dropped.[21] It appeared that the work of educating medical examiners to WAC

[19] M/R cited n. 11.

[20] (1) Ltrs, AGO to all SvCs, 1 Apr 44, AG 341 WAC PR-I; 19 May 44, SPX 341 WAC PR-I; 10 Jun 44, AG 341 WAC PR-I. (2) Ltr, SGO to all SvCs, 13 May 44. SGO Hist Div folder. (3) Memo, MPD ASF for Dir Pers ASF, 3 May 44. SPGAP 342 Gen-123, in SPAP 341 WAAC. (4) Memo, Actg Dir WAC to SGO, 3 Mar 44. SPWA 330.14 R. (5) Direct quotation from Memo, MPD ASF for TAG, 19 Aug 44. SPGAP 342 Gen-141, in SPAP 342 WAC.

[21] Rpt cited n. 2(2). Also Chart by Med Stat Div SGO, 12 Mar 45, sub: Trend of Med Rejections, WAC Candidates, Nov 42-Dec 44. Copy in WAC files, OCMH.