

Chapter Ten

The Shortage Intensifies

One major and recurring issue that the Army Medical Department (AMEDD) faced during the 1980s was a critical, wide-ranging shortage of personnel. Severe shortages of physicians and nurses existed in all components—Active, National Guard, and Reserve—for almost the entire decade. A shortage of enlisted medical specialists, the paraprofessionals who provided assistance and support services, exacerbated the situation. Inadequate training of enlisted service members and their lack of satisfactory qualifications also worsened the state of affairs. These trends also appeared in every echelon of the Army and the AMEDD and permeated the affairs of the Army Nurse Corps. The Surgeon General judged the disparity in pay between the military and civilian sectors as responsible for these shortages and deficiencies.¹ However, the dearth of personnel was not only limited to the Army but also was a worrisome issue in the civilian health care system.

In the 1980s, professional nursing literature reported dire staffing circumstances in the civilian world.² The nurse shortages were so profound that the U.S. Department of Health and Human Services Division of Health Professions Analysis studied the issues, conferred with stakeholders, compiled statistics, and published a report in 1981 that would serve “in a broad interpretive context” as a framework to enhance understanding and expand the dialogue and scrutiny of pertinent issues.³ Its findings oversimplified the economic interpretation of a highly complex problem and were predicated on the fact that nursing was a predominantly female profession highly sensitive to pay trends. The study revealed that nurses participated in the workforce at about the same rate as women in other analogous career fields and experienced approximately the same number of problems as did those in similar occupations with a significant ratio of female to male workers. When nurses’ salaries steadily rose in the late 1960s after the introduction of Medicare, according to the report, the supply of nurses correspondingly increased. This trend continued until 1976 when, inexplicably, nurses’ wages became static in relation

to those of other predominantly female professions. By 1978, there was a definite decrease in entrants into nursing educational programs, probably because females then took advantage of other professional options virtually denied them in the past. The report forecast that the continued shortage of professional nurses would endure until relative wages improved. This meant that little could “be done either to hasten the market processes that must unfold or to dampen the cyclical fluctuations in the nurse labor market.”⁴

Intensifying the nurse shortage, the numbers of college students considering a nursing career dwindled in the 1980s and also created a situation with long-range implications for Army Nurse Corps recruiting. In 1984, 63,257 students expected to become nurses. In 1985, that number fell to 53,321, a 16 percent decrease. In 1986, only 42,846 college students planned to major in nursing, approximately a 20 percent reduction, or an overall decrease of 33 percent from 1984 to 1986.⁵

Shortages of available nurses worsened over the years. The American Hospital Association claimed in 1987 that nationwide nurse vacancy rates stood at 13.5 percent and had more than doubled within a year.⁶ Contributing to the problem were decreased interest among young women in nursing as a career, the ill-advised use of nurses by administrators for nonnursing tasks, and low wages despite an individual nurse’s expanding educational level or increased experience.⁷

The AMEDD attributed the crisis within the military to the competition for nurses in a market where civilian hospitals were providing outstanding improvements in work scheduling, better staffing ratios, and enhanced benefit packages.⁸ Baptist Medical Center in Columbia, South Carolina, for instance, offered a \$1,200 bonus to new hires. Employees who recruited another nurse also received \$1,200. Providence Hospital in Columbia, South Carolina, offered similar enticements and paid nurses who worked two 12-hour weekend shifts the same amount as a 40-hour week.⁹ Some hospitals in Denver, Colorado, relied on benefits such as no-cost child care and free cars to attract nurses.¹⁰

The shortages prevalent in the civilian sector were much worse in the Army Nurse Corps. The Army considered the shortfalls a “war stopper,” meaning the deficits were so dire that they would prevent or seriously inhibit the Army from going into combat.¹¹ In fiscal year (FY) 1981 there was a slight incongruity between the Army Nurse Corps actual and authorized year-end strengths, 3,833 and 3,859, respectively. Still, the Corps perceived a pressing need for more nurses because manpower team surveys calculated huge discrepancies between authorized levels and required strength numbers. The Air Force Nurse Corps (AFNC) found itself in similar circumstances. In 1981, it reported an actual year-end strength of 4,149 officers vis-à-vis an authorized total of 4,141. It too predicted that more nurses would be required as the Air Force physician shortage resolved because more physicians generated a need for more nurses.¹² The AFNC traditionally had more officers than the Army, and its professional staffing was “plush”—in part, because it did not rely on licensed practical nurses to any great extent, and having smaller hospitals required proportionately larger staffs to maintain than bigger hospitals.¹³ In other words, those hospitals that operated fewer beds usually were

less efficient personnel wise than larger hospitals.¹⁴

By 1982, the Army Nurse Corps authorized year-end strength increased slightly to 3,891. However, at that time, manpower survey teams calculated personnel requirements at 6,343.¹⁵ Authorizations increased slightly again in 1983 and 1984 to 4,038 and 4,142, respectively.¹⁶ Nonetheless, the glaring incongruities between authorized and required numbers not only persisted, but also the gap steadily widened.¹⁷ In FY 1988, the Army Nurse Corps requirements for the active component stood at 7,417, with the authorizations set at 5,018.¹⁸

Also affecting the problem was the fact that during the 1980s, the Army Nurse Corps transitioned from using the Health Services Command manpower survey team as a tool for calculating requirements to using the Workload Management System for Nurses. The former, the Health Services Command manpower survey team, used a staffing guide—outdated even in the 1970s—with yardsticks as standards and extra personnel allowances based on added missions, greater acuity of patients, and physical facility factors. These criteria guided the local appraisal, conducted every two years, which was at best a subjective assessment to arrive at nursing requirements. The Workload Management System for Nurses, however, was an objective system that portrayed more accurately the required numbers of nurses needed to handle the workload. Other factors that caused the requirements to surge in the 1980s were the greater level of patient acuity, advanced technological complexity, and larger patient censuses.¹⁹

In 1986, 1987, and 1988, the Army Nurse Corps recruited only 26.2 percent, 38 percent, and 21.4 percent of its goals, respectively. Analogous statistics for the Navy Nurse Corps showed an 89.6 percent attainment in 1986, 97.9 percent in 1987, but a dramatic plunge to 17.5 percent in 1988 as the shortage intensified. The AFNC achievement of recruiting goals, recorded as 39.9 percent, 39.2 percent, and 36.9 percent during the same time, demonstrated the greatest consistency.²⁰ After recruitment but before commissioning, almost half of Army Nurse Corps applicants withdrew because the salary for beginning second lieutenants was about \$3,000 less annually than starting salaries offered in civilian hospitals. Compounding the servicewide shortage was the significant numbers of nurses who chose to leave the military after their first tour, most citing better civilian-sector pay as their reason for departing.²¹ From 1986 to 1988, the Army documented retention rates (the percentage of Army nurses who chose to remain in the Army after their first commitment) at 66 percent, 62 percent, and 62 percent.²² The Navy reported similar statistics of 66 percent, 54 percent, and 57 percent. The Air Force kept a slightly larger percentage of their nurses, 70 percent in 1986 and 1987 and 69 percent in 1988. Adding to the staffing woes were the unfilled civilian nurse positions. In 1988, the Army had a civilian vacancy rate of 10 percent; the Navy, 20 percent; and the Air Force, 6 percent.²³ By 1990, the statistics revealed improvements in the nurse corps officer retention. That year, the AFNC reported 90 percent retention, the Army cited 70 percent retention, and the Navy Nurse Corps had only a 60 percent rate of retention for civilian nurses.²⁴

Planners in the Department of Defense (DoD) Office of Reserve Medical

Planning also predicted huge mobilization shortfalls in the ranks of military reserve nurses. Post-Vietnam War reserve forces doctrine specified that, in times of war, reserve components would assume the bulk of responsibility for care of sick and wounded combatants.²⁵ Doctrine allocated responsibility for 70 percent of the AMEDD's field hospitals and 90 percent of the Air Force's medical evacuation crews to the U.S. Army Reserve (USAR) or Army National Guard (ARNG). In the event of a large-scale war, planners projected a need for 43,500 nurses across the three military services. However, as of March 1982, only 20,500 (or 47 percent) of the required Active, Guard, Reserve total force nurses were available. Shortages were most marked among numbers of operating room nurses and anesthesiologists. Surgical specialties in all DoD reserve component units were 60 percent below authorizations for operating room nurses and 59 percent below authorizations for nurse anesthetists.

To obtain more reservists, a DoD task force recommended that these specialists be allowed to participate in military-sponsored professional courses, offered financial assistance to underwrite anesthesia education, and encouraged to actively participate in professional nursing organizations, presumably during their active duty for training time. The services also eliminated the red tape in the reserve application process, thereby reducing the lag time from submission of request to commission as an Army Nurse Corps officer from three to four months to 30 days.²⁶ These measures failed to avert the looming crisis. The Army Nurse Corps saw little improvement in the reserve numbers. By 1987, the Corps had only 35 percent of nurse anesthetists and 50 percent of operating room nurses required for mobilization.²⁷

One strategy to bridge the gap was to employ civilian registered nurses in Army Nurse Corps positions. The situation was so serious that the Corps dropped its long-held reservations regarding the use of civilian professional nurses. Nonetheless, the supply of Army-employed civilian nurses also failed to meet demand. As of September 1981, 2,162 civil servants were working as professional nurses in Army health care facilities worldwide.²⁸ By FY 1984, however, the AMEDD's Civil Service Registered Nurse (CSRN) workforce had a vacancy rate of 18 percent and a voluntary resignation rate of 12.6 percent, which rose to 19.1 percent in FY 1987.²⁹ By 1990, the vacancy rate for CSRNs exceeded 24 percent and turnover was a turbulent 20 percent.³⁰ Upon resignation, CSRNs revealed various satisfaction or dissatisfaction factors either in questionnaires or comments. Satisfaction factors included practicing in a patient-focused environment—most notably with professional and clinical autonomy—providing care for a challenging population of patients, and working under the clear command and control structure in the military.³¹ Dissatisfaction factors included the unsettling and frequently changing duty shift rotations, bleak career-development prospects, recurrent conflicts with military nurses, supervisors' inattention to the federal civil service system, and salary rates.³² In 1987, outgoing Assistant Chief of the Corps Colonel Eily P. Gorman—with characteristic keen insight—advised the incoming chief, Brigadier General Clara L. Adams-Ender, that there were some correctable



Pictured is Colonel Eily P. Gorman, Assistant Chief of the Army Nurse Corps (1987).
Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

issues, specifically the work and time schedules and interpersonal relationship difficulties. She emphasized, however, that nurse administrators needed to be encouraged to address the concerns. Gorman acknowledged that the austere career development opportunities for CSRNs made for a difficult situation:

We can hardly stand (in terms of recruiting and retaining green suiters) to have fewer opportunities for ANC development, nor to have RNs [CSRNs] with lower educational attainment, in supervisory role[s] over persons [Army nurses] with higher edu[cational] level[s]. But we should have our perfor-

mance standards for [the] ANC written so that differences in education—as well as in rank—can be seen to make a difference in responsibilities and patient care.³³

Gorman noted that some installations had already begun writing such standards and recommended that an ad hoc group examine the issues.³⁴ Subsequently, a Civil Service Task Force composed of both military and civilians met in 1988 to develop a lateral progression of opportunities for career advancement for CSRNs.³⁵ The task force's consensus was that the Army Nurse Corps should develop incentives that were "*individually* based to facilitate lateral progression" or CSRN recognition. The task force hoped that incentives would motivate the individual's professional development and ultimately improve patient care. Thus, the task force recommended civil service grade and step increases for deserving employees. Criteria such as the employee's work toward educational advancement, participation in continuing professional education, personal improvement through specialty training, credentialing or certification, research activities, writing for publication, contributions to hospital committees, and active membership in professional organizations were the basis for justifying advancement.³⁶

The CSRNs' pay issues were most difficult to resolve. Title 5, U.S. Code, the General Schedule (GS) pay scale, dictated a fixed salary for CSRNs in military hospitals. In contrast, the Veterans' Administration hospitals and later the National Institutes of Health employed nurses under the authority of Title 38, U.S. Code, which allowed "flexibility . . . for entry level salaries to be established to remain competitive with civilian medical facilities wage and salary schedules."³⁷ For economic reasons, civilian registered nurses gravitated to Veterans' Administration hospitals because they offered more equitable and generous salaries for comparable duties compared with military hospitals.

DoD supported various pieces of legislation to attract and retain CSRNs. Some bills never became law and others took years to be enacted.³⁸ Nonetheless, the Army did obtain legislative approval to grant special pay categories for civilian nurses in high-cost areas, for those who functioned as charge nurses, and for those who practiced in critical-care settings.³⁹ To cut the lengthy application and hiring process, the U.S. Office of Personnel Management granted direct-hire authority to local military installations for nurses at the levels of GS-5, GS-7, and GS-9.⁴⁰ Moreover, Health Services Command advertised in national publications to attract more civilians. In the early 1980s, the Army Nurse Corps also authorized civilian participation in Area of Concentration courses and incorporated instruction about Department of Army Civilian issues into the Program of Instruction for the Officer Basic Course in April 1988.⁴¹ These improvements failed to alleviate the CSRN shortage.⁴² Clearly, CSRNs were an essential element of the nursing force in Army hospitals. The unsafe dearth in their numbers seriously affected the ability of the Army to provide quality nursing care.

Adams-Ender, chief of the Army Nurse Corps from 1987 to 1991, referred to CSRNs as "Army nurses in disguise."⁴³ Actually, many CSRNs were simultaneously Army nurses in the USAR or ARNG. Colonel John M. Hudock recalled that when "attempting to identify the numbers upon mobilization, many MTFs in



Colonel John M. Hudock, left, Assistant Chief of the Army Nurse Corps from 1987 to 1991, accepts the Legion of Merit award from General Clara L. Adams-Ender, right, on the occasion of his retirement in September 1991.

Photo courtesy of Colonel John Hudock, Hazleton, PA.

CONUS [military treatment facilities in the continental United States] would be short civilian nurses because they mobilized as Army Nurses.” Hudock noted that when he retired in 1991, civilian personnel offices “were still trying to sort out the numbers. The nurse shortage problem was actually amplified by the ‘double counting’.” Like the CSRNs, many contract nurses served in dual roles. While they worked as temporary or agency nurses in Army hospitals, they also were Army Nurse Corps officers in the USAR or ARNG.⁴⁴

On a grassroots level, Army nurses worked diligently to compensate for the insufficient staff. At Moncrief Army Community Hospital, Fort Jackson, South Carolina, shortages were particularly grave in 1988. Local staffing agencies could not provide Moncrief Army Community Hospital with contract nurses to supplement the permanent staff, and no replacements were available for the 7.5 civilian nurse vacancies. Fifteen Army Nurse Corps officers transferred from the hospital that year but it received only eight replacements, none of whom were the urgently needed company grade (captain or lieutenant) medical-surgical nurses.⁴⁵ One medical ward and the labor and delivery suite were forced into 12-hour shifts. Nursing supervisors admitted and discharged patients, transcribed orders, and did what they could to actively help the ward staff. Even in these difficult circumstances, nurses continued to draw blood samples after the laboratory staff made their daily morning rounds and they continued to transport patients throughout the hospital. Most department of nursing employees were extremely dissatisfied and resigned their positions when they could.⁴⁶

At Fitzsimons Army Medical Center (FAMC) in Aurora, Colorado, staff frustration underscored the extreme shortages of personnel and funding. Brigadier General Thomas Geer, the FAMC commander, admitted to sending patients to local civilian hospitals for care on a daily basis because there were not enough nurses. Major William Marx, a surgeon, acknowledged that often he did not know who would have surgery until the last minute, adding that FAMC had patients lined up “outside the operating room door, waiting to see who will get in and who won’t.” Major Kate Robertson, head nurse of the Surgical Intensive Care Unit, lamented that if there was insufficient nursing staff, “someone’s brain surgery or heart surgery gets postponed.”⁴⁷ Marx affirmed that FAMC was “top-heavy with doctors, but we can’t get enough nurses.” Consequently, nurses worked doubly hard. Major Sheila Harris, head nurse of the Coronary Care Unit, asserted that the nurses gave “110 percent constantly. You do more than should really be expected of you.” The military nurses also carried most of the overtime burden. Since the hospital had to “pay overtime to the civilian nurses but not military nurse officers, the latter [were] asked to work extra hours when necessary.” Marx concluded that “just to maintain, we abuse our military nurses.”⁴⁸

Similarly bleak working conditions existed at other Army medical centers. An unflattering investigative report published in *Reader’s Digest* divulged that personnel shortages compelled the commander of the Walter Reed Army Medical Center (WRAMC) to close four of 17 operating rooms at one point during the 1980s.⁴⁹ In the summer of 1985, WRAMC had to close 80 beds, or two average-

sized wards, because of shortfalls in the numbers of nurses and administrative staff.⁵⁰ In this same period, the Joint Commission for the Accreditation of Hospitals threatened to rescind its accreditation of Madigan Army Medical Center, Tacoma, Washington, because of staffing deficiencies, particularly intensive care nurses. A second civilian health care professional panel reviewed the situation at Madigan and declared the ratio of professional nurses “to lesser trained staff” was unacceptable.⁵¹ At Brooke Army Medical Center, similar unsatisfactory circumstances existed. There, patients languished, waiting in a queue for about three months to be hospitalized for orthopedic surgery.⁵²

Navy nurses also had concerns. A study quoted one Navy nurse: “I believe it is very dangerous, with 2 nurses on a 40-bed ward, with corpsmen staff . . . to supervise closely, but cannot, due to overworked nurses.” Another complaint about “always being asked to do more with less (people, supplies, etc.) is very discouraging. . . . Administrators seem more concerned with paperwork . . . than they are with the population we are trying to serve.”⁵³

A 1988 Air Force study revealed that 46 percent of Air Force nurses worked 50 hours or more a week and 59 percent considered their nursing unit understaffed. Moreover, 53 percent of the Air Force nurses responding to the questionnaire believed that “the compensation received is ‘less’ to ‘much less’ than the contribution they make toward health care service in the Air Force.”⁵⁴

A draft study report written by the Association of the United States Army, an unofficial, independent organization, concluded:

The Army has not exactly covered itself with glory in its treatment of nurses compared to other professions in the AMEDD. The accession, utilization and promotion policies of the Nurse Corps indicate a lack of imagination, image and fulfillment.⁵⁵

It added:

The mixture of military nurses and civilian nurses seemingly helps solve the problem. It also exacerbates the problem. From a labor relations point of view, the mixing of military, civilian, general schedule, civilian personnel contract, and other civilian contract personnel would try the patience of Job and require the labor acumen of Samuel Gompers, John L. Lewis, and Sidney Hilsman combined.

How the Army does as well as it does with the nurses it has is a tribute to the dedication of these great people.⁵⁶

Although the dimensions of the Army nurse shortage were overwhelming for a while, they were not insurmountable. A combination of evolving conditions in the civilian nursing world, a tincture of time, and a collection of ingenious strategies ultimately rectified that particular iteration of the nurse shortage problem. Both Brigadier General Connie L. Slewitzke and her successor, General Clara L. Adams-Ender, as Chief, Army Nurse Corps, worked to improve recruitment and retention. They initiated a large-scale survey of Army Nurse Corps officers to gather opinions, solicit ideas for solutions, and gauge levels of satisfaction.⁵⁷ They also convened focus groups to strategize on the issues. In addition, they

conferred with the sister services, the Navy Nurse Corps and AFNC, to create a unified approach.⁵⁸

Slewitzke and Adams-Ender also directed the concentrated intelligence of the annual Army Nurse Corps Strategic Planning Conference to brainstorm on issues and their solutions.⁵⁹ They supported unit-level efforts in the military treatment facilities to find answers to the shortages.⁶⁰ They answered numerous inquiries about the shortage from congressional and Department of Army levels.⁶¹ They also enlisted the support of the Defense Advisory Committee on Women in the Services that in turn recommended “that the Secretary of Defense take timely and positive action to resolve nurse accession, retention, compensation, promotion, and motivation issues.”⁶² Finally, they implemented their carefully considered plans to augment numbers in the Active Army (COMPO 1), the ARNG (COMPO 2), and the Reserve (COMPO 3).⁶³

At congressional direction, the Army Nurse Corps conceived, recommended, and carried out several recruitment and retention strategies. Major incentives to improve recruitment of Army nurses to the active component and make the Corps competitive with civilian hospitals included the Army Nurse Candidate Program and the Army Nurse Corps Accession Bonus Program.

The Army paid nursing students in the Army Nurse Candidate Program \$500 monthly for the final two years of their collegiate program and subsequently awarded them a one-time \$5,000 accession bonus when they were commissioned. In return, candidates agreed to serve on active duty for no fewer than four years. This program started in May 1990. By 1993, 91 nursing students were enrolled, and program participation grew steadily every year.⁶⁴

The Army Nurse Corps Accession Bonus Program also offered a one-time \$5,000 accession bonus to any eligible registered nurse who accepted a commission and agreed to serve on active duty for at least four years. As early as May 1990, the Army was processing 186 application packets for these programs.⁶⁵ The Army also implemented the program on a test basis for USAR recruiting in selected states. By 1993, the Army Nurse Corps leadership justifiably considered the program successful. In those states included in the test program, almost all available vacancies in the USAR were filled. Based on these results, the leadership speculated, expanding the program across the country would be a worthwhile venture.⁶⁶

Another proposal to open a collegiate nursing program at the Uniformed Services University of the Health Sciences (USUHS) surfaced as an option to deal with the militarywide nursing shortage in the late 1980s.⁶⁷ This was an old idea. In April 1974, the Army considered closing the Walter Reed Army Institute of Nursing (WRAIN) because of the limited budget. At that time, The Surgeon General asked the USUHS Board of Regents to consider assuming responsibility for a baccalaureate program in nursing. The board rejected this proposal because of the lackluster retention rate of WRAIN graduates. Of the 925 students who began the WRAIN program between 1964 and 1969, only 562 (61 percent) completed the course, and among graduates, only 232 (41 percent) fulfilled their service

commitment. By 1974, only 51 (22 percent) of those who fulfilled their obligation were still on active duty.⁶⁸ In 1976, when WRAIN was closing, USUHS reconsidered the proposal.⁶⁹ A USUHS Feasibility Study Group for a School of Nursing composed of nurse officers from all the federal services analyzed the issues and proposed options.⁷⁰ The group's most favored solution was to subsidize education in civilian institutions to achieve "a varied program selection, cheaper cost, less drain on available manpower, and cross fertilization resulting from exposure to diverse philosophies of education." If that option was unacceptable, an alternative was to establish a USUHS School of Nursing as a two-year upper-division course or a three-year accelerated baccalaureate program. All "other options considered would prove most difficult to justify and defend in any budget hearing."⁷¹ Since the shortage in military nurse accessions was gradually resolving, the board of regents did not act, concluding that although "the University stands ready to discuss any future need, it did not plan to become involved in nursing education at that time."⁷² Because nursing shortages are cyclical, so too are repetitive solutions, and this idea resurfaced about a decade later.

In 1989, Army Nurse Corps leaders collaborated with the other uniformed services to again probe the feasibility of a baccalaureate program in nursing at USUHS. An AMEDD Office of The Surgeon General task force had recommended to the secretary of the Army the restoration of an educational program that would allow the Army to educate its own baccalaureate nurses.⁷³ Jay P. Sanford, the dean of USUHS's medical school, responded by appointing Rear Admiral Faye G. Abdellah, a nurse who had served as the deputy surgeon general of the U.S. Public Health Service, to chair an ad hoc committee composed of representatives from the federal nursing services. Sanford instructed them to investigate the possibility of setting up a college of nursing within USUHS. The task force recommended a program "that would combine both academic and professional education with operational readiness, allow for multiple entry and exit options, and provide both baccalaureate and graduate programs." Members proposed admitting sufficient full-time students to graduate 300 nurses annually for the uniformed nursing services. Graduates would agree to active duty and reserve service in exchange for their education.⁷⁴ The Army, Navy, and Air Force surgeons general were reluctant to endorse the plan, however, predicting that, once more, low retention rates would plague the program. Consequently, the board of regents rejected the task force's recommendations.⁷⁵ The veto of the surgeons general was strange. Since May 1978, Army regulations prohibited female officers from having their service obligations for educational subsidies forgiven by reason of pregnancy, the usual cause for attrition in females in the past.⁷⁶

However, other factors were involved. Brigadier General Hazel Johnson, the last director of WRAIN, thought that a baccalaureate program "would have been a costly effort in terms of personnel." "Then again," she added, "did we want an undergraduate school in a school where all other students were in graduate education." She judged it better to handpick students from across the country and subsidize their education with the Reserve Officers' Training Corps (ROTC) in civilian

institutions rather than opening a school and moving all the students there. Johnson emphasized the importance of a “diversity of philosophies which has been a strength of the Corps, bringing together people from a variety of backgrounds to work together.”⁷⁷ Moreover, by the early 1990s, there were adequate numbers of military nurses and some even saw a glut, a dramatic upswing typical in the aftermath of nursing shortages. Furthermore, all three military nursing branches, like their services, were appreciably reducing personnel. Taken together, these factors contributed to the rejection of an undergraduate college of nursing at USUHS. The concept of having a permanent military entry-level nursing program fell victim to the circumstances of the post-Cold War period—budget constraints, difficulties in starting a new program when the Army was cutting divisions, high attrition rates, insufficient faculty, a lack of educational diversity, a dearth of clinical practicum sites, and unpredictability in the supply of nurses.

Having failed to gain the approval to establish a baccalaureate program, the planning group instead deliberated about opening a graduate program to educate family nurse practitioners, nurse anesthetists, and nurse midwives for the uniformed services. Senator Daniel K. Inouye was the strongest congressional ally for the Graduate School of Nursing (GSN) at USUHS. Through his efforts, Congress appropriated funds to support the school’s opening and operation.⁷⁸ The charter class of three family nurse practitioner students—all affiliated with the U.S. Public Health Services—began their studies in the summer of 1993. When the nurse anesthetist program earned academic accreditation in 1994, eight students matriculated in that advanced practice specialty.⁷⁹ The original demand for family nurse practitioners emanated from the U.S. Public Health Service. The push to open a facility to educate nurse anesthetists came from the U.S. Air Force because these specialists were in great demand in the smaller Air Force hospitals. Both the U.S. Public Health Service and the Air Force encountered great difficulty in recruiting and retaining these specialties.⁸⁰ In these early days, the Army did not participate in these programs.

According to the Army surgeon general, Lieutenant General Alcide LaNoue (1992–1996), the AMEDD would not furnish faculty for the school because Army nurses were in short supply as a result of Army-wide personnel reductions. Nor could the AMEDD sponsor Army students at USUHS, particularly in the anesthesia program, because it was supporting its own nurse anesthesia education program for direct accession applicants. AMEDD treatment facilities could not offer the USUHS students hands-on anesthesia clinical experience because their own internal anesthesia program was making full use of clinical facilities in the Washington, D.C., area.⁸¹

Brigadier General Nancy R. Adams, chief of the Army Nurse Corps (1991–1995), adopted a similar position regarding the GSN at USUHS. Adams was concerned that active participation in the GSN program would detract from the Corps ability to support students in civilian educational curriculums, adding that Army nurses’ attendance in civilian venues showcased the Army Nurse Corps talent to its civilian counterparts and helped to recruit new officers. Adams also favored



Several Army nurses served as the commandant of the Graduate School of Nursing at the Uniformed Services University of Health Sciences. One of those was Colonel Constance J. Moore.
Photo courtesy of Colonel Constance J. Moore, El Paso, TX.

the exposure to a wide diversity of civilian programs that ultimately contributed to the Corps diverse pool of professional knowledge but conceded that using the USUHS facilities for the didactic phase of anesthesia education made sense

because of the exposure afforded to the cutting-edge science courses already made available for the medical students. Still, she had significant reservations about the proposed advanced practice programs at USUHS because of the intense competition for practicum sites in the D.C. area and her reservations “about the influence of the medical model for the preparation of advanced practice nurses.”⁸² Adams believed that a “strong nursing component was lacking” at USUHS because the school was “essentially isolated from a mainstream academic setting” of nursing. She was convinced that “the motivation to have a nursing program was an attempt to increase the support of the school to make it more difficult to close.” During President Clinton’s administration, several attempts surfaced favoring the closure of USUHS. Their overriding objective was to save money. Within one year, the U.S. Senate successfully countered the first proposal spearheaded by Vice-President Albert Gore, Jr. Senator Russell Feingold subsequently introduced another legislative attempt to close USUHS. Senators Daniel Inouye and Sam Nunn effectively laid that scheme to rest with the dissemination of a highly favorable 1995 GAO (Government Accountability Office) report.⁸³

With new Army Nurse Corps leadership in 1996 and the continuing evolution of the GSN, the Army Nurse Corps relationship with the GSN at USUHS changed. The new chief of the Corps, General Bettye Simmons, sent a few Army students to USUHS to maintain the educational diversity of the Corps while simultaneously demonstrating Army support of USUHS in “deed as in word.” The Army Nurse Corps then found the program “sound.” Colonel Susan McCall, the new assistant chief of the Corps, saw a faculty linked with mainstream academia and publishing in professional journals. The Army Nurse Corps began to assign officers as faculty, and even the commandant of the GSN was an Army Nurse Corps officer. McCall and Simmons envisioned the GSN at USUHS as an opportunity to offer graduate education to more Army nurses when educational funding was diminishing. Henceforth, the Army Nurse Corps participated and supported the institution. Shortages among the ranks of nurse anesthetists and nurse practitioners were important factors in the establishment of the GSN. However, the Army Nurse Corps also implemented other measures to recruit and retain these and other specialists.

To relieve the extreme shortages of nurse anesthetists, Congress approved incentive pay for Certified Registered Nurse Anesthetists (CRNAs) in 1989. The Army Nurse Corps offered eligible CRNAs as much as \$6,000 annually as incentive special pay to remain on active duty.⁸⁴ This was the first time Congress passed legislation to award special pay bonuses to Army Nurse Corps officers.⁸⁵

By 1994, it became clear that compensation in the form of incentive pay was failing to retain CRNAs.⁸⁶ In the 1989 “Proud to Care” survey, Army Nurse Corps anesthetists cited monetary compensation as their most important point of dissatisfaction. Many expressed their unhappiness by leaving the service. In FY 1992 and FY 1993, an alarming 50 and 40 percent of the CRNAs, respectively, resigned their commissions before eligibility for retirement and immediately after fulfilling their active duty service obligation.⁸⁷ Consequently, Congress passed and the president signed another bill into law that authorized an increase in the maximum

amount of incentive pay available for payment to certain specialists, including CRNAs, to \$15,000 annually.⁸⁸ Adams noted this measure's ultimate success in affecting the retention of CRNAs, reporting that in FY 1995, 25 such specialists were eligible to separate from active duty after completing four years of obligated service. Of the 25, only three decided to leave active duty.⁸⁹ Moreover, other nonphysician health care providers in all three military services became eligible to apply for the benefit, newly referred to as Board Certification Pay (BCP). To qualify for the pay, the nurse provider needed a master's degree in the appropriate specialty, board certification, and local hospital privileging in the specialty. The applicant for BCP also had to substantiate years of creditable service because computation of the pay was based on years of service in the specialty.⁹⁰ By May 1997, 309 Army Nurse Corps officers were receiving BCP. The group included 210 nurse anesthetists, 25 family nurse practitioners, 27 adult nurse practitioners, 23 pediatric nurse practitioners, 11 obstetrics/gynecology nurse practitioners, and 13 midwives. Certain Army community health nurses and clinical nurse specialists also became eligible for BCP in 1997. At that time, one psychiatric clinical nurse specialist privileged by WRAMC to prescribe and refill certain psychotropic drugs applied for and was awarded BCP.⁹¹

In another effort to augment the supply of Army nurses, the Army Nurse Corps also increased the number of ROTC scholarships offered to collegiate nursing students. However, this effort did not produce many more ROTC cadets. In school year 1988–1989, it made available 40 four-year, 89 three-year, and 37 two-year ROTC scholarships. In school year 1989–1990, the number of four-year scholarships increased to 293; three-year scholarships increased to 174; and two-year scholarships increased to 69. Nevertheless, several students declined ROTC scholarships, leaving some scholarships unused.⁹² From 1988, numbers of ROTC cadets on scholarships fell for the next two years.⁹³ To reinvigorate the program, the ROTC Cadet Command implemented “Operation Golden Gale,” a program designed to spark the interest of high school students in Army nursing. In 1989, ROTC had available 750 Golden Gale scholarships for nursing students. The Army Nurse Corps also assigned four additional recruiters to find potential cadets. By 1989, 13 Army Nurse Corps officers were actively recruiting for ROTC, including the ROTC command chief nurse, four regional chief nurses, and eight nurse counselors.⁹⁴

The ROTC Command also used the Green to Gold program to educate more nurses for the Army. With the assistance of local commanders, the AMEDD Green to Gold Operation identified those enlisted soldiers in the AMEDD that demonstrated the potential to become officers and facilitated their transition from active military service into civilian collegiate nursing programs by simultaneously recruiting them into ROTC.

The Army discharged enlisted soldiers who participated in this program and ended all previous pay entitlements and allowances. The discharged soldiers then received ROTC scholarships augmented by the new GI bill or the Army College Fund. A ROTC counterpart battalion and the in-service recruiters assisted

participants in completing applications for ROTC scholarships. Soldiers had to have served at least two years on active duty to be eligible and apply for an early release for entry into the ROTC Nursing Program.

For the two-year scholarship, a Green to Gold participant needed the equivalent education of a college junior and, for a three-year scholarship, sophomore standing. The Army required students requesting a four-year scholarship to have freshman standing. Applications for the Green to Gold program required letters of acceptance from the appropriate college admissions office and from the school's professor of military science. The applicant had to be an American citizen no older than 25 years of age, had to achieve designated Scholastic Aptitude Test, American College Testing, or General Technical scores, and comply with weight and fitness standards. Scholarships covered tuition assistance, expenses, fees, required books, supplies, and equipment as well as a stipend of as much as \$1,000 annually.⁹⁵

In school year 1988–1989, ROTC offered nine Green to Gold scholarships and it offered 57 in the next year.⁹⁶ Major Cory V. Perkins, ROTC enrollment officer at the University of Texas at San Antonio, remarked that the students—mostly former 91Cs, Army practical nurses—were older and more mature than the typical student and sometimes needed waivers for age. Nonetheless, they were fine soldiers and goal-directed students.⁹⁷ Cadet Lisa A. Toven, for example, had served several years as an enlisted operating room technician in the AMEDD. She entered the Green to Gold program at Seton Hall University School of Nursing, where she completed 21 to 23 credits every semester of her two years in the program. Toven was on the Dean's List for her entire time at Seton Hall and graduated magna cum laude. She earned many awards, such as the Association of the United States Army ROTC Medal, the Pallas Athene Award, the George C. Marshall Award, and Seton Hall's Military Science Medal. The nursing faculty nominated her for membership in Sigma Theta Tau, the international nursing honor society. In 1991, Toven received the prestigious Hughes-Lambert Trophy at the Pentagon, distinguishing her as the most outstanding ROTC graduate in the nation.⁹⁸ She continued with an exemplary career in the Army, serving as an operating room nurse in subsequent assignments and as company commander with the 28th Combat Support Hospital at Fort Bragg, North Carolina.⁹⁹ Toven's achievements highlighted the wisdom and advantages of investing in the skills, knowledge, and credentials of a few, select, top-notch performers within the organization. The investment the Army made in this fine soldier nurse yielded significant dividends.

The AMEDD Enlisted Commissioning Program (AECPP), originally called the Medic to RN Program, was another effort to educate potential Army nurses that began in September 1990. In this program, selected AMEDD enlisted soldiers could complete educational requirements for a bachelor of science in nursing degree. Participating soldiers had to already have completed two years of general education credits before entering the program. As students, AECPP participants received their normal pay and allowance for up to two years, and the Army paid their tuition. Upon completion of their studies and after passing the National



Senior ROTC Cadet Lisa Toven, right, accepts the George C. Marshall Award at the George C. Marshall ROTC Award Seminar in April 1991. Seminar officials, Colonel McDevitt, center, and Command Sergeant Major Hills, left, presided at the award ceremony. Photo courtesy of Lieutenant Colonel Lisa A. Toven, Oakton, VA.

Council of State Boards of Nursing Licensure Examination, the state licensing examination for professional nurses, the Army Nurse Corps commissioned the AECF participants.

These nurses agreed to serve three years in return for the first year of Army support in school and to serve two more months for every month spent in school in the second academic year, not to exceed a total obligation of four years. Originally, the Army funded the first year of the program for up to 100 participants. The following year, the Army Nurse Corps, with the approval of the vice chief of staff of the Army, raised the quota to 125 participants.¹⁰⁰ In May 1992, the Army Nurse Corps commissioned the first cohort of 65 registered nurses who participated in the AECF.¹⁰¹ By 1992, a total of 370 enlisted soldiers had participated, while 77 had been commissioned. Corps leaders projected that number would rise to 88 commissioned by 1993.¹⁰² Although the program worked well for the Army Nurse Corps in the short term, it had serious long-term consequences for the participants.

After only a few years, the military careers of almost all the Army Nurse Corps officers who took advantage of the AECF were in jeopardy. By 1996, the Berlin Wall was rubble, the Cold War was only a memory, and the Army was in the midst

of a massive downsizing. That year, the AMEDD instructed a selection board to accept fewer than 50 percent of those applying for voluntary indefinite status.¹⁰³ The board accordingly failed to select many of the individuals, by then mostly first lieutenants, who took advantage of the AECP, effectively ending their active duty careers. Their options were to revert to their prior enlisted status, leave active duty and shift to the reserve components, transfer their commissions to another service, or separate and accept a lump sum payment as severance pay. Nearly all the AECP graduates did not initially qualify to retire as commissioned officers because the law specified that an officer must accrue 10 years of active commissioned officer service to retire as a commissioned officer after 20 years. The Army Nurse Corps pursued a one-time exception to the law and this exception was granted, thereby preserving the careers of a number of AECP graduates.¹⁰⁴

But as this process was unfolding, most of the AECP cohort was unsurprisingly disillusioned and angry. First Lieutenant Mary Andrews was bitter. Andrews had been in the Army since she was 17 and found it unbelievable that the Army “would do this to me now, at this point.” Andrews’ frustration was understandable, as one board denied her voluntary indefinite status while another selected her for a promotion to captain, almost simultaneously.¹⁰⁵ Army requirements, as usual, took priority over individual needs and preferences, with results that were irrational and overwhelming on a personal level.

The Army Nurse Corps used many strategies to recruit new officers. One inducement first made available early in the 1980s offered guarantees for certain area of concentration courses. If applicants accepted a commission, the Army Nurse Corps granted them the opportunity to attend full-time, on-duty classes at certain military treatment facilities and learn critical care, operating room, pediatric, psychiatric mental health, or obstetrics/gynecology nursing. When completed, the courses would qualify graduates to hold the appropriate area of concentration credentials and function in those specialties.¹⁰⁶

Other actions taken to retain Army Nurse Corps officers involved making full use of the personnel quotas for definite term extensions and expanding the conditional voluntary indefinite selection rates. In FY 1988, the Health Service Division, Army Nurse Corps Branch, added 100 slots for officers who chose to extend their service beyond their initial obligation for a specific time, which was referred to as a definite term extension. In FY 1989, it added 66 more slots and increased the conditional voluntary indefinite selection rate to almost 100 percent.¹⁰⁷ This allowed more Army nurses to remain on active duty beyond their initial obligation.

Another strategy to improve morale, update skills and knowledge, and encourage retention was to protect the funds appropriated for continuing health education from the Army’s budget ax. In FYs 1988 and 1989, the AMEDD approved the Army Nurse Corps Professional Development Funding Package for full funding.¹⁰⁸

With such adverse conditions, the Army Nurse Corps considered any and all strategies to obtain new officers. The accession of foreign nurse graduates was one such option that Colonel Claudia Bartz explored in detail, although Immigration and Naturalization Service regulations, licensure requirements, language difficul-

ties, and educational discrepancies ultimately led the Corps to reject the option.¹⁰⁹

The Army Nurse Corps also attempted to achieve relief from the constraints of the Defense Officer Personnel Management Act (DOPMA) grade tables to improve recruitment and retention. DOPMA mandated that Army Nurse Corps officers be managed by year groups.¹¹⁰ But year groups, especially those consisting of field grade officers, were over strength because of the practice of awarding constructive credit (increased rank) for civilian experience and education upon recruitment to what were referred to as “non–due course” officers.¹¹¹ With such huge year groups, too many officers found themselves in the zone of consideration for promotion at any one time, and the keen competition significantly decreased their chance for promotion. The practice of awarding constructive credit did improve Army Nurse Corps recruitment and professional quality but became a disincentive to retention.¹¹²

While participating in the AMEDD Officer Structure Study, a task force formed on 1 March 1985 to examine topics such as structure and inventory, the Army Nurse Corps realized that the problem was not in DOPMA but in the Corps “broken” structure. It concluded that it could “not get well in [the] short term without [an] increase in field grade allocations” and recognized that the medical grade table for AMEDD officers contained in Army Regulation 611-101 was obsolete, inaccurate, and undergraded for Army Nurse Corps officers.¹¹³ For example, DOPMA directed that 4.7 percent of all active duty personnel be colonels, but the medical grade table allowed only about 1 percent of the Army Nurse Corps to be colonel. In other words, the problem with the Army Nurse Corps structure was that the template used to assign grades to various positions did not consider increases in the complex scope of responsibility, span of control, and requisite education and experience required in those positions.¹¹⁴ Some thought that the inequities in the allocation of colonel authorizations to the Army Nurse Corps occurred because the Corps was a predominantly female branch and traditional practices restricted grade advancement or even permanently assigning advanced grades to female officers.¹¹⁵ The problem eventually was corrected, but only after a prodigious three-year struggle.¹¹⁶

To rectify imbalances, the Army Nurse Corps asked its senior officers to apply their professional expertise to evaluate and regrade all the Corps positions. They identified approximately 100 additional colonel allocations. The Army Nurse Corps then approached the Army deputy chief of staff for personnel through the Office of the Surgeon General and requested and received the additional allocations. These new allocations authorized the promotion of a sizable number of Army nurse colonels and broke the promotion logjam. As Colonel John Hudock, assistant chief of the Army Nurse Corps, observed, each one of these promotions was—in effect—three promotions. When the Army promoted a lieutenant colonel to colonel, that promotion produced a ripple effect, because a major could be promoted to lieutenant colonel and a captain to major.¹¹⁷ Rank restructuring brought the Army Nurse Corps into compliance with DOPMA’s configuration, allowed the Corps to continue awarding constructive credit for recruitment purposes and over-

all quality, enhanced morale, improved retention, opened up promotions, preserved the existing end strength, and conferred the appropriate rank for the specific responsibilities on principal Army Nurse Corps positions. The Army Nurse Corps achieved its AMEDD Officer Structure Study purpose, “to develop an AMEDD officer structure for the future that will serve Army needs and provide career progression opportunities on a parity with the Total Active Army Force.”¹¹⁸

During the 1980s, the Army implemented initiatives to increase the numbers of nurses in the USAR and ARNG. It relaxed the policy governing training schedules, thus making training requirements more flexible and adaptable for individual needs.¹¹⁹ It also allowed constructive credit for a nurse’s education and civilian experience. The Army extended the maximum age to 52 for the initial appointment to the ARNG and USAR, and it collaborated with national nursing organizations in a direct-mail campaign and a media blitz to publicize the opportunities available with reserve service.¹²⁰

The team dedicated to recruiting Army Nurse Corps reserve components grew. Program Budget Guidance authorized 140 additional Army Guard and Reserve nurse recruiters.¹²¹ It also authorized 77 more civilians to support Army Nurse Corps recruitment and retention. The USAR also established the National AMEDD Augmentation Detachment to retain those AMEDD officers who found it impossible to train with units “on a regular basis.”¹²² Operating room nursing, anesthesia, and medical-surgical nursing specialties were the areas of greatest need, and so the three services requested and Congress funded financial incentives for these specialists.¹²³

The Army implemented the New Specialized Training Assistance Program to increase personnel in the surgical specialties in the USAR. In 1988, this program subsidized educational expenses for reservists in Troop Program Units and the Individual Ready Reserve at the rate of \$664 and \$332 a month, respectively. In return, the Army required these reservists to serve two years in the reserves for every year of funding. The Army likewise financed those in the Individual Ready Reserve who were pursuing a bachelor of science in nursing degree at \$100 a month. All of these grants had an annual per-soldier expenditure ceiling of \$7,900.¹²⁴

Another program, the Health Professional Loan Repayment Program, was an incentive for the same nursing specialties—operating room nurses, anesthetists, and medical-surgical nurses. The Army repaid a participant’s outstanding student loans in the amount of \$3,000 for each year served in the Selected Reserve.¹²⁵ The total loan forgiveness package could not exceed \$20,000.¹²⁶ Anecdotal feedback provided hints as to the success of this program. These unconfirmed reports indicated that some nurses chose to accept a reserve rather than an active commission for the generous loan repayment program.¹²⁷

The Army Nurse Corps also encouraged local programs to relieve the nurse shortage. In 1987, Tripler Army Medical Center in Hawaii surveyed nurses’ attitudes. Based on the investigational findings, the Department of Nursing adjusted work scheduling to accommodate nurses’ personal preferences whenever

feasible and expanded training opportunities and staff recognition. The effort reduced staff turnover from 40 percent to 20 percent. By April 1988, registered nurse staffing was at 102 percent.¹²⁸

At Blanchfield Army Community Hospital at Fort Campbell, Kentucky, Colonel Charles Bombard set up a nursing pool of 13 civilian nurses to work when more nurses were needed on nursing units. The civilian nurses could be hired either as intermittent employees on an on-call basis, as part-time employees working from 16 to 32 hours weekly, or as full-time staffers.¹²⁹

Colonel Sandrah Johnson, the chief nurse at FAMC in Aurora, Colorado, awarded \$50 prizes to individual nurses who excelled in one of 14 areas, such as education, training, or community service. The purpose was to keep and reward nurses and to attract new employees from the local area. Within six months Johnson had already awarded \$1,000.

Advertising to create interest in employment was also an effective recruitment tool. The chief nurse at Gorgas Army Community Hospital in Panama, Colonel Randall L. Oliver, invested \$4,000 to publicize the benefits of employment in the Canal Zone. The advertisements, published in a number of national nursing journals, touted features such as “a 15 percent tropical pay differential, a good-sized overseas housing allowance, [and] the opportunity to ship a car” to the Central American country.

Another chief nurse, Colonel Janet Southby, put up a poster in the Fort Belvoir, Virginia, One-Stop Employment Center, to recruit nurses who might then seek employment at DeWitt Army Community Hospital. The poster displayed the advantages of employment at DeWitt, such as working intermittently, job sharing, preferential scheduling, or tuition subsidies.

The tuition assistance program also served as a magnet at Eisenhower Army Medical Center at Fort Gordon, Georgia. There, Colonel Marilyn DiGirol, chief of nursing education and staff development, reported that the hospital discussed the benefits with about 20 potential employees and received four applications for employment within weeks as a result of the tuition assistance program.¹³⁰

The Fort Leonard Wood, Missouri, Medical Department Activity held a nurse information day in 1989, inviting 51 civilian nurses from the local area to learn about the post’s employment opportunities. Coordinated by Lieutenant Colonel Ann Stanton and Major Niranjan Balliram, the day’s activities included presentations and tours of the hospital guided by civilian nurses already employed by the institution. Eight new civilian employees soon filled vacant nursing positions.¹³¹

All of these creative and mostly unprecedented programs contributed to the eventual resolution of the profound and long-term nurse shortage of the 1980s. As the 1980s ended, the strength of the Army Nurse Corps improved conspicuously.

When DoD hospitals were unable to provide nursing coverage by either Nurse Corps officers or CSRNs, they relied on contract nurses as a last resort.¹³² Various referred to as temporary, agency, or contract nurses, these providers relieved certain employee vacancies, served as an entire staff, or lent support where additional resources have not been allocated.¹³³ The contract nurses worked

for proprietary agencies that paid their nurse employees directly and in turn were reimbursed for expenses according to their contracts with the specific military hospital.¹³⁴ The use of contract nurses had both disadvantages and advantages. The financial cost of using such workers was steep as compared to the expense of employing CSRNs, and their temporary employment could adversely affect continuity of care.¹³⁵ Contract nurses were not allowed to serve in leadership roles, that is, as a charge nurse or team leader, thus limiting their overall utility. There was also a heavy investment in time by the permanent nursing staff that had to devote many hours to various issues such as negotiating contracts and setting proficiency standards for the contract employees. The better pay and more convenient hours accorded contract nurses influenced some of the permanent staff to resign their civil service employment or their active commissions in the Army Nurse Corps to become contract nurses. On the plus side, Colonel Mary Messerschmidt, who had extensive exposure to contract nurses while chief, Department of Nursing, at WRAMC, recalled that many of the contract nurses were former CSRNs or junior officers who separated from the service. These former civil servants and junior officers required little to no orientation and proved to be dependable employees. Moreover, if they failed to deliver high-quality service, it was not difficult to remove them. The hospital simply told the agency not to schedule that particular temporary nurse to work in that institution anymore. Messerschmidt observed that these workers were venturesome in ways that many CSRNs were not. Nonetheless, they were “certainly not anywhere near as adventuresome as someone who joins the military and stays” in the service.¹³⁶ Another chief nurse at WRAMC, Colonel Clara Adams-Ender, remembered that some of the contract nurses “liked what we were doing and sometimes would decide to join the Army or Civil Service and become salaried people on our staff.”¹³⁷ In the final analysis, the use of contract nurses was an unwelcome expedient used in very straitened circumstances.

By 1989, the military Nurse Corps began to see positive results from the many incentive programs implemented across the decade. In FY 1989, the Army Nurse Corps met recruitment goals and accessed 524 new officers for the active component. Voluntary recalls to active duty numbered 47, a striking increase from FY 1988’s total of 15 returnees. The chief nurse of the U.S. Army Recruiting Command, Colonel Susan (Shipley) Christoph observed that this statistic reflected the growing propensity for former Army nurses to return to active duty after observing working conditions, salary, and benefits in civilian institutions. The ARNG also accessed 297 Army nurses, and the USAR commissioned 1,600 Army Nurse Corps officers.¹³⁸ By 1990, the Army Nurse Corps was only 27 officers short of its 4,551 authorizations. The AFNC exceeded its 5,352 nursing billets by 57 officers. However, the Navy Nurse Corps had a shortage of 476 officers, or only 3,000 nurses against 3,476 authorizations.¹³⁹ In the early 1980s, the Navy surgeon general acknowledged that the Navy Medical Department had always functioned “with fewer monetary and manpower assets than the Army or Air Force.” It subsequently made concerted attempts to correct “those inadequacies” through the addi-

tion of “sufficient manpower and monies and an efficient command structure.”¹⁴⁰ But success was long in coming.

In the context of a nationwide shortage of professional nurses, an exponentially growing demand for more care providers, and stringent military budget constraints, it was the imagination and hard work of many dedicated individuals who enabled the Army Nurse Corps to maintain an adequate force. The concentrated attention and insight of Army Nurse Corps leaders, the support of officials in Congress and the Department of Army, the collaboration with sister services, the herculean efforts of recruiters, and the day-to-day commitment of the rank and file of the Army Nurse Corps and the Army all contributed to the positive outcome.

Notes

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37. "Department of Defense Report on the Military Nursing Shortage," Typewritten Draft Copy of Report, 12, n.d.; "Military Nurses Task Force Report on the Military Nursing Shortage, Prepared for Department of Health and Human Services, Secretary's Commission on Nursing," December 1988, VI-7; Clyde R. Cunningham, "Lack of Competitive Pay for Civilian Medical Occupation Positions," Information Paper, 14 March 1989; and John

Hudock, "Contract Nurses," Information Paper, 7 August 1990 (all in ANCC, OMH).

38. Many of the bills failed to become law for a variety of reasons. In some instances they were not considered as important as other pressing concerns. Alternately, budgetary constraints precluded their passage. Some of the bills did not have strong advocates to shepherd them through the law-making process. P.L. 99-103 sought to match Veterans' Administration (VA) and civilian hospital salaries. Congress formulated the Wolf-Trimble bill to authorize bonuses and special pay rates. The Ackerman bill was another effort to raise pay, authorize bonuses, and test "alternative pay systems." None of these bills became law. Tracy E. Strevey, "Civilian Registered Nurse (RN) Shortage," TM, 2, 18 April 1988, ANCC, OMH. The Office of Personnel Management (OPM) and Senator John Glenn also proposed bills to change the wage system for nurses. Tom Shoop, "Wage Wars," *Government Executive* (June 1990): 40-44, 46.

39. CSRN's working in the D.C. area; Letterman, Fitzsimons, and Eisenhower Medical Centers; Fort Ord; Fort Monmouth; Fort Jackson; Fort Knox; and the U.S. Military Academy had special salary rates. Clyde R. Cunningham, "Civilian Registered Nurse Task Force," Information Paper, 14 March 1989, ANCC, OMH. The AMEDD effected the promotion of ICU nurses to GS-10 and GS-11 "in recognition of the level of complexity and authority for these special skills." Tracy E. Strevey, "Civilian Registered Nurse (RN) Shortage," TM, 2, 18 April 1988, ANCC, OMH.

40. Tracy E. Strevey, "Civilian Registered Nurse (RN) Shortage," TM, 2, 18 April 1988, ANCC, OMH.

41. The Army Nurse Corps added "one civilian slot per course per iteration" in Area of Concentration courses. The civilian slot was an addition "not a replacement for an AN [Army Nurse] slot." The purpose of this action was "to give the civilian nurses career progression." John M. Hudock, "US Army Nurse Corps, Nursing Research Advisory Board (NRAB), 24-26 July 1989," Typewritten Minutes, 4, ANCC, OMH. Sunnie Scarlett, "Four Army Civilian Nurses Will Attend Military Courses," *HSC Mercury* 16 (September 1989): 3.

42. John Hudock, "The Registered Nurse Shortage," Information Paper, n.d.; Clara Adams-Ender, "Hearing before the Senate Appropriations Committee, Subcommittee on Defense," Transcript of Testimony, 16 March 1989; Wil Nieves, "Status of Nursing Shortage Initiatives," Information Paper, 4, 5, 19 July 1989; and "Army Nurse Corps Strategic Plan Summary," TD, 7, December 1988 (all in ANCC, OMH).

43. Clara L. Adams-Ender, Interview by Virginia Ruth Cheney, 155, 1992, Project 92-3, U.S. Army Military History Institute, Senior Officer Oral History Program, ANCC, OMH.

44. John Hudock, "Chapter Two-1980s's Review," Handwritten Comments, 15 September 2003, ANCC, OMH.

45. Surgical specialties also were the Medical Corps areas of greatest need. In 1982 and 1983, The Surgeon General authorized increased procurement efforts to bring orthopedists, neurosurgeons, general surgeons, and otolaryngologists into the AMEDD. These specialties were the most challenging to recruit and retain. Bernhard T. Mittemeyer, "Army Medical Department," *Military Medicine* 147 (November 1982): 918-28. Bernhard T. Mittemeyer, "Army Medical Department," *Military Medicine* 148 (November 1983): 833-40.

46. Karl H. Pfaehler, Typewritten Letter (TL), 12 December 1988, ANCC, OMH.

47. Steven Eisenstadt, "Money, Nurse Shortages Deal Hospitals a One-Two Punch," *Army Times* 48 (28 March 1988): 1, 8. Some civilian hospitals reported similar circumstances. One publication noted that the nursing shortage "resulted in delays in scheduling elective surgery." Also, "hospital administrators have been frustrated by disruptions in the day-to-day operation of their institutions, revenue lost from beds closed" attributable to a lack of nurses. *Nursing in the 1980s, Crises, Opportunities, Challenges*, ed. Linda H.

Aiken and Susan R. Gortner (Philadelphia: J.B. Lippincott, 1982), 57, 58.

48. Steven Eisenstadt, "Money, Nurse Shortages Deal Hospitals a One-Two Punch," *Army Times* 48 (28 March 1988): 1, 8.

49. Donald Robinson, "The Mess in Military Medicine," *Reader's Digest* 126 (February 1985): 49–53.

50. Judy E. Fox, "Army May Gain Funds Easing Staff Shortages," *U.S. Medicine* 21 (1 December 1985): 1, 20.

51. *Ibid.*

52. Donald Robinson, "The Mess in Military Medicine," *Reader's Digest* 126 (February 1985): 49–53.

53. "Individual Organizational and Job Factors Affecting the Quality of Work Life among Navy Nurse Corps Officers," quoted in "Summary Analysis of the Following Studies," TD, n.d., ANCC, OMH.

54. "Vital Signs: A Survey of the Air Force Nurse Corps," quoted in "Summary Analysis of the Following Studies," TD, n.d.; and Lt. Col. Black, "Talking Paper on Vital Signs: A Survey of the USAF Nurse Corps," 26 October 1988 (both in ANCC, OMH).

55. Association of the United States Army, "The Army Medical Department—An Assessment," Typewritten Draft Report compiled under the auspices of the Institute of Land Warfare, August 1989, n.p., in chapter titled "The Nurse Problem," ANCC, OMH.

56. Association of the United States Army, "The Army Medical Department—An Assessment," Typewritten Draft Report compiled under the auspices of the Institute of Land Warfare, August 1989, n.p., in chapter titled "The Nurse Problem," ANCC, OMH. These comments did not appear in the final report of the following study: Jack N. Merritt, *The Army Medical Department, Caring for the Troops in War and Peace*, Special Report (Arlington, VA: Association of the United States Army, 1989).

57. The "Proud to Care" survey had an 80 percent response rate from the active component nurses. It revealed that key elements affecting Army nurses' decisions to remain on active duty were "time for personal and family life," job satisfaction, and pay and benefits. Valerie E. Biskey and others, "The Army Nurse Corps Proud to Care Survey," Executive Summary, December 1991; and Clara Adams-Ender, "Hearing before the Senate Appropriations Committee, Subcommittee on Defense," Transcript of Testimony, 16 March 1989 (both in ANCC, OMH).

58. Department of Health and Human Services, Secretary's Commission on Nursing, "Military Nurses Task Force Report on the Military Nursing Shortage," December 1988, ANCC, OMH.

59. "Army Nurse Corps Strategic Plan Summary," December 1988; and "Army Nurse Corps Strategic Plan Summary," March 1989 (TDs, both in ANCC, OMH).

60. Tracy E. Strevey, "Civilian Registered Nurse (RN) Shortage," TM, 2–3, 18 April 1988, ANCC, OMH. G.A. Vidis, "Tripler Keeps Nurses with Job Satisfaction," *HSC Mercury* 15 (December 1987): 6. Charles Bombard, "Civilian Nurses Fill Campbell Gaps," *HSC Mercury* 12 (July 1985): 6. Sunnie Scarlett, "Chief Nurses Find Publicity Attracts More RNs," *HSC Mercury* 16 (April 1989): 9. "Wood Greets New Nurses," *HSC Mercury* 16 (February 1989): 12.

61. In 1987, the assistant chief and the chief of the Army Nurse Corps wrote it was "most unfortunate that despite congressional expectations that nurses should be exempt from reductions, they must undergo review. In fact the ANC and PAs get singled out for an additional 20 percent reduction in training. Almost daily, DASG-CN [chief of the Corps office] must deal with issues related to the nurse shortage from AMEDD sources and others such as DA, DOD, etc." John M. Hudock for Clara L. Adams-Ender, "Officer End Strength

Reduction—Authorizations,” TM, 9 December 1987, ANCC, OMH. Undoubtedly, crafting justifications to respond to unrealistic proposals about reductions in numbers and to explain the dire necessity for more and better-educated Army nurses detracted from the time available to concentrate on other important concerns, such as quality issues or career matters. It seems counterintuitive that the upper echelons of the Army and DoD behaved in such a manner.

62. “DACOWITS 2000 Spring Conference, History of Recommendations, 1951–1999,” Printed Brochure, n.d., ANCC, OMH.

63. COMPO 1 is all active duty personnel and is priority funded. COMPO 2 consists of the National Guard. COMPO 3 is made up of the United States Army Reserve. COMPO 4 comprises unresourced structure—that is, units that exist on paper but have no funding. However, COMPO 4 potentially can be activated and subsequently funded. “This is how the Army structures itself . . . to meet requirements.” It is laid out in the Total Army Analysis (TAA), a part of the entire budget process, and is calculated annually. Jennifer Petersen to Author, E-mail Correspondence, 20 May 2003, ANCC, OMH.

64. “Statement of Brigadier General Nancy R. Adams, Chief, Army Nurse Corps,” 1, 5 May 1993, ANCC, OMH. Carolyn M. Feller and Debora R. Cox, *Highlights in the History of the Army Nurse Corps* (Washington, DC: U.S. Army Center of Military History, 2000), 62.

65. Clara L. Adams-Ender, “Legislative Awareness,” *Memo from the Chief, Army Nurse Corps* (31 December 1989): 1; John Hudock, “Army Nurse Corps (ANC) Active Component (AC) Recruitment Bonus,” 28 August 1989; and John Hudock, “Nursing Shortage,” 8 May 1990 (Information Papers, all in ANCC, OMH). Mary C. Smolenski, Donald G. Smith, and James S. Nanney, *A Fit, Fighting Force, The Air Force Nursing Services Chronology* (Washington, DC: Office of the Air Force Surgeon General, 2005), 44.

66. “Nurse Corps Testimony Issues,” TD, 3, n.d., ANCC, OMH.

67. Soraya S. Nelson, “Initiatives May Help Ease Nursing Shortage,” *Army Times* 50 (18 December 1989): 18. Soraya S. Nelson, “Federal Nursing School Concept Being Studied,” *Navy Times* 39 (18 December 1989): 8. Soraya S. Nelson, “Federal Nursing School Plan Advances,” *Air Force Times* 50 (22 January 1990): 14. Soraya S. Nelson, “Federal Nursing School Plan Clears First Hurdle,” *Navy Times* 39 (29 January 1990): 18. “Military Nurse Chiefs Fight for Federal Nursing College,” *American Journal of Nursing* 90 (March 1990): 96. Mary C. Smolenski, Donald G. Smith, and James S. Nanney, *A Fit, Fighting Force, The Air Force Nursing Services Chronology* (Washington, DC: Office of the Air Force Surgeon General, 2005), 42.

68. David Packard, “Minutes of the Board of Regents of the Uniformed Services University of the Health Sciences,” Amendment to Minutes of 13 May 1974, 9 July 1974, 54; and “Uniformed Services University of the Health Sciences, School of Nursing Feasibility Study,” Typewritten Draft, June 1989 (both in ANCC, OMH).

69. “Minutes of the Board of Regents of the Uniformed Services University of the Health Sciences,” 171, 18–19 October 1976.

70. Hazel W. Johnson to Madelyn N. Parks, TL, 26 July 1977, ANCC, OMH.

71. “Final Report, Uniformed Services University of the Health Sciences (USUHS) School of Nursing Feasibility Study Committee,” TD, June 1997, ANCC, OMH.

72. “Uniformed Services University of the Health Sciences, School of Nursing Feasibility Study,” Typewritten Draft, June 1989, ANCC, OMH.

73. Christine M. Galante, “Staff Study Report, Program to Increase Use of Certain Nurses, Section 706, HR 2461/Report #101-121, National Defense Authorization Act for Fiscal Years 1990–1991, Committee on Armed Services, Subcommittee on Military Per-

sonnel and Compensation, House of Representatives, 101st Congress,” TD, 16, n.d.; and Wil Nieves, “Status of Nursing Shortage Initiatives,” Information Paper, 2, 19 July 1989 (both in ANCC, OMH).

74. “USUHS College of Nursing Feasibility Study Task Force Report,” 24 September 1990, in Alma S. Woolley, *Good Nursing in Difficult Places: The First Eight Years of the Graduate School of Nursing, Uniformed Services University of the Health Sciences* (Bethesda, MD: privately printed, 2001), 5.

75. “USUHS College of Nursing Feasibility Study Task Force Report,” 24 September 1990, in Alma S. Woolley, *Good Nursing in Difficult Places: The First Eight Years of the Graduate School of Nursing, Uniformed Services University of the Health Sciences* (Bethesda, MD: privately printed, 2001), 5–6.

76. “Pregnant Officers Must Serve Out Obligations,” *Pentagram News* (27 April 1978): 13, Newspaper Clipping and Inclosure 8, in Madelyn N. Parks, “Information for ANC Officers,” Memorandum, 5 July 1978, ANCC, OMH.

77. Hazel W. Johnson-Brown, Interview by Charles F. Bombard, 111–12, 1984, USAWC/USAMHI Senior Officer Oral History Program, Project No. 84-15, ANCC, OMH.

78. “USUHS College of Nursing Feasibility Study Task Force Report,” 24 September 1990, in Alma S. Woolley, *Good Nursing in Difficult Places: The First Eight Years of the Graduate School of Nursing, Uniformed Services University of the Health Sciences* (Bethesda, MD: privately printed, 2001), 8–9.

79. Eugene Levine, “Needs Assessment for Advanced Practice Nurses for the Uniformed Services,” *Military Medicine* 159 (October 1994): 50–54. “USUHS College of Nursing Feasibility Study Task Force Report,” 24 September 1990, in Alma S. Woolley, *Good Nursing in Difficult Places: The First Eight Years of the Graduate School of Nursing, Uniformed Services University of the Health Sciences* (Bethesda, MD: privately printed, 2001), 15–16.

80. Robert J.T. Joy to Author, TL, 24 November 2003, ANCC, OMH.

81. “USUHS College of Nursing Feasibility Study Task Force Report,” 24 September 1990, in Alma S. Woolley, *Good Nursing in Difficult Places: The First Eight Years of the Graduate School of Nursing, Uniformed Services University of the Health Sciences* (Bethesda, MD: privately printed, 2001), 18–19.

82. The term medical model referred to the typical physician approach of diagnosing and treating illness. It was disease focused. The nursing model viewed the patient as a social being within the context of the environment and focused on caring for the patient by identifying and fulfilling needs. *Mosby’s Medical, Nursing, & Allied Health Dictionary*, fifth ed. (St. Louis: Mosby, 1998), 1001. Often these paradigms were encapsulated into a cure/care dichotomy. Many nurses viewed the medical model with repugnance and expressed reservations about advanced practice nurses who functioned within both paradigms. Nancy R. Adams to Author, E-mail Correspondence, 28 February 2003, ANCC, OMH.

83. Robert J.T. Joy to Author, TL, 24 November 2003, ANCC, OMH. “USUHS College of Nursing Feasibility Study Task Force Report,” 24 September 1990, in Alma S. Woolley, *Good Nursing in Difficult Places: The First Eight Years of the Graduate School of Nursing, Uniformed Services University of the Health Sciences* (Bethesda, MD: privately printed, 2001), 19–22. John Sherner to Author, E-mail Correspondence, 11 August 2003, ANCC, OMH.

84. Prior to being eligible for incentive pay, military CRNAs were required by DoD to complete the pay-back service time for their anesthesia education that was subsidized by the military services. Usually the pay-back period encompassed 4–4 years for 2–2 years of anesthesia education. “Incentive Special Pay for Certified Registered Nurse Anes-

thetists," 19 May 1995, in "Statement of Rear Admiral Joan M. Engel, Nurse Corps, Director, Nurse Corps, United States Navy before the Subcommittee on Defense of the Senate Appropriations Committee," Transcript, ANCC, OMH. John Hudock, "Army Nurse Corps (ANC) Active Component (AC) Incentive Pay," 28 August 1989; and John Hudock, "Nursing Shortage," 8 May 1990 (Information Papers, both in ANCC, OMH). Mary C. Smolenski, Donald G. Smith, and James S. Nanney, *A Fit, Fighting Force, The Air Force Nursing Services Chronology* (Washington, DC: Office of the Air Force Surgeon General, 2005), 44.

85. Clara L. Adams-Ender, "Legislative Awareness," *Memo from the Chief, Army Nurse Corps* (31 December 1989): 1, ANCC, OMH.

86. Office of the Assistant Secretary of Defense (Health Affairs), "Certified Registered Nurse Anesthetists Incentive Special Pay Study," Report, March 1994, ANCC, OMH.

87. Terris Kennedy, "Retention Issues," Information Paper, 26 July 1993, ANCC, OMH.

88. While Congress authorized the \$15,000 ISP in 1994, it did not, however, immediately appropriate the dollars to fund the legislation. Michael J. Foster, "Minutes of the Army Nurse Corps Staff Meeting on 4 January 1994," Typewritten Minutes, 2, 6 January 1994, ANCC, OMH.

89. "Statement by Brigadier General Nancy R. Adams, Chief, Army Nurse Corps, Army Medical Department, before the Defense Subcommittee, Committee on Appropriations, United States Senate, 1st Session, 104th Congress, Health Programs, 13 June 1995," Record Version, 7, ANCC, OMH.

90. House of Representatives, 103rd Congress, 2nd Session, "National Defense Authorization Act for Fiscal Year 1995, Report of the Committee on Army Services, House of Representatives, on H.R. 4301, Together with Additional and Dissenting Views (Including Cost Estimate of the Congressional Budget Office)," Report 103-499, Section 611, 251, 10 May 1994. Michele L. Kohl, "Board Certification Pay for Army Nurse Corps Health Care Providers," Memorandum, 1 November 1996; and Carolyn Bulliner, "PERSCOM Update," *The Army Nursing Newsletter* (October 1999): 5 (both in ANCC, OMH).

91. Monica A. Secula, "Board Certification Pay for Psychiatric and Community Health Clinical Nurse Specialists," Memorandum, 6 May 1997, ANCC, OMH.

92. Charlene Peterson, "Nursing Scholarship Update," Information Paper, 28 August 1989, ANCC, OMH. One primary reason that nursing students failed to accept scholarships had to do with curriculum and constructive credit problems. Collegiate nursing students typically carried a heavier load of academic and clinical course work than most other students. At the same time, many nursing schools refused to award credit for the additionally required military science courses for ROTC cadets, even for elective requirements. The Army Nurse Corps, the Recruiting Command, and the ROTC Command responded by educating individual nursing school faculties and deans about the applicability of ROTC studies to nursing and education in general. Their efforts eventually rectified the injustice, and most schools subsequently awarded constructive credit for ROTC courses. Another serendipitous outcome of the recruiters' outreach was the recruitment of many faculty members into the Army Reserve. Clara L. Adams-Ender to Author, E-mail Correspondence, 26 January 2004, ANCC, OMH.

93. John Hudock, "The Registered Nurse Shortage," Information Paper, n.d., ANCC, OMH.

94. Wil Nieves, "Status of Nursing Shortage Initiatives," Information Paper, 19 July 1989; and Charlene Peterson, "Annual Historical Report Input," TM, 18 December 1989 (both in ANCC, OMH). "Soldiers Go 'Green to Gold' to Become Nurses," *HSC Mercury* 16 (March 1989): 7.

95. "Operation AMEDD Green to Gold," Fact Sheet, 28 August 1989, and attached briefing slides; "Soldiers Can Swap Army Green for Officers' Gold Bars," *USA Today*, n.d., n.p., Newspaper Clipping; and Lorraine Fritz to Jennifer Petersen, "ROTC History Questions," E-mail Correspondence, 8 December 2003 (all in ANCC, OMH).

96. Charlene Peterson, "Nursing Scholarship Update," Fact Sheet, 28 August 1989; and Frank F. Ledford, "Nurse Action Plan—INFORMATION MEMORANDUM," 21 September 1989 (both in ANCC, OMH).

97. "Soldiers Go 'Green to Gold' to Become Nurses," *HSC Mercury* 16 (March 1989): 7.

98. "Lieutenant Gets 'Green-to-Gold' Award," *Pentagram* (21 May 1992): 7, 13. Jeri Chappelle, "Nurse Earns Honor as U.S.'s Best ROTC Cadet," *HSC Mercury* 19 (May 1992): 7.

99. Lisa A. Toven, "Curriculum Vitae," n.d., ANCC, OMH.

100. John Hudock, "Nursing Shortage," Information Paper, 8 May 1990; Clara Adams-ENDER, "Hearing before the Senate Appropriations Committee, Subcommittee on Defense," 16 March 1989, Transcript of Testimony; and Clara L. Adams-ENDER, "Legislative Awareness," *Memo from the Chief, Army Nurse Corps* (31 December 1989): 2 (all in ANCC, OMH). "Program Helps Medics Get Nurse Commissions," *HSC Mercury* 17 (March 1990): 3.

101. Carolyn M. Feller and Debora R. Cox, *Highlights in the History of the Army Nurse Corps* (Washington, DC: U.S. Army Center of Military History, 2000), 64.

102. "Statement of Brigadier General Nancy R. Adams, Chief, Army Nurse Corps," 5 May 1993, 1, ANCC, OMH.

103. VI was a level of officer career status that followed an obligated tour but preceded Regular Army status. Several years after VI became available, Conditional Voluntary Indefinite (CVI) became a preliminary option conferred before VI status. A board selected Army nurses for VI, and the number chosen was "dependent upon how many vacancies recruiting would not be able to fill." CVI evolved into being the Army Nurse Corps "way of hedging [their] bets about candidates who were not the most stellar performers." It also was a bolt hole for officers who "were only staying in to see if they could get a certain assignment or if they were applying for specialty training/school." Darlene McLeod to Author, E-mail Correspondence, 12 June 2003, ANCC, OMH. For a while, an officer had to be in CVI status before applying for VI. Later, however, certain officers could apply directly for VI. Gail Croy to Author, E-mail Correspondence, 29 July 2003, ANCC, OMH.

104. "AMEDD Enlisted Commissioning Program (AECPP)," *Memo from the Chief, Army Nurse Corps* (December 1993): 3; Terris M. Kennedy, Interview by Constance J. Moore, Transcript, 302–03, 25 October 1995; Terris M. Kennedy, Interview by Constance J. Moore focusing on "One Moment in Time," Briefing Slides, Transcript, 25, 11 February 1997; Terris Kennedy to Author, E-mail Correspondence, 24 January 2004; Nancy Adams to Author, E-mail Correspondence, 30 January 2004; and Stephanie Marshall to Author, E-mail Correspondence, 2 February 2004 (all in ANCC, OMH).

105. G.E. Willis, "Feelings of Betrayal Abound as Drawdown Hits Nurses," *Army Times* 57 (16 September 1996): 3. Colonel John Hudock noted that these inequities happened frequently. Sometimes an Army nurse had just completed graduate school at Army expense and immediately failed to be selected for promotion. He explained that "the criteria for selection does vary slightly for schooling, voluntary indefinite, promotion, etc., and perceptions of board members vary, not to mention that there are cutoff points to be made. The concept of *best qualified* versus *fully qualified* sometimes leaves good people behind." John Hudock to Author, Handwritten Letter, 15 September 2003, ANCC, OMH.

106. Frank F. Ledford, "Nurse Action Plan—Information Memorandum," 21 September

1989; Wil Nieves, "Status of Nursing Shortage Initiatives," Information Paper, 19 July 1989; and Clara L. Adams-Ender, "If You Have an AOC/SI Producing Course Guarantee," *Memo from the Chief, Army Nurse Corps* (31 December 1989): 4–5 (all in ANCC, OMH).

107. Conditional voluntary indefinite (CVI) was "the preferred method" for extension of active duty service beyond the officer's initial obligated tour. It conferred "career status" on the officer. To apply for CVI, officers had to have completed two years of Active Federal Commissioned Service (AFCS). A selection board met twice yearly to recommend officers for CVI, basing their decisions on the officers' performance, recommendations of superiors, and compliance with the fitness regulations and weight standards. CVI status obligated officers to one year of Active Duty Service Obligation (ADSO) but allowed them to continue through eight years of AFCS if they so desired. Clara L. Adams-Ender, "Lieutenant's Corner," *Memo from the Chief, Army Nurse Corps* (31 December 1989): 3–4, ANCC, OMH. At the seventh year of AFCS, an Army nurse could apply for VI (Voluntary Indefinite) status. Applicants could be considered for CVI two times. They could be considered only once for VI. Clara L. Adams-Ender, *Memo from the Chief, Army Nurse Corps* (30 June 1990): 2, ANCC, OMH.

108. Frank F. Ledford, "Nurse Action Plan— Information Memorandum," 21 September 1989; Wil Nieves, "Status of Nursing Shortage Initiatives," Information Paper, 2, 19 July 1989; and Clara L. Adams-Ender, "ANC Branch, Health Services Division, PERSCOM (TAPC-OPH-AN)," *Memo from the Chief, Army Nurse Corps* (31 December 1989): 5 (all in ANCC, OMH).

109. Claudia Bartz, "Foreign Nurse Accession into the Army Nurse Corps," Staff Study, 4 October 1989, ANCC, OMH.

110. A year group was a collection of due course officers whose entry date on active duty occurred within the same fiscal year. The officers were sorted into year groups as a way of managing promotions and other board actions. Jennifer L. Petersen to Author, E-mail Correspondence, 30 January 2004, ANCC, OMH.

111. Due course officers entered the Army as second lieutenants and were promoted according to a set schedule. They never were selected above or below the zone for promotion, never had a break in service, and received no constructive credit upon commissioning. "AMEDD Officer Structure Study (AMOSS)," Briefing Slides, n.d.; and Clara L. Adams-Ender, *Memo from the Chief, Army Nurse Corps* (30 June 1990): 2–3 (both in ANCC, OMH).

112. Untitled TD, no author, n.d., that used an "Issue, Question, Answer, Rationale" format to strategize on recruitment and retention topics; Delbert L. Spurlock, "Army Medical Department Promotions," Memorandum for Chief of Staff, United States Army, 1 October 1985; and "Field Grade Structure in the Army Nurse Corps," Information Paper, 5 December 1991 (all in ANCC, OMH). "From the Ferment, Profound Changes," *Army* 36 (March 1986): 42.

113. Colonel Audre McLoughlin served as the study group's deputy director. Lieutenant Colonel John Hudock and Major Dena Norton were the Army Nurse Corps representatives. Connie L. Slewitzke, "Memorandum from the Chief, Army Nurse Corps," Typewritten Newsletter, 2, March 1985, ANCC, OMH. John M. Hudock, "Revision of Medical Grade Table AR 611-101," Action Summary Sheet, 18 September 1986, ANCC, OMH. DA Pam 611-21, "Military Occupational Classification and Structure," 21 March 1999, superseded AR 611-101, "Commissioned Officer Classification System."

114. John Hudock to Author, 7 Telephone Interview, March 2003. "AMEDD Officer Structure Study (AMOSS)," Briefing Slides, n.d., ANCC, OMH.

115. John Hudock to Author, Telephone Interview, 12 March 2003. Connie L. Slewitzke,

Interview by Beverly Greenlee, 146–49, n.d., USAWC/USAMHI Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

116. John Hudock to Author, E-mail Correspondence, 6 March 2003, ANCC, OMH.

117. John Hudock to Author, Telephone Interview, 7 March 2003. “AMEDD Officer Structure Study (AMOSS),” Briefing Slides, n.d.; and Clara L. Adams-Ender, *Memo from the Chief, Army Nurse Corps* (30 September 1989): 3 (both in ANCC, OMH).

118. “AMEDD Officer Structure Study (AMOSS),” Briefing Slides, n.d.; and Clara L. Adams-Ender, *Memo from the Chief, Army Nurse Corps* (30 September 1989): 3 (both in ANCC, OMH).

119. Marie P. Alire, “Input to Readiness Issue on ANC Strategic Plan,” TM, June 1988; and Craig L. Urbauer, “Strategic Planning Recommendations,” Information Paper, 1 June 1988 (both in ANCC, OMH).

120. The maximum age for the initial appointment in the Navy and the Air Force reserves was 47 years old. Annie R. Spurlin and Donna F. Owen, “What Nurses Ask about the Military Reserves,” *American Journal of Nursing* 89 (October 1989): 1311–12. Donna F. Owen, “Direct Mail Campaign for Physicians and Nurses with Critical War Time Skills,” Fact Sheet, 6 January 1988, ANCC, OMH. Sunnie Scarlett, “Army Needs Nurses, Supply Shrinks,” *HSC Mercury* 16 (January 1989): 1, 6, 7.

121. Active, Guard, Reserve (AGR) recruiters were members of the National Guard who came on active duty to fill certain positions that required full-time staffing. Their pay could come from federal coffers (Title 10) or from state funds (Title 32). Jennifer L. Petersen to Author, E-mail Correspondence, 30 January 2004, ANCC, OMH.

122. PBG 698A; and Wil Nieves, “Status of Nursing Shortage Initiatives,” Information Paper, 19 July 1989, 3, 4 (both in ANCC, OMH).

123. “Nursing Shortage Hits Guard, Reserves,” *The American Nurse* 20 (March 1988): 18. “Military Reserves Offer Nurses Opportunities, Benefits, Options,” *The American Nurse* 20 (March 1988): 20.

124. Clara L. Adams-Ender and John Hudock, “Nurse Recruiting, SA-3-1,” 18 July 1988, ANCC, OMH. “Nursing Shortage Hits Guard, Reserves,” *The American Nurse* 20 (March 1988): 18. “Military Reserves Offer Nurses Opportunities, Benefits, Options,” *The American Nurse* 20 (March 1988): 20.

125. A similar loan repayment program for active duty members failed to garner legislative approval in 1989. Lark A. Ford, “Active Duty Loan Repayment Program for Army Nurse Corps: Status Report of Legislative Proposal,” TD, 18 May 1994, ANCC, OMH.

126. Clara L. Adams-Ender and John Hudock, “Nurse Recruiting, SA-3-1,” 18 July 1988, ANCC, OMH. “Nursing Shortage Hits Guard, Reserves,” *The American Nurse* 20 (March 1988): 18. “Military Reserves Offer Nurses Opportunities, Benefits, Options,” *The American Nurse* 20 (March 1988): 20. Annie R. Spurlin and Donna F. Owen, “What Nurses Ask about the Military Reserves,” *American Journal of Nursing* 9 (October 1989): 1311–12. Committee on Armed Services, House of Representatives, Title 10, United States Code, Armed Forces (as Amended through April 21, 1987), §2172.

127. “Nurse Corps Testimony Issues,” TD, 3, n.d.; and “Active Component Health Professionals Loan Repayment Program for Nurses,” Information Paper, 6 May 1993 (both in ANCC, OMH).

128. Tracy E. Strevey, “Civilian Registered Nurse (RN) Shortage,” TM, 2–3, 18 April 1988, ANCC, OMH. G.A. Vidis, “Tripler Keeps Nurses with Job Satisfaction,” *HSC Mercury* 15 (December 1987): 6.

129. Charles Bombard, “Civilian Nurses Fill Campbell Gaps,” *HSC Mercury* 12 (July 1985): 6. Charles F. Bombard and Terris E. Kennedy, “An Aid to Temporary Staffing Short-

ages: The Nursing Pool,” *Military Medicine* 152 (March 1987): 136–38. When Kennedy was a University of Colorado graduate student in 1980, she and Major Ed Kurlansick, the Nurse Methods Analyst at Fitzsimons Army Medical Center, created a very successful internal float pool with Hire Lag Funds. Later, Kennedy implemented a similar program in Korea. Terris L. Kennedy to Author, Typewritten Comments on 1980s chapter, n.d., ANCC, OMH.

130. Sunnie Scarlett, “Chief Nurses Find Publicity Attracts More RNs,” *HSC Mercury* 16 (April 1989): 9.

131. “Wood Greets New Nurses,” *HSC Mercury* 16 (February 1989): 12.

132. Charlotte Asch, “Increased Authorizations to Relieve Army Nurse Shortage,” *HSC Mercury* 13 (August 1986): 4.

133. “Military Nurses Task Force Report on the Military Nursing Shortage, Prepared for Department of Health and Human Services, Secretary’s Commission on Nursing,” December 1988, VI-10, ANCC, OMH.

134. Patricia A. Prescott, “Supplemental Agency Employment of Nurses,” in *Nursing in the 1980s, Crises, Opportunities, Challenges*, ed. Linda H. Aiken and Susan R. Gortner (Philadelphia: J.B. Lippincott, 1982), 399–417.

135. The Army paid the agencies about \$60 per hour for the nurses. The nurses then earned approximately \$35 hourly. John Hudak to Author, E-mail Correspondence, 9 September 2003, ANCC, OMH. In FY 1989 the Army funded \$2,529,800 for contract nurses at Walter Reed Army Medical Center. In FY 1990, that allocation rose to \$5,575,759. John Hudak, “Contract Nurses,” Information Paper, 7 August 1990, ANCC, OMH. Connie L. Slewitzke, Interview by Beverly Greenlee, 266–67, n.d., USAWC/USAMHI Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

136. Mary Messerschmidt to Author, E-mail Correspondence, 11 February 2003, ANCC, OMH.

137. Clara L. Adams-Ender, Interview by Virginia Ruth Cheney, 156, 1992, Project 92-3, U.S. Army Military History Institute, Senior Officer Oral History Program, ANCC, OMH.

138. Clara Adams-Ender, “Hearing before the Senate Appropriations Committee, Subcommittee on Defense,” Transcript of Testimony, 16 March 1989; and Susan B. Christoph, “Chief, ANC Division’s Comments on ANC FY 90 Communications Plan,” TD, 2 October 1989 (both in ANCC, OMH).

139. Sid Balman, “Rx for Nurses,” *Air Force Times* 50 (19 February 1990): 14–16. Soraya S. Nelson, “Initiatives May Help Ease Nursing Shortage,” *Army Times* 50 (18 December 1989): 18.

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