

Part One

The Decade After the Vietnam War

Chapter One

Evolution and Reorganization

The Vietnam War (1961–1975) was a watershed event for the United States. It had a significant impact on the Army Nurse Corps, the Army Medical Department (AMEDD), the Army, and the nation. The protracted war drained the Army, cost it a decade of modernization, alienated the military from society, and left a “hollow force” to rebuild and reinvigorate. In effect, the infrastructure of the Army languished to pay for the war.

After the conclusion of the Vietnam War, several wide-ranging and significant changes exerted myriad effects on the Army Nurse Corps. The most influential of these phenomena included the dismantling of the Selective Service System, the reorganization of the Army, the launch of Health Services Command (HSC), the opening of the Academy of Health Sciences, the transformation of the Office of the Army Surgeon General, the inauguration of improvements in the Army Reserve and National Guard, and the revolution in the roles and status of women.

Between 1968 and 1974 the United States dismantled its Selective Service System and ended the draft. The Army became an all-volunteer force, a movement whose genesis lay in the nation’s “historic . . . antimilitary tradition” coupled with “its aversion to compulsion.”¹ An equally significant explanation for the end to the draft was President Richard Nixon’s need to have support for the 1972 election and to produce a peace dividend. The country’s widespread antipathy to the Vietnam War doubtlessly also tipped the scales. All of these realities resulted in the end of conscription. Critics predicted that the new volunteer army would not meet its quotas for both reserve and active officers. Because women had never been drafted, however, and the Army Nurse Corps had relied successfully on volunteers to fill its ranks in the past, most Army Nurse Corps officers anticipated only minor problems, if any, in recruiting sufficient nurses.² Simultaneously, critical shortages were expected to surface among physicians in the Army Medical Corps. Pundits articulated the curtailment of the draft and the suspension of the Berry plan as causes for the shortages. The Berry plan was a program that

allowed physicians temporary deferment from the draft so that they might complete their medical specialty training. Following their completion of individual training programs, physicians subsequently were obliged to serve the usual two years in the military. Without the coercion of conscription, the AMEDD leaders expected significant shortfalls among Army physicians. To circumvent this eventuality, the Army implemented several countermeasures—among them, creating the Health Professions Scholarship Program; establishing the F. Edward Hébert Medical School at the Uniformed Services University of the Health Sciences in 1972³; encouraging the enactment of the Uniformed Services Variable Incentive Pay Act for Physicians of 1974; modernizing the Army Medical Treatment Facilities (MTFs), which, it was hoped, would enhance physician efficiency⁴; launching a course to train physician assistants in 1971; and, in 1972, commencing and later elaborating on the advanced practice roles,⁵ as defined by the Army Nurse Corps Contemporary Practice Program or, as it was subsequently referred to, the Army Nurse Corps Clinician Program or Army Nurse Clinician Program. Planners conceived and implemented these last two initiatives to relieve available physicians of certain responsibilities, a trend emerging within the civilian health care community.⁶

As certain incentive programs to enhance AMEDD procurement evolved, others were terminated. On balance, the Army Medical Corps gain in funded initiatives such as the Health Professions Scholarship Program, Uniformed Services University of the Health Sciences, and special pay programs ultimately was offset to some degree by the Army Nurse Corps loss of educational subsidies such as the Army Student Nurse Program and Army Registered Nurse Program. To pay for these programs to support physician recruitment, the Army leadership shifted assets and eliminated Army Nurse Corps educational procurement incentives. Each participant in an Army Nurse Corps student program was commissioned in the last six months of his or her training program, thereby occupying one active duty personnel slot. To tie up hundreds of billets with no immediate return over a period of up to six months was no longer possible. Another consideration was economic, an unavoidable consequence in the postwar context of strict financial retrenchment, leading to the truncation or elimination of long-standing Army Nurse Corps programs. Because the Army Nurse Corps was managing, albeit with difficulty, to maintain its authorized strength in the immediate post-Vietnam War era, the Corps ended the Army Registered Nurse Program and the Army Student Nurse Program in 1975 and closed the Walter Reed Army Institute of Nursing in 1978.⁷ Meantime, the Army Nurse Corps continued its successful recruiting, which some believed was the seeds of its undoing.⁸ The AMEDD justified its decisions to cut educational subsidy programs by explaining that any future Army Nurse Corps recruiting deficits could be easily remedied. One recommendation was to suspend the basic educational standard for entry into the active component of the Corps (set by a 1974 regulation at the baccalaureate degree level) and accept non-baccalaureate nurses, that is, diploma graduates or associate degree nurses.⁹ However, Army Nurse Corps leaders did not resort to such a strategy. Following the unsuccessful warrant officer/associate degree nurse program of the Vietnam War era, the only nurses accessed to active duty

were those with baccalaureate degrees. College Reserve Officers' Training Corps (ROTC) programs with or without scholarships for prospective Army Nurse Corps officers seemed a promising source for future Army nurses. Army ROTC first accepted women as cadets in 1972 and, as hoped, this program has provided more and more Army nurses with the passage of time.¹⁰

The Army also restructured its forces as part of the modernization and reform of the post-Vietnam institution. Organizational changes began in January 1973 and were virtually completed by December 1975, but planning had been ongoing since 1967, particularly within the AMEDD through the Worldwide Organizational Structure for Army Medical Support Study Group.¹¹ Several factors precipitated the massive organizational makeover of the Army. These factors included the urgent necessity for more efficient use of people and money, the increased reliance on the reserves, the need for greater levels of readiness, and the commitment to enhance esprit de corps and service members' morale, which—it was thought—would render the Army a more attractive career choice in the context of the modern volunteer army.¹² The reorganization also reflected the prevailing opinion that the Army should assume a lower profile and decentralize its operations and command functions away from Washington, D.C. In the immediate post-Vietnam War period, both the wearing of uniforms and the massive military presence in Military District of Washington arguably were projecting an unpalatable image of the nation's capital as an "armed fortress."¹³ Key among the organizational changes for the Army was the elimination of the Continental Army Command and the creation of the Forces Command, Training and Doctrine Command, and HSC.¹⁴

On 1 April 1973, HSC evolved at Fort Sam Houston, Texas; it was completely functional by 1 July 1973. Major General Spurgeon H. Neel, a Medical Corps officer, was HSC's first commander.¹⁵ He functioned under the direct supervision of the chief of staff of the U.S. Army.¹⁶ From the outset, HSC assumed command of almost all Medical Centers, General Hospitals, and Medical Department Activities, the Academy of Health Sciences, and certain other installations and activities, predominantly within the continental United States.¹⁷ Formerly, the command of most of these facilities was vested in the local post commander and ultimately resided under the jurisdiction of the commander, Continental Army Command.¹⁸ Frequently this command and control structure created financial issues. Installation commanders often favored funding of other higher priority on-post programs over the needs of the local MTFs. Thus, HSC evolved into a Major Command not only to consolidate the continental U.S. health care system but also to foster equitable resource distribution.¹⁹

As a Major Command, HSC's mission generally encompassed health care delivery, medical combat doctrine development, and provider education. First, the command furnished health care services for the Army within the continental United States, Alaska, Hawaii, and Panama, using a "single-manager approach." The professional services encompassed "hospitalization, outpatient care, environmental hygiene, dental care, veterinary services, nursing care, physical and occupational therapy, and dietetic services."²⁰

Gradually, the responsibility for some Army Nurse Corps operations that previously had resided in the Office of The Surgeon General, Continental Army Command, and the various Army area headquarters moved to HSC.²¹ Colonel Virginia L. Brown was the senior officer among the 12 Army nurses first assigned to HSC, and she served as the first chief of the Nursing Division and chief nurse of HSC. Brigadier General Lillian Dunlap, the chief of the Army Nurse Corps at that time, appointed Brown to this newly created position because it required “someone who was knowledgeable and a good staff officer.” Other criteria that Dunlap deemed crucial for this post included abilities to deal with complex organizational relationships, garner respect among colleagues, and demonstrate loyalty in personal relations. Dunlap recalled that Brown “was one of the best choices I ever made.”²²

Among the 12 original Army Nurse Corps officers assigned to HSC were a nurse consultant, a nurse staff officer, an ambulatory care nurse administrator, and an Army health nurse consultant.²³ Another Army Nurse Corps officer served in the Troop Basis Branch.²⁴

Four of the 12 Army nurses functioned on the HSC Manpower Team.²⁵ This unit developed policies for management of manpower resources; conducted on-site surveys at installations to evaluate manpower requirements; and programmed, controlled, and allocated command military and civilian manpower resources.²⁶ They usually surveyed all HSC facilities such as hospitals, clinics, garrisons, dental labs, and schools onsite on a biennial basis. Thus, the four Army nurses, approximately 12 Medical Service Corps officers, and six civilian employees of the Manpower Survey Branch were grouped into three teams, which were in travel status for 50 percent of their duty time. The primary mission of the branch was to determine staffing needs. However, because the Army Nurse Corps officers were “the only clinical professionals in the branch,” they had an additional charge while on temporary duty to the various HSC installations, serving as consultants on matters of nursing as well as surveyors of manpower conditions.²⁷

Two Army Nurse Corps officers served as the first Army nurses on the HSC Inspector General team.²⁸ The team’s primary areas of concern were monitoring nursing mission performance and quality of care issues in nursing departments in the various MTFs of HSC.²⁹ Dunlap disclosed that it was a challenge to achieve the integration of Army nurses in the various HSC missions. She recalled that the Army Nurse Corps “had to fight for spaces every time.” Other branches challenged their presence, asking, “Why do you need nurse spaces?” Dunlap relied on her administrative background and working relationships cemented in past assignments to counter the opposition. She recalled that

“. . . fortunately, one of the officers who was the IG [inspector general] officer had been the IG up in The Surgeon General’s Office and had been a student of mine when I was teaching in [the] hospital admin[istration course]. . . . he appreciated and wanted a nurse on the IG team. We really worked hard in establishing and trying to work within the formal organizational structure, but recognized that we had to work in an informal structure also, to be kept fully informed.”³⁰



Pictured is Colonel Virginia L. Brown, first chief of the Nursing Division and first chief nurse of the Health Services Command (1973).
Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

Although the shape of the Army organization changed, the ceaseless bureaucratic struggle remained constant. Also, the pervasive organizational culture did not change. The need to justify the existence of nursing, the necessity to explain its role, and the prodigious effort to gain and retain resources remained the same.

After existing approximately one year, HSC underwent an evaluation. During the year, a report noted that the Nursing Division inspected 43 installations to evaluate the quality of patient care and suggest methods for improvement. The assessment also showed that the division was developing guidelines of care for the new nurse clinicians, as the original nurse practitioners were called. The division had also achieved official recognition through manpower surveys for selected nurse clinician slots. The report also recognized and authorized a number of ward clerk spaces. Additionally, HSC promoted the formation of audit committees in various treatment facilities to develop criteria to bring facilities into compliance with the requirements of the civilian accrediting body, the Joint Commission for the Accreditation of Hospitals.³¹ The division also set up a mechanism for chief nurses to request temporary replacement staff from HSC during times of acute personnel shortages.³² The report had no negative findings.

Another major mission of HSC was to provide education for AMEDD personnel. It was thought that better-educated health providers would enhance the quality of health care that would, in turn, improve the quality of life for service members and their families. This then would promote recruitment and retention in the all-volunteer army.³³ HSC launched the Academy of Health Sciences at Fort Sam Houston, Texas, to support this arm of the mission.³⁴ The Academy of Health Sciences assumed the functions of both the Medical Field Service School and the Medical Training Center. Both of these latter organizations, whose emphases were officer and enlisted training, respectively, ceased to exist as such.

The massive reorganization also shuffled positions in the Office of The Surgeon General, which evolved into an Army staff agency with proponenty for the worldwide AMEDD program. It placed The Surgeon General (TSG) in a staff position subordinate to the Army chief of staff.³⁵ TSG retained the traditional medical and administrative duties and functioned as chief of the AMEDD worldwide. TSG's global responsibilities, to name but a few, were the formulation of health policy, the exercise of accountability for AMEDD personnel management, the planning and directing of medical training, the setting of Army health standards, and the overseeing of research and development activities. In this latest organizational matrix, the chief of the Army Nurse Corps enjoyed direct access to TSG. She exercised special staff supervision over all Army Nurse Corps officers; directed nursing doctrine, practice, standards, and education; approved supplies and equipment used by Army nurses; proposed and reviewed legislation affecting Army nurses; and served as liaison for nursing matters with civilian nursing organizations, other agencies, and governments.³⁶ The Corps chief also had responsibility for nursing policy within the Army Reserve and National Guard.³⁷ In 1975, Army staff elements of the Surgeon General's Office moved from the Forrestal Building on Independence Avenue in Washington, D.C., across the Potomac River to the

Pentagon. The move's purpose was to improve collaboration and efficiency, to enhance access by the chief of staff, and "to consolidate all staff agencies" under a single roof.³⁸

In this decade of turbulent change, still another reorganization occurred in the Surgeon General's Office. TSG formed four internal directorates: (1) Resources Management, (2) Health Care Operations, (3) Personnel, and (4) Professional Services.³⁹ The AMEDD assigned a number of Army nurses, including the nurse consultant, to the Directorate of Health Care Operations.⁴⁰ Additionally, in 1972, planners realigned the Army Nurse Corps Branch, situating it under the Directorate of Personnel, Army Medical Department Personnel Support Agency. At that time, the branch adopted a new identity as the Career Activities Office with two functional subunits: (1) Career Planning and (2) Assignments.⁴¹

Another major change in the post-Vietnam era was the political decision to assign an earlier, more active and inclusive role for the Army Reserve and National Guard components. During the Vietnam War, only a handful of reserve units served on active duty. In contrast, after the Vietnam War, the Army Reserve and National Guard were given a larger part to play in future conflicts. The Total Army Concept, the existing doctrine, specified that in the event of war, the active Army would assume the immediate taskings, while the reserve components would serve as a follow-up force. New doctrine specified that the reserve unit might augment and concurrently contribute to the active component's mission. Thus, reserve units had to assume their assignments promptly and efficiently as a result of the training and planning relationships they established during implementation of mutual support activities, variously referred to as Affiliation, Roundout, and Capstone concepts.⁴² However, the Total Army Doctrine brought its own set of issues.

One major challenge faced by the Army Reserve and National Guard components was the age-old question of adequacy of numbers. Army-wide attrition rates in the reserve components were exceedingly high in the 1970s, a reaction to the end of the coercive effect of the draft and the wide-ranging antimilitary sentiment of the time. The mobilization requirement (the number required to go to war) of the Army National Guard overall was short 70,000 soldiers. U.S. Army Reserve strength was less than half of its mobilization requirement.⁴³ Difficulty in filling reserve authorizations involved not only finding applicants but also finding those who met the established standards. As discussed later in this volume, maintaining an adequate reserve force of nurses similarly proved problematic.

A final factor that profoundly shaped the Army Nurse Corps of the 1970s was the national feminist movement that struggled to obtain equality for women in all aspects of American life. Earlier in the century, the women's suffrage movement left its mark on the Army Nurse Corps trajectory to officer status, albeit only relative rank, and to other benefits such as retirement for service and/or disability for Army nurses. Likewise, the women's liberation crusade of the 1960s and 1970s had a powerful effect on the status of military women.

However, a unique group, predating the recent women's liberation movement, coalesced and began to serve as an advocate in support of women in the military.

General George C. Marshall, then secretary of defense, created The Defense Advisory Committee on Women in the Services in 1951. Composed of selected, usually influential, civilians, the committee members were appointed by the secretary of defense and served a three-year term. The committee directed itself to such objectives as providing consultation on women's concerns to the secretary of defense and serving as a conduit between the civilian and the military worlds as spokespersons on behalf of military women. Defense Advisory Committee on Women in the Services membership rolls occasionally included prominent civilian nurse leaders. Its contributions to military nursing included such achievements as promoting equal housing and equitable treatment in the service and publicizing to support recruiting efforts, particularly in times of nursing shortages.⁴⁴

The women's movement also had significant consequences in the personal and professional lives of military women. A very determined women's liberation movement achieved a number of incremental victories in the struggle against sexism. In the early 1960s, President John F. Kennedy appointed former First Lady Eleanor Roosevelt to the helm of a Presidential Commission on the Status of Women. This commission sought to assess "women's place in the economy, the family, and the legal system." Its final report, submitted in 1963, brought to light women's issues such as "discrimination in employment, unequal pay, lack of social services such as child care, and continuing legal inequality." The commission's efforts resulted in new legislation, including a presidential order mandating gender-free hiring for federal jobs and the passage of the Equal Pay Act of 1963 that promulgated equal pay for equal work in both the federal and private workforce. The mid-1960s brought the passage of the Civil Rights Act, the creation of the Equal Employment Opportunity Commission, and the birth of the National Organization for Women, a private organization whose articulated objective was to "take action to bring women into full participation" so that they might assume a totality of "privileges and responsibilities . . . in truly equal partnership with men." By 1972, Congress had endorsed the Equal Rights Amendment.⁴⁵ However, only 35 states subsequently ratified the proposed amendment.⁴⁶ Nonetheless, the ever-increasing tide of women's activism ultimately resulted in "changing patterns of societal expectations," and its outcomes were felt in "the military organization itself."⁴⁷ Social change with the overwhelming magnitude of the women's movement could not fail to create a variety of aftershocks that reverberated through the foundations of the military world.

Change that could be attributed at least in part to the women's movement was evident in the education of potential female officers. In 1972 the Army began a pilot program, admitting women to ROTC at 10 civilian colleges and universities. The experiment succeeded beyond all expectations. By 1979, 25 percent of all Army ROTC cadets were women.⁴⁸

Having achieved entrance into ROTC, women visionaries and their advocates turned their attention to having women appointed to the service academies. However, certain congressmen and Department of Defense (DoD) officials vehemently opposed the idea. The Army as a whole, including Brigadier General Mildred

Bailey, director of the Women's Army Corps, opposed the notion. Bailey argued that the Army could attract as many women as it needed "at no expense to the government" and questioned, "Why should we spend money to train them?" She concluded that the military should devote more time to issues of "national defense" and less attention to "items like this that we don't need and that would not really serve a useful purpose."⁴⁹ Lawsuits, congressional hearings, and challenges to the precedent banning women from the service academies soon followed. In spite of all efforts to the contrary, a bill authorizing the admission of women to the military academies passed Congress and was signed into law on 7 October 1975. In 1976 West Point admitted its first female cadets for the class of 1980.⁵⁰

Another element of inequity affected significantly by the women's movement was spousal rights. Before 1973, married military women were forced to prove that they contributed more than half of the total family financial support for their civilian husband before the spouse was eligible for certain entitlements. These benefits included medical care, on-post housing or an off-post housing allowance, and commissary and exchange shopping privileges. In contrast, these stringent restrictions were not levied on families in which the husband was the military member. The 1973 Supreme Court ruling in the case of *Frontiero v. Richardson* rendered the requirement to prove the degree of family support unconstitutional.⁵¹ Additionally, the Court directed the comptroller general of the Army to pay women retroactively for any Basic Allowance for Quarters, Family Separation Allowance, Station Housing Allowance, Cost of Living Allowance, Temporary Lodging Allowance, Dislocation Allowance, and Dependent Travel Allowance to which they were entitled.⁵²

The long-standing policy barring women in the military from maintaining custody of minor children (those under 18 years of age) also came under scrutiny in the 1970s. To provide care in the home for children, whether adopted, step-children, or biological children, a military woman had to seek a waiver. Such a stipulation was never imposed on male officers who had sole custody of their minor children. Regardless, women had to obtain a formal approval to override the prohibition. The waiver process was arduous and time-consuming, and a positive response to the application was never a matter of certainty. However, after a number of protracted challenges and battles waged by concerned women throughout the military services, DoD lifted the requirement for waivers in 1975. Thereafter, military women were not prohibited by tradition, policy, regulation, or law from being the primary caretakers of their minor children.⁵³

The next hurdle involved the contentious and emotion-laden subject of service-women's pregnancies. The campaign for pregnancy rights also entailed a progression of challenges and litigation.⁵⁴ Up to this time, DoD-wide policy mandated the immediate discharge of pregnant women irrespective of the wishes of the servicemember. But by the early 1970s, radical change was on the horizon. After several years of impassioned and volatile dialogue, DoD finally directed all services in October 1970 to allow pregnant servicewomen the right to submit a waiver to remain on active duty. The pregnant service member was to send the waiver to the

Department of the Army, where it was to be reviewed on a case-by-case basis. It might or might not be approved.⁵⁵ By April 1971 the Army complied with the directive but followed a policy allowing only pregnant soldiers who were married to remain on active duty. In December 1973 the Army amended the policy to allow all pregnant service members, “regardless of marital status, to request retention on active duty.” By 1974 more than 3,000 pregnant service members, representing 6 percent of all enlisted women, were leaving the services annually. Thus, DoD concluded that “the involuntary separation with waiver policy [was] no longer ‘viable’.” Consequently, DoD eliminated the requirement to seek a waiver and discontinued involuntary separations because of pregnancy. After September 1974 all pregnant officers were allowed to elect to remain on active duty. DoD granted enlisted women the same right in April 1975.⁵⁶

Among all the services, the Army was most unyielding and reluctant to accept the DoD directive, to change their system, and to accommodate all pregnant women, perhaps because of the positions taken by some of its leaders. For instance, Brigadier General Elizabeth Hoisington, Women’s Army Corps director from 1966 to 1971, strongly opposed allowing married women and mothers to serve.⁵⁷ Army senior leaders routinely used a number of delaying tactics, requesting impact statements, suggesting modifications of policy, and announcing postponements of policy implementation. Still largely dissatisfied with the policy as late as 1978, the Army continued to try to reverse the directive but failed in one final attempt when the director of the Women’s Army Corps and strong advocate for women’s rights in the military, Brigadier General Mary E. Clarke, sided with the pregnant women’s advocates and refused to support the Army’s resistance any longer. Overwhelming forces compelled the Army to fully comply with the DoD edict in the long run and forced the institution to give the pregnant soldier her choice to leave or remain in the service. Although other attempts to regress to the old involuntary discharge for pregnancy policy followed in subsequent years, each one failed.⁵⁸ In the final analysis, the tidal wave of societal change overcame long-standing military tradition.

All of these national influences and military issues spurred a building momentum of change and created a vast ripple effect that coursed through the world of Army nursing. Although external forces imposed some of the realities, others evolved from within the Army and the Army Nurse Corps. The Corps managed some issues with painstaking wisdom and foresight. It confronted others in a spontaneous fashion. It viewed some challenges with distrust and resistance, while it welcomed and embraced others with enthusiasm. The post-Vietnam Army Nurse Corps evolved into a new chapter defined by golden opportunities, puzzling questions, unprecedented changes, and uncertain trends.

In the late- and post-Vietnam era, recurring change also occurred in the senior leadership ranks of the Army Nurse Corps. Three distinguished Army Nurse Corps officers served in that time frame as successive chiefs of the Army Nurse Corps and left their imprint for decades to come. Their organizational skills, acumen, extensive experience, and practical wisdom greatly enhanced the day-to-day



Pictured is Brigadier General Lillian Dunlap, 14th chief of the Army Nurse Corps from 1971 to 1975.
Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

function of the Corps.

Dunlap, previously chief nurse of Walter Reed Army Medical Center, assumed the responsibilities of the chief of the Army Nurse Corps and simultaneously was promoted to brigadier general on 1 September 1971. Dunlap followed her predecessor, Brigadier General Anna Mae V. Hays. Colonel Louise C. Rosasco was the first in a series of assistant chiefs of the Corps under Dunlap until she retired in December 1971, after which, Colonels Edith J. Bonnet, Rose V. Straley, and Edith M. Nuttall subsequently served.

Dunlap's initial tenure as chief of the Corps coincided with the drawdown of the Vietnam War. She presided over the final Army Nurse Corps presence in Southeast Asia and guided the Corps through the tumultuous transition to a period of national peace and phenomenal change. Dunlap adeptly managed the introduction of the expanded practice movement that augmented the Army Nurse Corps expertise, aptitudes, and abilities to make an even greater contribution to the health of the Army. Additionally, she continued the efforts of prior chiefs of the Corps in promoting improved levels of education for Army nurses.

After 33 years of active duty, Dunlap retired from the Army in September 1975, but never relinquished her sense of commitment to the Army and the Army Nurse Corps. Her retirement years continued to be equally prolific. She enthusiastically supported the Retired Army Nurse Corps Association and the Army Medical Department Museum, and she served on many charitable boards and nonprofit foundations. Dunlap died on 3 April 2003 in her hometown, San Antonio, Texas.

On 1 September 1975, Colonel Madelyn N. Parks, formerly chief of the Department of Nursing at Walter Reed Army Medical Center and earlier chief nurse of the Forces Command, assumed her responsibilities as the 15th chief of the Army Nurse Corps, replacing Dunlap. Parks was the third Army Nurse Corps officer to be promoted to the rank of brigadier general. Colonels Edith M. Nuttall and Virginia L. Brown served in turn as Parks' assistant chiefs of the Army Nurse Corps.

Park's four-year assignment at the helm of the Army Nurse Corps happened in exceedingly turbulent times. In four brief years, she confronted many complex issues, such as a major transformation of the organization, a persistent shortage of nurses, shifting personnel policies, and seismic doctrinal and role changes against the backdrop of a rapidly changing larger U.S. society. With a steady hand, Parks led the Army Nurse Corps through the troubled post-Vietnam era across the threshold of a new day. Her tenure continued until 31 August 1979, when she retired from active Army service. Following her retirement, Parks resided in San Antonio, Texas. This veteran of World War II, Korea, and Vietnam passed away on 24 November 2002.

In 1979 Colonel Hazel W. Johnson, a former director of the Walter Reed Army Institute of Nursing and chief nurse of the 18th Medical Command in Korea, became the 16th chief of the Army Nurse Corps. She was Park's successor. Johnson was the first nurse with a doctorate to serve as the chief of the Army Nurse Corps and the first African-American female general officer in DoD. During the



Pictured is Brigadier General Madelyn N. Parks, 15th chief of the Army Nurse Corps from 1975 to 1979. Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.



Pictured is Brigadier General Hazel W. Johnson, 16th chief of the Army Nurse Corps from 1979 to 1983. Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

first months of Johnson's tenure, Colonel Virginia L. Brown served as her deputy. Following Brown's retirement, Colonel Connie L. Slewitzke became the assistant chief of the Corps.

Like her predecessor, Johnson dealt with many unparalleled changes and challenges that exerted a significant impact on the careers and practice lives of Army nurses. Additionally, she refined, strengthened, and professionalized many facets of Army Nurse Corps life. Both Johnson and Slewitzke served as incumbents in these two most senior positions until 31 August 1983.

Following her retirement, Johnson remained extremely active in professional nursing. She served for several years as the director of governmental affairs for the American Nurses Association. At the same time she was an assistant professor in nursing administration at Georgetown University in Washington, D.C. Johnson also accepted a full professorship in the School of Nursing at George Mason University in Fairfax, Virginia.

The Army Nurse Corps was fortunate to have such exceptionally inspired leaders in the tough times that followed the Vietnam War. As a result of its caring diligence, the Army Nurse Corps survived and for the most part thrived in this difficult era.

Notes

1. Robert K. Griffith, Jr., *The U.S. Army's Transition to the All-Volunteer Force, 1968–1974* (Washington, DC: Center of Military History, U.S. Army, 1996), Howard H. Callaway to Lillian Dunlap, Typewritten Letter (TL), 11 October 1973, Army Nurse Corps Collection (ANCC), Office of Medical History (OMH).

2. Robert K. Griffith, Jr., *The U.S. Army's Transition to the All-Volunteer Force, 1968–1974* (Washington, DC: Center of Military History, U.S. Army, 1996), 255, 259. Mary E. Viehdorfer Frank and Robert V. Piemonte, “The Army Nurse Corps: A Decade of Change,” *American Journal of Nursing* 85 (September 1985): 985–88.

3. Public Law 92-426, the Uniformed Services Health Professions Revitalization Act, 21 September 1972. Richard R. Taylor, “Team Work Needed for Army Medicine,” *U.S. Medicine* 10 (15 January 1974): 60.

4. From 1969 to 1971, the Department of Defense commissioned two large studies using systems theory as a conceptual framework to design a “health care system for domestic military bases.” Harry B. Wissman, *Systems Analysis for a “New Generation” of Military Hospitals, Summary, Final Report* (Cambridge, MA: Arthur D. Little, 1971), 1.1. The studies arose from a request by Secretary of Defense Melvin Laird for a program “that would involve medicine, be humanitarian, be a spin-off to the civilian community, and [not explicit] make the Nixon administration, then in trouble in Vietnam, look good.” Robert J.T. Joy to Author, TL, 18 October 2002, ANCC, OMH. The goals of the dual-pronged venture were “to improve operating efficiency” of military MTFs to include all staff, facility construction, outpatient design, computer support, etc., while simultaneously “maintaining or improving the quality of patient care.” Another objective of the studies was “to reduce costs.” C.A. Sadlow, *Systems Analysis Study Towards a “New Generation” of Military Hospitals, Volume I: Executive Summary* (Pittsburgh, PA: Westinghouse Electric Corporation, 1970), iii. The Little (Wissman) contract was for \$712,065, while the cost of the Westinghouse (Sadlow) version totaled \$892,000. Only one military MTF was built on these models, the David Grant USAF Medical Center at Travis Air Force Base, California. Robert J. T. Joy, Conversation with Author. Robert A. Patterson, “AF Meets Demand of Volunteer Force,” *U.S. Medicine* 10 (15 January 1974): 51. The studies recommended “unit dose pharmacies; . . . introduction of convenience foods; physicians’ assistant programs; . . . and providing a suite of a private office with two adjoining examining rooms for each physician.” Richard S. Wilbur, “Department of Defense,” *Military Medicine* 137 (September 1972): 340.

5. "Advanced practice" is a term that came into common usage in the 1990s. As defined by the National Council of State Boards of Nursing in 1993, it is "practice based on the knowledge and skills acquired in a basic nursing education, through licensure as a registered nurse, and in graduate education and experience, including advanced nursing theory, physical and psycho-social assessment, and treatment of illness." Frances K. Porcher, "Licensure, Certification, and Credentialing," in *Advanced Practice Nursing: Changing Roles and Clinical Applications*, ed. Joanne V. Hickey, Ruth M. Ouimette, and Sandra L. Veneconi (Philadelphia: Lippincott, 1996), 180.

6. Robert K. Griffith, Jr., *The U.S. Army's Transition to the All-Volunteer Force, 1968–1974* (Washington, DC: Center of Military History, U.S. Army, 1996), 256–58. *Annual Report, The Surgeon General, United States Army Fiscal Year 1974* (Washington, DC: Office of the Surgeon General, U.S. Army, 1974), 2–4, 20–23. Richard S. Wilbur, "Department of Defense," *Military Medicine* 137 (September 1972): 337–38. Diane O. McGivern, "The Evolution to Advanced Nursing Practice," in *Nurses, Nurse Practitioners; Evolution to Advanced Practice*, ed. Mathy D. Mezey and Diane O. McGivern (New York: Springer Publishing Company, 1993), 4.

7. The Navy curtailed its student subsidies for potential Navy nurses in 1975 as well. Willard P. Arentzen, "Advances Logged by Navy Medicine," *U.S. Medicine* 13 (15 January 1977): 34.

8. Just as Army nurses were losing educational subsidies, the civilian world of nursing also was facing the loss of federal government support of nursing education. In 1978, President Jimmy Carter vetoed the Nurse Training Act. Letitia Cunningham, "Nursing Shortage? Yes!" *American Journal of Nursing* 79 (March 1979): 469–80.

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12. Francis T. Julia, *Army Staff Reorganization, 1903–1985* (Washington, DC: Analysis Branch, U.S. Army Center of Military History), 35. "10th Anniversary, US Army Health Services Command," *HSC Mercury* 10 (April 1983): A1. U.S. Army Health Services Command,

“Activation, Evolution of a New Command,” Program, 2, April 1973; and “The 196th Year,” News Release No. 135-FO, 1 July 1971, Office of the Surgeon General, U.S. Army Technical Liaison Office (both in ANCC, OMH). “Army Reorganization, ’74, Moving, Realignment at the Top; Pruning and Heavy Cutting Below,” *Army* 24 (April 1974): 8–9. Manley G. Morrison, “The Modern Volunteer Army: Implications for Health Care Organization and Administration,” Speech presented to Current Trends in Health Care Administration Professional Short Course on 29 March 1971, ANCC, OMH.

13. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 266.

14. Francis T. Julia, *Army Staff Reorganization, 1903–1985* (Washington, DC: Analysis Branch, U.S. Army Center of Military History), 35.

15. J. Meidl, “Appointment of Commander,” 16 July 1973, OTSG Collection, OMH.

16. Headquarters, Department of the Army, “Organization and Functions, United States Army Health Services Command,” AR 10-43, 2, 27 June 1973.

17. Department of the Army, Headquarters, “United States Health Services Command,” HSC Reg 10-1, 2-1, 30 May 1973.

18. *Annual Report, The Surgeon General, United States Army Fiscal Year 1974* (Washington, DC: Office of the Surgeon General, U.S. Army, 1974), 89. *U.S. Army Health Service Command, Annual Historical Review, 1 July 1975 to 30 September 1977* (Fort Sam Houston, TX: Historical Office, HSC, 1979), 3.

19. “Analysis of Alternatives,” 12 March 1991, Draft Enclosure 2, in “Army Medical Department Realignment Study,” n.d., ANCC, OMH.

20. *Annual Report, The Surgeon General, United States Army Fiscal Year 1974* (Washington, DC: Office of the Surgeon General, U.S. Army, 1974), 88. U.S. Army Health Services Command, “Activation, Evolution of a New Command,” Program, 2 April 1973, ANCC, OMH.

21. Lillian Dunlap, “From the Chief,” *U.S. Army Medical Department Newsletter* 4 (Summer 1973): 19, ANCC, OMH.

22. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 267.

23. Lieutenant Colonel Barbara R. Costello served as nurse consultant; Lieutenant Colonel Elizabeth A. Labbe was the nurse staff officer; Major Mary Lou Spine served as the ambulatory care nurse administrator; and Lieutenant Colonel Patricia A. Greene was assigned as Army health nurse consultant. “Army Nurse Corps Key Officer Assignments,” Typewritten Document (TD), 5–6, 13 August 1973, ANCC, OMH.

24. This officer was Lieutenant Colonel Essie M. Wilson. “Army Nurse Corps Key Officer Assignments,” TD, 6, 13 August 1973, ANCC, OMH.

25. The four were Lieutenant Colonel Mary A. Foley, Lieutenant Colonel Jeanne Hoppe, Major (P) Francis M. Rausch, and Major Nickey J. McCasland. “Army Nurse Corps Key Officer Assignments,” TD, 6, 13 August 1973, ANCC, OMH.

26. Department of the Army, Headquarters, “United States Health Services Command,” HSC Reg 10-1, 5-4, 30 May 1973.

27. Nickey J. McCasland to Author, E-mail Correspondence, 27 February 2002, ANCC, OMH.

28. The two were Colonel Patricia A. Silvestre and Major Claire M. McQuail. “Army Nurse Corps Key Officer Assignments,” TD, 6, 13 August 1973, ANCC, OMH.

29. Edith Nuttall, “Presentation to First HSC’s Chief Nurses’ Conference, Gunter Hotel, San Antonio, Texas, 19 April 1974,” Typewritten Text of Speech; and “Army Nurse Corps Key Officer Assignments,” TD, 6, 13 August 1973 (both in ANCC, OMH). Carolyn M.

Feller and Debora R. Cox, eds., *Highlights in the History of the Army Nurse Corps* (Washington, DC: U.S. Army Center of Military History, 2000), 45–46.

30. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 270.

31. The function of the Joint Commission on Accreditation of Hospitals, a private, non-profit group founded in 1951, was to evaluate and accredit hospitals. Carole H. Paterson, "Joint Commission on Accreditation of Healthcare Organizations," *Infection Control and Hospital Epidemiology* 16 (January 1995): 36–42.

32. "US Army Health Services Command, Command Evaluation, 1 April 1973, 30 June 1974, Detailed Evaluation, 15 November 1974," E-15, ANCC, OMH.

33. *Annual Report, The Surgeon General, United States Army Fiscal Year 1974* (Washington, DC: Office of the Surgeon General, U.S. Army, 1974), 36.

34. *Annual Report, The Surgeon General, United States Army Fiscal Year 1974* (Washington, DC: Office of the Surgeon General, U.S. Army, 1974), 89. "United States Army Medical Field Service School, Dedication Ceremonies, 10 December 1972," Program, ANCC, OMH. "MFSS Dedication at Brooke," *San Antonio Light* (10 December 1972), 1L–7L.

35. Richard R. Taylor, "Team Work Needed for Army Medicine," *U.S. Medicine* 10 (15 January 1974): 60. Richard R. Taylor, "Army Changes Its Ideas, Structure," *U.S. Medicine* 11 (15 January 1975): 55.

36. Francis T. Julia, *Army Staff Reorganization, 1903–1985* (Washington, DC: Analysis Branch, U.S. Army Center of Military History), 34–40. Edith Nuttall, "Presentation to First HSC's Chief Nurses' Conference, Gunter Hotel, San Antonio, Texas, 19 April 1974," Typewritten Text of Speech, 2; "Office of the Surgeon General," Washington, DC, n.d., appendixes A and H; and U.S. Army Health Services Command, "Activation, Evolution of a New Command," Program, 2 April 1973 (all in ANCC, OMH).

37. Connie L. Slewitzke to Author, E-mail Correspondence, 22 November 2002, ANCC, OMH.

38. *Annual Report, The Surgeon General, United States Army Fiscal Year 1975* (Washington, DC: Office of the Surgeon General, U.S. Army, 1975), 77. Richard R. Taylor, "Landmarks Point to Army's Future," *U.S. Medicine* 12 (15 January 1975): 39. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 297.

39. *Report of the Surgeon General United States Army Fiscal Years 1976–1980* (Washington, DC: Office of the Surgeon General, Department of the Army, 1988), 255. Charles C. Pixley, "Army Eyes Doctor Pay, Entitlements," *U.S. Medicine* 16 (15 January 1980): 49.

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ment of an active Army unit by a particular reserve unit. With the Affiliation program, the reserve unit augmented the capabilities of an active unit in a period of mobilization. Margaret B. Regan, "A Plan to Develop an Army Nurse Corps Reserve Component (ANCRC) Organizational Structure to Coordinate and Control ANCRC Nursing Activities, August 1976," TD, 3, ANCC, OMH. James H. Carter, "Mutual Support and Mobilization Preparedness: The Method of an Army Reserve Hospital," *Military Medicine* 155 (August 1990): 379–81.

43. Vincent Demma, "The Army in the 1970s," Information Paper, 2–3, ANCC, OMH.

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48. Jeanne Holm, *Women in the Military: An Unfinished Revolution* (Novato, CA: Presidio, 1992), 270.

49. Jeanne Holm, *Women in the Military: An Unfinished Revolution* (Novato, CA: Presidio, 1992), 306.

50. *Ibid.*, 305–12. M.C. Devilbiss, *Women and Military Service, A History, Analysis, and Overview of Key Issues* (Maxwell Air Force Base, AL: Air University Press, 1990), 20.

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