

Chapter Eleven

Preparing for Action

A major theme dating from the 1970s that grew significantly stronger in the 1980s was the Army's clear-cut determination to better prepare for future combat. The major components of this movement involved maintaining proper physical fitness and improving the overall readiness of the Army.¹

A Healthy and Fit Force was the first pillar of the Health Service Support Air-Land Battle, the doctrine for contemporary combat service support derived from lessons learned from World War II to the campaign in Grenada.² The Honorable John O. Marsh, secretary of the Army, espoused the belief that readiness began with physical fitness and encompassed all aspects of total fitness. General E.C. Meyer, the chief of staff of the Army, insisted that each individual was personally responsible for developing and maintaining lifestyles for themselves and their soldiers to meet the rigors of military service, affirming that appropriate physical training and proper nutritional habits affected professional competency. General Hazel Johnson explained that the components of a total fitness routine for Army nurses included eating a sensible diet, coping with stress, controlling weight, eschewing substance abuse, participating in regular physical exercise, and preventing disease. Johnson instructed all Army nurses to begin such an all-encompassing program, and advised them that failure to do so would adversely affect their Army career.³

One indication of the Army's intent to promote all soldiers' fitness was its increased emphasis on successful completion of the Army Physical Fitness Test and compliance with the height and weight standards twice yearly.⁴ Meeting the standards significantly affected selections for promotion, continuation on active duty, and schooling opportunities. The Army required officers to meet the fitness standards before it approved their attendance at educational courses. Those who did not meet standards had their course attendance delayed. General Clara L. Adams-Ender advised officers that the "rationale for the delay is for the benefit of you, the officer." Attaining the standards was part of course completion require-

ments, and so not meeting them could precipitate a student's failure in a specific course or could result in a poor academic efficiency report.⁵ This could adversely impact selection for promotions and other opportunities. The Army's emphasis on the fitness benchmarks meant failure to meet them could doom a career.

The Army Medical Department (AMEDD) officers occasionally singled out Army Nurse Corps officers for their failure to meet the fitness requirements. Colonel Charles J. Reddy, chief of the Nursing Division at the Health Services Command (HSC), allowed that much was written and said about Army nurses who did not meet weight standards, but only 5 percent (151 of 2,999) of Army Nurse Corps officers assigned to the U.S. Army HSC exceeded weight standards. Less known and publicized were the pounds that Army Nurse Corps officers shed to conform to benchmarks. The majority of Army nurses were complying with the weight standards, passing the Army Physical Fitness Test, living healthy lives, and excelling in athletics.⁶

Army Nurse Corps officers also worked to improve overall Army fitness levels. They succeeded beyond anyone's expectations. Many of them obtained graduate degrees and experience as cardiac rehabilitation clinical nurse specialists or as critical care nurses.⁷

In March 1984, Captain Leslie Brousseau became the health fitness consultant to Europe's 7th Medical Command. In that role, she wrote a monthly health and fitness column for the command newspaper and served as a project officer for many health promotion activities, such as the European Command's Great American Smokeout, a tobacco-cessation program, and high blood pressure month. She also coordinated health fairs and health fitness conferences in Europe.⁸

Captain Jeanne Picariello was another Army nurse involved in improving fitness. She was a member of the U.S. Army Pentathlon Team from 1975 to 1978, the first woman and Army nurse to participate.⁹ Picariello was program director of the Army Staff Corporate Fitness Program in 1985 and 1986. She worked with two other Army nurses, a health risk appraisal and intervention coordinator, and the surgeon general's nursing consultant on fitness to gauge the cost effectiveness of health promotion activities of 6,000 military and civilian Pentagon employees. As a part of the project, volunteers underwent a preliminary physiological assessment of current fitness levels and then started physical conditioning. Based on individual needs, volunteers could enroll in classes on smoking cessation, weight control, and stress management. With control and experimental groups, the researchers measured and statistically analyzed the variables of work productivity, reductions in health care expenses, job absenteeism, and turnover/retraining costs.¹⁰ The study demonstrated a positive physiological advantage from structured cardiovascular screening and health education classes.¹¹ Picariello concluded that the program was cost effective and well accepted. Using civilian staff, the Department of Defense (DoD) continued the program for the Pentagon workforce over the succeeding years.¹² Picariello later served as commandant of the U.S. Army Physical Fitness School at Fort Benjamin Harrison, Indiana, from 1994 to 1997, where she oversaw the Army's studies on the Army Physical Fitness Test



Pictured is Colonel Charles Reddy, Chief Nurse, Health Services Command, 1985.
Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.



Captain Jeanne Picariello assesses a participant in the Army Staff Corporate Fitness Program in the Pentagon in 1985.
Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

standards that led to revisions in the existing benchmarks.¹³

In 1987, Lieutenant Colonel Antoinette Hagey, a health promotions nurse specialist, made her contribution to the Army fitness program. She oversaw the development and implementation of the health risk assessment component of the Army Health Promotion Program. Hagey concurrently served on the DoD Health Promotion Coordination Committee and tested and selected materials for education on smoking cessation and hypertension.¹⁴

Fitness was a key component of readiness. Without soldiers fit to fight, readiness was a difficult if not impossible state to achieve on both a personal and unit level.

AMEDD leaders defined readiness as the ability to immediately deploy qualified military medical personnel in support of combat.¹⁵ Other elements also determined readiness. A multidimensional construct, readiness presupposed unit cohesion or a state where soldiers worked efficiently in unison for a common goal. Achieving the goal required physical agility, mental power, psychological aptitude, and effective leadership.¹⁶ Appropriate Table of Organization and Equipment (TO&E) equipment, adequate levels of training, and personnel strength also influenced readiness. For Lieutenant General Quinn Becker, the surgeon general, readiness demanded the integration of finely honed medical skills with the logistical ability to get the right equipment and people to the appropriate place at the necessary time.¹⁷

As the AMEDD entered the 1980s, serious readiness problems existed. In 1982, Assistant Secretary of Defense (Health Affairs) (ASD[HA]) John Beary warned that the military medical services could provide surgery for only one in 10 wounded combatants in the event of war.¹⁸ By the mid-1980s officials described the level of medical readiness as extremely critical. Speaking in 1985, ASD(HA) William E. Mayer shared his dour assessment with the nation's physicians:

I regret to tell you that if we entered a major conventional war today, the system could not render an adequate level of emergency surgery and resuscitation to the wounded in action. Morbidity and mortality rates could be high.¹⁹

One year later, in 1986, Mayer wrote of steady improvements, although the military health care system was still not up to par. In the event of war, Mayer wrote, "scarcely three out of ten wounded [would] receive the prompt care that can spell the difference between life and death."²⁰

At the same time, medical readiness became a high-profile issue that proved embarrassing when details became public.²¹ Both civilian and military newspapers and magazines chronicled readiness deficiencies from the level of DoD all the way down to the AMEDD. In 1985, *Reader's Digest* quoted a U.S. Air Force physician who believed that were the United States to go to war prior to 1991, "a lot of people are going to die unnecessarily."²² Around the same time, a former Navy physician proclaimed in the *Washington Post* that the entire military medicine system should be abolished, with resultant annual savings of hundreds of millions of dollars by the elimination of medical department salaries and by the

sale of military medical facilities, located on prime real estate around Washington, D.C., California, and Hawaii.²³ In 1986, *U.S. News & World Report* characterized readiness of the military medical services as substandard, recounting that only 30 percent of infantrymen wounded in battle could rely on prompt medical care because of personnel and logistical deficits.²⁴ *Army* magazine acknowledged that Army medicine was the object of intense controversy because of its lack of readiness for combat.²⁵ The *Department of Army Historical Summary* added its voice to the calamity, recording that the “ability to provide wartime medical support has been severely limited by a shortage of the medical equipment and professional medical personnel.”²⁶ Everyone realized shortcomings had to be corrected. Fortunately, plans for improving and upgrading medical combat support were already in the works.

In 1982, the acting ASD(HA), Beary, instructed the three military services’ medical departments to use only field health facility systems developed by a quad-service task force, the Military Field Medical Systems Standardization Steering Group, and approved by Beary’s office. His aim was to improve the services’ medical support levels and logistical capability.²⁷ Becker, the Army surgeon general, opposed Beary’s dictum, questioning the wisdom of a joint, strictly homogeneous approach. Becker saw the mandate as an attempt to take control away from the Army and allow DoD to dictate the size and configuration of the medical departments of the services. Without the destiny of the entire AMEDD in his hands, Becker saw only trouble ahead.²⁸ Nonetheless, the Deployable Medical System (DEPMEDS), as it came to be known, moved forward. By 1984, the Military Field Medical Systems Standardization Steering Group had agreed on the use of the TEMPER, as the standardized fabric wall (exterior side of the tent) for the chosen single-system DEPMEDS. The fabric design incorporated a layer of air that served as insulation to counter extremes of hot or cold weather. All the military services tested the new equipment at Fort Hood, Texas, in November 1984 and determined that the DEPMEDS was able to carry out the mission, as long as improvements were made to make it more easily transportable.²⁹

During the next few years, Congress funded 30 sets of DEPMEDSs for the AMEDD, and the Army erected a complete prototype hospital at Camp Bullis, Texas, in August 1987.³⁰ The DEPMEDS’ cost for a 60-bed mobile army surgical hospital (MASH) in 1987 was \$8.2 million and \$16.6 million for a 1,000-bed general hospital.³¹

In February 1988, the 8th Evacuation Hospital at Fort Ord, California, became the first TO&E unit to field DEPMEDSs. It deployed to Fort Hunter Liggett, California, and set up a 400-bed DEPMEDS hospital, staffing it with 85 Professional Officer Filler System personnel.³² The assigned staff implemented a Department of the Army–directed assessment and validation of the equipment and forwarded their findings to the Test and Experimentation Command. Field testing did validate the utility of DEPMEDS equipment. In January 1989, the 8th Evacuation Hospital deployed to Honduras with its DEPMEDS facility to support Fuertes Caminos 89.³³ The detachment in Honduras treated the first surgical case and

delivered the first baby in a DEPMEDS. Active Army, Army National Guard, and Army, Navy, and Air Force Reserve units took part in the deployment.³⁴ By 1990, the Army had fielded 46 DEPMEDS hospital sets and expected to equip a total of 129 hospitals in the near future.³⁵

DEPMEDS used modules that offered almost unlimited potential for configuration.³⁶ The hard-walled containers, referred to as ISO containers, housed the operating room, radiology, laboratory, pharmacy, and central supply elements. The TEMPER, soft-sided tents, contained the triage area, intensive care units, and inpatient wards.³⁷

The DEPMEDS model had both advantages and disadvantages. Its many advantages were its fuel efficiency compared to the Mobile Unit, Surgical, Transportable (MUST) facility, its relative ease in assembly and disassembly, its flexible configuration, its improved level of lighting, and its standardized medical and nonmedical equipment.³⁸ The nonmedical standardized items in DEPMEDS were electrical generators, dietary systems, water distribution and utilities support equipment, bathing facilities, oxygen-generating mechanisms, water-production systems, power distribution infrastructure, and environmental-control components.³⁹ These advantages outweighed the major problem of the sets: their immobility and excessive weight.

The size and weight of the DEPMEDS forced Colonel Jerome Foust, Medical Services Corps (MSC), commander of the 44th Medical Brigade, to reduce the bulk of combat support hospitals and MASHs during Operation Desert Storm. This enabled the DEPMEDS to move with organic vehicles and keep pace with the combat units.⁴⁰ In turn, that led to the dual development of a mini-MASH and to the creation of a Contingency Medical Force. The mini-MASH downsized the MASH unit from 60 beds to a 30-bed intensive surgical hospital. Adoption of the Contingency Medical Force, first utilized in the Balkans during the 1990s, further streamlined combat medical support.⁴¹ The DEPMEDS facility also was vulnerable to biological and chemical warfare attack. After the first Gulf War, planners debated hardening the DEPMEDS equipment to protect against biological and chemical warfare, but the added weight and complexity would render its use extremely difficult for a field unit. However, in the immediate aftermath of the war, planners created an insert for the TEMPER tents and retrofitted a filter for the air handlers to lessen the threat from biological and chemical warfare.⁴²

DoD arrived at medical logistical standardization of DEPMEDS by convening 23 panels of expert clinicians to identify therapeutic regimens to treat more than 300 combat-related diagnoses based on actual combat data. The Task/Time/Treater database, as it was known, detailed precise supplies and equipment required to provide each diagnosis-specific treatment.⁴³ The Defense Medical Standardization Board (DMSB) gradually assumed the overall responsibility for obtaining equipment and determining staffing levels for the DEPMEDS.⁴⁴

DEPMEDS began as a logistical system, a physical field hospital, but with time it also became a personnel element.⁴⁵ A subunit of the DMSB, the Joint Services Nursing Advisory Group, a tri-service task force with Army Nurse Corps representation,

originally calculated the required nursing assets needed in theater.⁴⁶ However, the DMSB slashed the Joint Services Nursing Advisory Group's recommendations, rejecting the proposed numbers and mix of nursing staff because field staffing had to be "austere but adequate."⁴⁷ Nurses countered that while the DMSB's staffing levels were austere, they were neither adequate nor safe. General Connie Slewitzke felt that the Medical Corps and Medical Service Corps officers never took nurses seriously when they talked about safe staffing levels. Many time-consuming and acrimonious sessions justified and rejustified staffing.⁴⁸ Only after several years of struggle could the Army Nurse Corps produce firm evidence demonstrating the amount of time each nursing procedure consumed based on Sherrod's previously described Nursing Care Hour Standards Study. With the established estimates of the potential types and numbers of different patients requiring care at the DEPMEDS facility calculated against the known care needs for these patients, the Army Nurse Corps used Sherrod's statistics to show an accurate picture of the numbers and types of nurses required.⁴⁹ Without Sherrod's hard work, the Army Nurse Corps, in Slewitzke's words, would "really have been behind the eight ball."⁵⁰

By the 1990s, however, even these more realistic staffing levels seemed inadequate for cutting-edge, adequate medical care. At that time, the Army Nurse Corps recognized that basing mobilization staff numbers on the task times of the Workload Management System for Nurses (WMSN), as then recommended by a Manpower Requirements Criteria document, created unrealistic and insufficient numbers of staff. General Nancy Adams wrote that even a modified WMSN was inappropriate for staff forecasting in mobilization situations. Corps leaders concluded the WMSN had been developed many years in the past and needed updating. The system, moreover, was never intended for use in a combat setting. Field conditions such as reduced communications, limited electrical power, inadequate climate control, lack of plumbing, poor automation, and restricted infrastructure resources dramatically increased a nurse's time to do even the simplest tasks. Combat nursing staff necessarily spent more time and energy building and maintaining the hospital, and on duties relating to nuclear, biological, and chemical concerns, sentry duty, field sanitation chores, staff officer and driver duty, erecting and maintaining bunkers, filling sandbags, and many other unanticipated responsibilities. There were many other arguments against using the WMSN to gauge staffing. For instance, there was the erroneous belief that the administration of multiple antibiotics, the standard of care for trauma patients with contaminated combat wounds, would be underestimated and counted in the WMSN as only one task. In reality, the administration of multiple antibiotics would actually require more time because limited pharmacy support was available to prepare the medications. Also, assumptions that less nursing care was needed with limited technological equipment failed to comprehend the certainty that less-sophisticated equipment increased the need for one-on-one care, demanding a more labor-intensive effort. The WMSN presupposed that nurses were working five eight-hour shifts (40 hours) a week, but mobilization staffing assumed that personnel would



Throughout her assignment as chief nurse of the 121st Evacuation Hospital and the 18th Medical Command in Korea, as pictured here, and in her subsequent role as assistant chief of the Corps, Colonel Terris Kennedy used her wealth of practical knowledge about personnel strength issues and readiness concerns to improve the ability of the Army Nurse Corps to support future combat operations. Photo courtesy of Colonel Terris Kennedy, Onancock, VA.

work longer shifts with less time off duty. Adams believed that it was unrealistic in times of continuous operations to require nurses to work at their peak for lengthy periods without time off and wanted flexibility built into the system. Her office stayed dedicated to creating rational, meaningful, and validated Manpower Requirements Criteria standards for combat nursing.⁵¹ Colonel Terris Kennedy, the assistant chief of the Corps, subsequently recommended that the Health Care Studies/Clinical Investigations Agency at Fort Sam Houston validate and document

actual nursing care requirements for mobilization. Until such a study was completed, the Army Nurse Corps had no way of knowing if its field staffing requirements were accurate and if the discrepancies identified with Manpower Requirements Criteria's numbers would be resolved.⁵²

Many Army Nurse Corps officers spent a great deal of time with the DEPMEDS project developing an improved field facility with functional equipment and supplies and appropriate nursing staff levels. Lieutenant Colonel Collette Keyser, an operating room nurse, became the first military nurse to work with DEPMEDS as a staffer in the Health Care Operations Office in the Surgeon General's Office in 1983. Keyser meticulously computerized information and lists of supplies required for Operating Room/Central Materiel Supply sets and trays. Since no other military service had assigned a nurse that early to the DEPMEDS project, the sister services had to accept Keyser's recommendations.⁵³ Lieutenant Colonel Roger Hopkins, who had been assigned to the Academy of Health Sciences and worked with the Manpower Requirements Criteria process and had experience with TO&E matters, chose ward equipment.⁵⁴ Colonel Eily P. Gorman collaborated on the quad panels. Lieutenant Colonel Diane Corcoran, while assigned to the Proponency Office of the Directorate of Training and Development at the Academy of Health Sciences, did extraordinary work to justify numbers of nursing staff for the DEPMEDS.⁵⁵ This was crucial because Colonel Demetrios G. Tsoulous, a key project officer, drastically underestimated nurse staffing requirements. For instance, he believed a total staff of two people could manage the holding ward 24 hours a day/seven days a week. Slewitzke's comeback was that they could, but "they aren't going to get any sleep." When Tsoulous failed to adjust his computations, Corcoran would notify the Army Nurse Corps leadership in Washington, D.C., about what was happening by back channel, thus providing senior officers with information to fight for the cause of adequate, safe, levels of staff. Slewitzke's office worked closely with Corcoran defending requirements and providing rationale that in turn she would communicate to Tsoulous. The Army Nurse Corps regained some—but not all—of its authorized nursing slots.⁵⁶ Lieutenant Colonel Elizabeth Wanersdorfer later carried on the effort when she served as chief, hospital nursing, and DEPMEDS nurse consultant at Medical Research and Development Command. There she monitored more than 5,000 items of medical supplies and equipment and chaired the Quad-Service Nursing Panel that defined intensive, intermediate, and minimal care patients for the mobilization doctrine, developed mobilization standards of practice, and reviewed and revised the DEPMEDS nursing database consisting of nursing tasks, times, and treaters.⁵⁷ At the end of the tumultuous period in 1988, Slewitzke reflected:

We are able to keep on hammering home our point so that we don't lose. As I said many times over, we are the patients' advocate. If we don't do it, there won't be anyone there that will do it for the patients . . . there is no way under God's name that our people would not be stressed out because of the category of the patient that we are taking care of. We fought many iterations. . . . We have done an awful lot of work.⁵⁸

With attention sharply focused on readiness issues, the Army Nurse Corps responded to the imperative to better prepare nurses for field operations. Johnson ordered a review of all Army Nurse Corps courses to identify deficiencies that needed to be remedied in subjects such as field skills and knowledge.⁵⁹ She expanded the emphasis already being placed on field nursing in the Army Nurse Corps Officer Basic Course and Officer Advanced Course at Fort Sam Houston, Texas.

In July 1983, the Army Nurse Corps initiated a Field Nursing Course at the Academy of Health Sciences and at Camp Bullis, Texas. The first class met for two weeks, but budget constraints forced the Army Nurse Corps to shorten the course to one week the following year. TO&E chief nurses and staff nurses received priority for attendance. Any further vacancies were sequentially allocated to Table of Distribution and Allowances/Augmentation chief nurses, senior Army Nurse Corps officers, and finally, fixed unit staff nurses.⁶⁰ Faculty included selected TO&E chief nurses, such as Major Lynne Connelly, who taught classes on the care of nuclear, biological, and chemical patients. Others provided tutelage on various other aspects of field care. Classes were held in tents, and field training exercises were the preferred method of instruction. Gradually, more nurses attended the Combat Casualty Care Course (C4). However, because much of the material in the Field Nursing Course Program of Instruction replicated that of C4, Army Nurse Corps leaders discontinued offering the Field Nursing Course.⁶¹

Both the Navy Nurse Corps and the Air Force Nurse Corps sponsored similar courses in combat nursing. The Naval Health Sciences Education and Training Command offered a nurse operational readiness course for its nurses for the first time in September 1981 to provide information and practice for fleet and field activities. Originally, the Navy limited the course to classroom activities but later expanded the curriculum to Camp Lejeune, North Carolina, and Camp Pendleton, California, to provide more realistic exercises.⁶² The Air Force graduated the first class of its quarterly Battlefield Nursing Course in July 1982. The course was held for five days to prepare nurses for treating battlefield casualties and to develop patient management skills in the field. Instruction relied on seminars and laboratory and field work.⁶³ All the military nursing services were striving to improve levels of combat readiness.

Another major effort to prepare tri-service personnel for their combat roles was the C4 program. In the early 1980s, the Joint Medical Readiness Education Committee, composed of the surgeons general and the president of the Uniformed Services University of Health Sciences, established this educational opportunity to instruct health care professionals in techniques of casualty care on the integrated battlefield during a mid- to high-intensity conflict. The eight- to ten-day course at Camp Bullis, Texas, taught Advanced Trauma Life Support skills, care of casualties in deployed hospitals, the fundamentals of triage, management of nuclear, biological, and chemical casualties, patient evacuation, combat roles, prevention of environmental problems in combat, selection of field sites, and field living conditions.⁶⁴ In 1985, the Joint Medical Readiness Education Committee implemented an improved curriculum, the C4A, designed to focus on medical treatment facilities



Major Lynne M. Connelly teaches a class focusing on the decontamination of patients in the field during a 1984 iteration of the Field Nursing Course at Camp Bullis, Texas. Here the students are in Mission Oriented Protective Posture 4 gear with gas masks. Photo courtesy of Colonel Lynne M. Connelly, Basehor, KS.

in the rear guard.⁶⁵ It was similar to its precursor, with added subjects such as communications and management of medical resources.⁶⁶

At first only active component Medical Corps officers attended the C4. But the “One Army” concept relied heavily on the reserve components (RCs) and could not deploy on a major mission without reserve augmentation. Because the reserves were essential, DoD began to include a few RC officers in the course. Dentists, nurses, veterinarians, and physician assistants were later assigned to the course, testimony to its growing success.⁶⁷ Major Barbara J. Smith was the first Army Nurse Corps officer to attend the C4 course in January 1983.⁶⁸

Soon, more RC officers had to attend the C4 than there were slots available. Consequently, the Office of the Surgeon, Army National Guard (ARNG), established its own Combat Nursing Course, with instruction paralleling that of the C4. Colonel Amelia J. Carson, who was instrumental in setting up this program, organized the first class of nurses at Fort Meade, Maryland, where she contracted with the University of Maryland for Advanced Trauma Life Support training. The course also later welcomed RC Medical and Dental Corps officers and physician assistants.⁶⁹

Although developing readiness skills and knowledge in a structured learning environment was an important approach the Army also understood the value of



Pictured is Colonel Amelia J. Carson, the first Chief Nurse of the Army National Guard (1983).
Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

fostering local grassroots efforts to upgrade readiness among individual soldier nurses. The Army Nurse Corps repeatedly emphasized the need for its officers to maintain familiarity with skills associated with mobilization. Readiness featured prominently at the 1980 Professional Development Workshop, where participants recommended that Professional Officer Filler System officers and Mobilization Designees, those active and RC Army nurses who were preassigned to units on a contingency basis, train with their units.⁷⁰ This would create an awareness of the unit's capability and how its personnel and equipment functioned. Participants also proposed that more Army Nurse Corps officers attend the Officer Advanced Course in residence status to strengthen their wartime skills. A consensus emerged that it was essential for all regular Army nurses to finish the Resident Advanced Course between their fourth and ninth year of service.⁷¹

Slewitzke reaffirmed that the primary combat roles involved duties normally assumed by nurse administrators, operating room nurses, anesthetists, and medical-surgical nurses, but upon mobilization almost all pediatric, obstetrics/gynecology, psychiatric mental health, and community health nurses would take on the medical-surgical role. She insisted that all Army nurses be ready to competently function during war or peace and asked that Army community health nurses receive in-hospital training at least two weeks annually to maintain competence in nursing tasks such as intravenous therapy and the operation of equipment. Slewitzke asserted that all Army nurses needed adequate field training with a TO&E unit to competently carry out their wartime responsibilities.⁷²

Misunderstandings and discontent surfaced about the need to gain or renew medical-surgical nursing aptitudes. A few nurses, particularly U.S. Army Reserve (USAR) officers with highly specialized skills deemed irrelevant to combat roles, voiced dissatisfaction with the requirement. In civilian life, USAR Captain Mark O. McMorris was an obstetrics and gynecology practitioner in a highly specialized civilian practice. His military superiors ordered him to reserve duty at Eisenhower Army Medical Center on a medical-surgical unit. McMorris felt uncomfortable in this role and objected to his assignment, citing patient safety and quality care issues and concerns about professionalism and jeopardizing his nursing license. As a consequence of his reservations, McMorris' reserve unit asked for his resignation. Officials at HSC verified that USAR nurses had to be prepared for mobilization assignments.⁷³

Major Christine E. Cobb, a nurse counselor (recruiter), responded to McMorris' predicament by affirming that "nurses are seeking Reserve and Active Duty nursing because of and not in spite of its perceived challenges." Cobb listed the challenges as "potential mobilization, the probability of cross-training in a different specialty, and the need to creatively utilize nursing's tight resources."⁷⁴

A few months later, another USAR obstetrics/gynecology nurse practitioner in circumstances comparable to those of McMorris spoke out on a more positive note. First Lieutenant M. Denise Palmer accepted that in times of war she had to be ready, according to her understanding of the responsibilities inherent in her commission:

Not only do I agree with this policy, I appreciate the diversity. Membership in the Army Nurse Corps offers many benefits and incentive programs, along with many challenges. It is not easy, nor is it meant to be, but it is worthwhile. Patriotism, leadership, team work, discipline and dedication are attributes we can all admire; my experience in the Army Reserve has given me a sense of purpose and individual growth beyond my initial expectations of a “part-time job.”⁷⁵

Skills in obstetrics/gynecology, pediatrics, and other unique specialties proved invaluable in subsequent deployments to Grenada, Panama, the Persian Gulf, Bosnia, Kosovo, and Haiti. Nonetheless, a firm foundation in medical-surgical nursing was essential for all Army nurses.

To boost nurses’ readiness at Walter Reed Army Medical Center, Lieutenant Colonel Sharon Bystran, chief of nursing education and staff development, developed a practical tool to serve as a guide and a gauge of personal preparedness. Bystran’s comprehensive inventory detailed planning the mobilized officer should make, specifying legal responsibilities, personal military equipment, clothing, comfort items, and immunizations. It stressed the imperative for advanced groundwork, included practical packing hints, and provided an extensive checklist for the Army spouse who would remain behind.⁷⁶ It is likely that Bystran’s efforts facilitated the mobilization of many Army nurses, such as those who deployed soon thereafter in Operation Desert Shield/Operation Desert Storm.

Another innovative plan that improved readiness while relieving the shortage of Army nurses came to fruition in 1984. That year, the Army Nurse Corps assigned 180 additionally authorized officers to Forces Command (FORSCOM) units with a Memorandum of Understanding (MOU) detailing the agreement in writing. In general, the MOU specified that the FORSCOM nurses would participate in an orientation to their field unit after first signing in to a post and subsequently would work on a more or less permanent basis at the co-located military treatment facility. The MOU obliged military treatment facility commanders to release these FORSCOM nurses from their fixed facility responsibilities when their field unit conducted field training exercises or upon deployment.⁷⁷

A controversial point surfaced in the MOU negotiations. All parties finally achieved a consensus on the issue, but only after extensive dialogue. The area of dissent had to do with officer efficiency report rating chains. FORSCOM wanted the Army nurses, mostly junior officers, to have their performance evaluated by the local FORSCOM commanders, usually an MSC officer. Slewitzke opposed this idea, preferring that other nurses (in the fixed facilities) rate the nurses on their clinical nursing performance rather than MSC officers from the field units rate them on their field nursing skills. She based her objection on a fear that some of the junior officers’ careers would be adversely affected because the “MSC . . . commanders in the unit[s] were sometimes a problem.” In the end, Slewitzke prevailed but only after making a personal visit to FORSCOM at Fort McPherson in Atlanta, Georgia, to clarify her position. Her vision of the officer efficiency report rating scheme ultimately became reality.⁷⁸

But another glitch also had to be resolved. Not infrequently, the FORSCOM nurses held key positions, such as that of clinical head nurse in the fixed facilities.



As chief of nursing education and development, Colonel Sharon F. Bystran, right, had many diverse responsibilities. Here she is depicted celebrating on Nurses' Day, 1989, at Walter Reed Army Medical Center with Colonel Jane L. Hudak, left, and Colonel Brooke Serpe-Ingold, center, wearing old Army Nurse Corps uniforms.

Photo courtesy of Colonel Sharon Bystran, Aptos, CA.

Administrators in the fixed facilities expressed some foreboding about a possible mass exodus resulting in widespread vacancies in these vital positions when future deployments would occur. Despite the administrators' reservations, Slewitzke insisted on placing Army nurses into head nurse positions because their careers would be negatively affected if they were not afforded leadership opportu-

nitities.⁷⁹ Slewitzke optimistically acknowledged that “there will be some ‘growing pains’ with the new system but we are confident they can be worked out through good communication.”⁸⁰ In the final analysis, she concluded that field exposure significantly improved Army nurses’ ability to function in general. Before the FORSCOM program, almost all Army nurses had a “big shock” when confronted with the use of post–World War II field equipment in the field hospitals. Although with time the nurses adapted, made do, and learned to improvise, preemptively avoiding such crises was a judicious approach.⁸¹ In spite of the inevitable wrinkles that had to be ironed out, the FORSCOM scheme greatly enhanced readiness.

Another aspect of the readiness picture had to do with retired Army Nurse Corps officers, a largely unknown quantity of relatively untapped resources for use in future emergencies. In 1986, the Health Care Studies and Clinical Investigation Activity at Fort Sam Houston surveyed retired Army nurses younger than age 60 to determine their personal and professional readiness for mobilization. The overall response rate to the questionnaire was 81.7 percent, or 748 retirees. Of the total sample, 93 percent were cognizant of their potential to be recalled, 80 percent had “hip pocket” orders, and 75.4 percent were willing to be recalled if they were physically able.⁸² Almost all (93 percent) still maintained a nursing license but 82 percent felt they needed about six weeks to become clinically competent. Among the anesthetists who responded, 71 percent continued to hold specialty certification in anesthesia and, of those, 77.2 percent were actively practicing in that specialty field.⁸³ This study furnished the Army Nurse Corps with an estimate of the numbers of retirees who would be available to answer the call in times of national need. Most were remarkably willing to serve in such an emergency.

Like the retirees, those Army nurses assigned to USAR or ARNG units, the citizen soldier nurses, also stood ready and committed to activate when called to the service of their nation. Both Army and the Health Service Support Air Land Battle doctrine assigned a significant mobilization role and an increased readiness function to the RCs in the post–Vietnam Army. The Surgeon General acknowledged, however, that the medical RC units were in bad shape in terms of mobilization.⁸⁴ Slewitzke concurred after reviewing the findings of a survey she sent to 3,000 USAR and ARNG officers in 1982.⁸⁵ The quality of chief nurse leadership was a major problem. Some senior officers, many educated with less than a baccalaureate degree, had remained in their positions for almost 20 years, thwarting any kind of upward mobility for better-educated, younger Army nurses. Slewitzke implemented a regulation that limited the tenure of RC chief nurses, but by that time the stagnation had already led many more junior officers to abandon their reserve commissions.⁸⁶ Clearly, the USAR and the ARNG had to revamp their organization as well as their readiness levels. The Individual Mobilization Augmentee (IMA) program was one effort to achieve this end.

As of 1983, the Reserve Components Personnel and Administration Center had assigned 81 Individual Ready Reserve Army Nurse Corps officers to specific positions that they would occupy upon mobilization. Colonel Charles Reddy, the chief, Nursing Division, HSC, encouraged all military treatment facility chief

nurses to make full use of their IMAs in their assigned positions during annual training.⁸⁷ The numbers of IMAs slowly increased over the years, and by 1988, there were about 144 Individual Ready Reserve Army nurses slotted into IMA assignments.⁸⁸

Many talented, accomplished professionals served in IMA roles, such as Lieutenant Colonel Margaret McClure, who in civilian life was executive director of nursing at New York University Medical Center and president of the American Organization of Nurse Executives. McClure's IMA mobilization position was as a senior staff officer at HSC. On active duty, she familiarized herself with specific role responsibilities and implemented special projects, including one on the recruitment of civilian nurses that capitalized on her doctorate in research administration. McClure was uniquely qualified to carry out a research project focusing on the recruitment of civilian nurses.⁸⁹ Later, McClure would serve as the IMA to the assistant chief of the Army Nurse Corps.

The IMA program, however, had some problems. Sometimes chief nurses did not actively support the concept. At one large medical center, for instance, Slewitzke identified about 100 potential IMA positions, but the institution had only two IMAs assigned despite repeated guidance to justify more. Active Army prejudice against reservists persisted, although the majority of reservists could work wonders with proper guidance.⁹⁰ As chief nurse at Letterman Army Medical Center, then-colonel Slewitzke relied on reservists to the greatest possible extent. When one particular reservist came for a two-week annual training period, she assigned the individual as chief of ambulatory care. The next year, she made the same assignment and allowed the Army nurse who normally held that position to go on leave. She reasoned that there was always someone around to prevent the IMA from failing. At the Fort Bragg hospital, an entire reserve unit took over the facility while the permanent active component hospital staff did their field training.⁹¹

Another measure taken to enhance RC readiness placed officers full-time in key USAR and ARNG positions. Johnson posted an active component War College graduate, Colonel Amelia J. Carson, to the ARNG Surgeon's Office as its chief nurse. Slewitzke increased the staff at the Army Reserve Personnel Center, formerly the Reserve Components Personnel and Administration Center, from one Army Nurse Corps officer to five, a number more appropriate to deal with the personnel issues of almost 7,000 RC nurses. She justified a position at FORSCOM to manage RC concerns and arranged RC positions in the Office of The Surgeon General, Quality Assurance, and Procurement.⁹² Another USAR officer, Lieutenant Colonel Donna Owen, served on the staff of the ASD(HA) in the Directorate of Manpower, Personnel, and Training as the deputy director for reserve affairs in January 1987.⁹³

During the last year of Slewitzke's tenure as chief of the Corps, she directed her IMA, Colonel Catherine Foster, to prepare and propose legislation to create an Army Nurse Corps general officer position for the reserves. In 1988, Congress approved the new position.⁹⁴ Brigadier General Dorothy B. Pocklington became the first reserve Army nurse and the first female reserve officer to become a briga-

dier general.⁹⁵ Pocklington served as the IMA to Adams-Ender, the chief of the Army Nurse Corps, assisting her on mobilization issues as they applied to both the USAR and ARNG.⁹⁶ She represented the chief in boards and meetings; assisted in the formulation of RC integration and mobilization policy; participated in RC recruitment, retention, and training activities; and increased RC visibility.⁹⁷

After three years in her IMA position, Pocklington pioneered another unusual assignment by assuming responsibilities of a non-branch-specific position as deputy chief for public affairs on the Department of the Army level. At first, Pocklington considered her new responsibilities in public affairs as worlds apart from her former role as a nurse. After considering it, however, she concluded there were similarities between the two missions because survival was the crucial attribute of both these disciplines. In the AMEDD, Pocklington envisioned survival of the soldier as fundamental, while in public affairs the focus was the survival of the Army's reputation. This approach provided her with a framework through which to view her responsibilities and allowed her to make use of her AMEDD background to enhance her contributions in public affairs. Pocklington was the first female and nurse to serve in this atypical role and the first general officer Army nurse to fill a position not in the AMEDD.⁹⁸

In 1993, Brigadier General Sharon Vander Zyl blazed a parallel trail in the Army National Guard. Vander Zyl, likewise the first female general officer in the ARNG, served as special assistant to the chief of the Army Nurse Corps.⁹⁹ Many talented Army Nurse Corps officers in the Active Component, Reserve, and National Guard helped to widen the access to future branch immaterial and command positions for Army nurses.

During the 1980s, the Army Nurse Corps made an effort to improve the quality of RC training to enhance readiness skills. As early as 1981, Major Diane Corcoran, chief of the Nursing Education and Training Service (NETS) at Fitzsimons Army Medical Center, and Sergeant First Class David Steffenson, Non-Commissioned Officer in Charge, NETS, tackled readiness issues on a unit level when reservists arrived at their installation for training. Corcoran observed that the reservists typically felt that their annual two-week active duty for training assignment did not furnish them with what they needed, indeed, they "weren't even sure what they were supposed to accomplish."¹⁰⁰ Consequently, the pair formulated a reserve training program, the Systematic Modular Approach to Realistic Training (SMART), to educate officers and enlisted troops about their actual wartime responsibilities. Previously, the reservists provided peacetime health care services during their annual training time.¹⁰¹ This improved routine nursing skills but did not enhance combat nursing proficiencies. SMART was one answer to that problem. It began with a program briefing. Next, NETS furnished the participants with booklets that delineated learning objectives and assignments in specific roles, such as wardmaster, head nurse, practical nurse, or medic. The booklets explicitly outlined clinical and administrative tasks and specified individual and unit training responsibilities. The reserve units became accountable for each soldier's implementation of the training and tasks, while NETS provided assistance



Pictured is Brigadier General Dorothy B. Pocklington, the first reserve Army nurse and the first female reserve officer to serve in the grade of brigadier general (1988).
Photo courtesy of Dorothy Pocklington, Ellicott City, MD.



Pictured is Brigadier General Sharon Vander Zyl, the first female general officer in the Army National Guard who served as the Special Assistant to the Chief Army Nurse Corps for Mobilization and Guard Affairs (1993).

Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

on an as-needed basis.¹⁰² Also, an evaluation of the soldier's performance served to document training and capabilities. By 1984, after three years of using SMART, both Fitzsimons staff and reservists agreed that SMART fostered a higher level of training and better utilization of active component and ARNG/USAR personnel.¹⁰³ Nonetheless, SMART had its detractors among hospital commanders. In fact, some of the commanders created "a lot of flak" about the program.¹⁰⁴ Some observers felt the added RC support in meeting the everyday needs of providing health care in fixed facilities in times of peace was viewed as more important than enhancing combat readiness knowledge and skills.

From 1987 to 1989, USAR nurses participated in a number of practical field exercises. They erected a pre-positioned, 1,000-bed hospital in Great Britain and field tested its equipment, e.g., ventilators, infusion pumps, and suction machines.¹⁰⁵ The nurses fine-tuned an evacuation plan in a combined British-U.S. Air Force exercise. They also repacked the facility so that it could be put to use quickly if the reserve forces mobilized. Other realistic training occurred in the summer of 1988, when Army Nurse Corps officers and others assigned to the 399th Combat Support Hospital staffed a field hospital during a 15,000-soldier ARNG two-week field training exercise at Fort Hood, Texas. The Army nurses cared for approximately 1,500 patients, about 75 of the soldiers being admitted to the hospital for treatment of illness or injury.¹⁰⁶

Throughout the 1980s, Army Nurse Corps officers committed themselves to improving readiness and built on the progress achieved earlier in the immediate post-Vietnam War years. Army nurses' preparedness steadily improved and, whether relief mission or combat operation, Army nurses were ready to provide care.

Notes

1. Karl E. Cocke, and others, *Department of the Army Historical Summary, Fiscal Year 1982* (Washington, DC: Center of Military History, United States Army, 1988), 81–82. Dwight D. Oland, *Department of the Army Historical Summary, Fiscal Year 1984* (Washington, DC: Center of Military History, United States Army, 1995), 196–197. William Joe Webb, *Department of the Army Historical Summary, Fiscal Year 1988* (Washington, DC: Center of Military History, United States Army, 1993), 29. Bernhard T. Mittemeyer, “Army Medical Department,” *Military Medicine* 148 (November 1983): 833.

2. AirLand Battle doctrine, a combined arms concept, involved a number of innovations in operations, training, and joint air-ground operations. It emphasized the operational level of war and stressed maneuver warfare, fostered a major change in education and training with opposing forces exercises at the National Training and Combat Training Centers, and emphasized coordination between Training and Doctrine Command and the Tactical Air Command of the Air Force. Harry G. Summers, *On Strategy II: A Critical Analysis of the Gulf War* (New York: Dell, 1992), 139–50. Frank N. Schubert and Theresa L. Kraus, eds., *The Whirlwind War, The United States Army in Operations Desert Shield and Desert Storm* (Washington, DC: Center of Military History, United States Army, 1993), 26–28. Health Service Support AirLand Battle was the template for the AMEDD’s wartime structure. Emerging Medical Force 96 and Medical Force 2000 later replaced Health Service Support AirLand Battle and served to outline the 21st century field medical doctrine and force structure. Frank F. Ledford, “Surgeon General Outlines Priorities for AMEDD Action,” *HSC Mercury* 16 (March 1989): 2. Medical Force 2000 proposed reducing the structure from seven hospitals down to a medical holding company and four hospitals. The four hospital units were a Mobile Army Surgical Hospital, a Combat Support Hospital, a Field Hospital, and a General Hospital. Richard V.N. Ginn, *The History of the U.S. Army Medical Service Corps* (Washington, DC: Office of the Surgeon General and Center of Military History, United States Army, 1997), 376, footnote 7, 411. “MF2K Medical Units,” Printed Handout, n.d., Army Nurse Corps Collection (ANCC), Office of Medical History (OMH). Basic tenets of Medical Force 2000 doctrine included “far-forward surgical care; a focus on returning soldiers to duty from as far forward as possible; increased intensive care capability in the combat zone; new medical logistics systems that incorporate blood distribution capabilities; improved ground and air evacuation capabilities; and improved management of combat stress.” Frank F. Ledford, “Army ‘Innovative’ in Use of Funds,” *U.S. Medicine*

25 (January 1989): 41–42. “HSSALB: New Medical Operational Doctrine Receives Approval,” *Medical Soldier’s Outlook, Army Medical Department Enlisted Training News* 3 (Spring 1986): 1. Frank F. Ledford, “Army Medicine Balancing Needs with Resources,” *Army* 40 (October 1990): 180–83, 185. Frank F. Ledford, “Medical Support for Operation Desert Storm,” *The Journal of the US Army Medical Department*, PB8-92-1/2 (January/February 1992): 4. The other five pillars of Health Service Support AirLand Battle were “prevention, immediate far-forward care, a hospital structure which is deployable and mobile, a timely dedicated evacuation system and a continental U.S. support base.” Raymond Leahey, “Implementing ‘Pillars of Wellness/Fitness and Prevention’,” *Army* 36 (March 1986): 46–47. “Health Service Support, Futures,” AHS White Paper, Final Draft, i-ii, March 1989, ANCC, OMH.

3. Hazel W. Johnson, “Notes from the Chief, US Army Nurse Corps,” 1, March 1983, ANCC, OMH.

4. The APFT consisted of three components. It involved a timed two-mile run and a prescribed number of push-ups and sit-ups. The regulation based the minimum acceptable number of items in each event on the gender and age of the participant. Joseph Knapik, “The Army Physical Fitness Test (APFT): A Review of the Literature,” *Military Medicine* 154 (June 1989): 326–29. Department of the Army, Field Manual 21-20, “Physical Fitness Training” (Washington, DC: Department of the Army, 1985). Prior to 1982, the Army allowed only soldiers under the age of 40 to take the Army Physical Fitness Test, fearing that its widespread implementation across the age spectrum would contribute to increased numbers of sudden cardiac death. To prevent such catastrophes, the Army began screening active component soldiers over age 40 in 1982, evaluating their cardiac risk factors and subjecting them to physical exams. The reserve components implemented the Over-40 Medical Screening Program in 1987. Bernhard T. Mitemeyer, “Facing Challenges, Army Goals Endure,” *U.S. Medicine* 18 (5 January 1982): 41–42. Bernhard T. Mitemeyer, “Army Medical Department,” *Military Medicine* 148 (November 1983): 833. Bernhard T. Mitemeyer, “Army Total Fitness Program a Success,” *U.S. Medicine* 19 (15 January 1983): 29–34. Karl E. Cocke, and others, *Department of the Army Historical Summary, Fiscal Year 1982* (Washington, DC: Center of Military History, United States Army, 1988), 81–82. Dwight D. Oland, *Department of the Army Historical Summary, Fiscal Year 1984* (Washington, DC: Center of Military History, United States Army, 1995), 196. Donna Bolinger, “Reserve Components to Get Same Over-40 Screening as Active Duty,” *HSC Mercury* 14 (February 1987): 8.

5. Clara L. Adams-Ender, “Memo from the Chief, Army Nurse Corps,” 4, 31 December 1989, ANCC, OMH.

6. Charles Reddy, “Nursing Newsletter Number 84-1,” 1, 1 February 1984, ANCC, OMH.

7. “Army Nursing in the 1990’s (NLN Conf),” Typewritten Text for Speech, June 1985, ANCC, OMH.

8. “ANC Annual Historical Report FY 85,” 5, n.d., ANCC, OMH.

9. “Army Nurse Aims for World Games,” *HSC Mercury* 4 (May 1977): 11. 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), 48.

10. Connie L. Slewitzke, “Memorandum from the Chief, Army Nurse Corps,” 4–5, March 1985; Connie L. Slewitzke, “Memorandum from the Chief, Army Nurse Corps,” 5–6, July 1986; and “ANC Annual Historical Report FY 85,” Typewritten Document (TD), 11–12, n.d. (all in ANCC, OMH).

11. Quinn H. Becker, “Medical Readiness Primary Army Focus,” *U.S. Medicine* 22

(January 1986): 39–40.

12. Other Army nurses who actively participated in various phases of the program were captains Sandy Yaney, Catherine Schemp, Jill Phillips, and Leslie Dempsey Brousseau, majors Carolyn Bernheim and Mary C. Davis, and lieutenant colonels Antoinette Hagey and Susanne Allen. Jeanne Picariello to Author, E-mail Correspondence, 24 March 2003; and “Army Nurse Corps (ANC) 1986 Annual Historical Report,” 24 (both in ANCC, OMH).

13. Jeanne Picariello to Author, E-mail Correspondence, 24 March 2003. Alcide M. LaNoue to Barry R. McCaffrey, 6 April 1994; Jerry A. White to Alcide M. LaNoue, 5 May 1994; Nancy R. Adams to Jerry A. White, 20 May 1994 (all Typewritten Letters in ANCC, OMH). Some time later, the Army Panel on Sexual Harassment’s findings of unfairness instigated the setting of new, higher Army Physical Fitness Test standards for women soldiers. The existing women’s standards, dating back to 1986, became more stringent and more closely approximated those set for men soldiers. “Army to Raise Fitness Standards for Women,” *Minerva’s Bulletin Board* (Summer 1997): 3. “New Army Fitness Test Imposes Higher Standards of Women,” *Minerva, Quarterly Report on Women and the Military* 4 (Spring 1986): 72–73.

14. “Army Nurse Corps (ANC) FY 87 Annual Historical Report,” 10, ANCC, OMH.

15. Hudak and Mouritsen identified readiness as “the overriding reason for [the] AMEDD’s existence.” Ronald P. Hudak and Paul B. Mouritsen, “Improving the Army’s Primary Care Delivery System,” *Military Medicine* 153 (June 1988): 282–86.

16. Rosemarie Skaine, *Women at War, Gender Issues of Americans in Combat* (Jefferson, NC: McFarland & Company, Inc., 1999), 154.

17. Quinn H. Becker, “The ‘We Care People’ in Army Medicine,” *Army* 36 (October 1986): 240–43.

18. “Medical Readiness of the Armed Services, Hearings before the Subcommittee on Manpower and Personnel of the Committee on Armed Services, United States Senate, 97th Congress, 2nd Session, May 4, 26, 1982” (Washington, DC: U.S. Government Printing Office, 1982), 2.

19. William E. Mayer, “Medical Readiness DoD Top Priority,” *U.S. Medicine* 21 (15 January 1985): 7–10. “Hearings before a Subcommittee of the Committee on Appropriations, House of Representatives, 99th Congress, 1st Session,” Part 3 (Washington, DC: U.S. Government Printing Office, 1985), 1022, 1026–27, 1069.

20. William E. Mayer, “DoD Not Medically Ready for War Needs,” *U.S. Medicine* 22 (January 1986): 13–14.

21. “Hearings before a Subcommittee of the Committee on Appropriations, House of Representatives, 99th Congress, 1st Session,” Part 3 (Washington, DC: U.S. Government Printing Office, 1985), 1022–23.

22. Donald Robinson, “The Mess in Military Medicine,” *Reader’s Digest* 126 (February 1985): 52.

23. Lawrence H. Fink, “Military Medicine Is a Terminal Case; It’s Time to Pull the Plug,” *Washington Post* (24 November 1985): C1, C4. A number of writers, including the Army surgeon general, penned letters to the *Washington Post* editor countering this extreme viewpoint. Quinn Becker, Edward Weiss, Eileen Matthews, and Nicholas Dunlap, “Letters,” *Washington Post* (30 November 1985): A25.

24. David Whitman, “Under Attack: Military Care,” *U.S. News & World Report* (27 January 1986): 69.

25. “U.S. Army Medicine, from the Ferment, Profound Changes,” *Army* 36 (March 1986): 22.

26. Terrence Gough, *Department of the Army Historical Summary, Fiscal Year 1986*

(Washington, DC: Center of Military History, United States Army, 1989), 61.

27. John F. Beary, "Department of Defense," *Military Medicine* 148 (November 1983): 857–63. John F. Beary, "Medical Readiness DoD's Main Goal," *U.S. Medicine* 19 (15 January 1983): 9–12. "Medical Readiness of the Armed Services, Hearings before the Subcommittee on Manpower and Personnel of the Committee on Army Services, United States Senate, 97th Congress, 2nd Session, May 4, 26, 1982," (Washington, DC: U.S. Government Printing Office, 1982), 5, 27–28.

28. "U.S. Army Medicine, from the Ferment, Profound Changes," *Army* 36 (March 1986): 23.

29. Bernhard T. Mitemeyer, "'Volatile' Year Sees Army Medical Gains," *U.S. Medicine* 21 (15 January 1985): 15, 16, 21. Dwight D. Oland, *Department of the Army Historical Summary, Fiscal Year 1984* (Washington, DC: Center of Military History, United States Army, 1995), 197. "Hearings before a Subcommittee of the Committee on Appropriations, House of Representatives, 99th Congress, 1st Session," Part 3 (Washington, DC: U.S. Government Printing Office, 1985), 1071. "DEPMEDS the Latest in Portable Medical Care," *Army Reserve Magazine* 33 (Fourth Issue of 1987): 26–27. Kevin Ropp, "Review Hits DEPMEDS Shortages," *HSC Mercury* 17 (June 1990): 10. Academy of Health Sciences, *Deployable Medical Systems Users' Manual, Final Draft* (Fort Sam Houston, TX: 1989), 1–4, Smith Collection, U.S. Army Medical Department Museum. Quinn H. Becker, "Medical Readiness Primary Army Focus," *U.S. Medicine* 22 (January 1986): 39–40.

30. Terrence Gough, *Department of the Army Historical Summary, Fiscal Year 1986* (Washington, DC: Center of Military History, United States Army, 1989), 61. "Medics Train in New Field Hospital," *HSC Mercury* 14 (October 1987): 12. By 1990, the Army had fielded more than 40 DEPMEDS facilities with 17,560 beds. Captain Clyburn, "Status of Deployable Medical Systems (DEPMEDS) Fieldings," Information Paper, 28 February 1990, ANCC, OMH.

31. "DEPMEDS the Latest in Portable Medical Care," *Army Reserve Magazine* 33 (Fourth Issue of 1987): 26–27.

32. Department of the Army, Headquarters, U.S. Army Health Services Command, Medical Services, "AMEDD Professional Officer Filler System," Memorandum No. 40-2, 13 November 1973, Record Group 112, National Archives. The Professional Officer Filler System (PROFIS) program's intent was to predesignate officers "for forward deployed and deploying units" so as "to hasten the mobilization process." Bernhard T. Mitemeyer, "Facing Challenges, Army Goals Endure," *U.S. Medicine* 18 (5 January 1982): 41–42. Dwight Oland and Jeffrey Greenhut, *Report of the Surgeon General, United States Army Fiscal Years 1976–1980* (Washington, DC: Office of the Surgeon General, U.S. Army, 1988), 301. Nelia Schrum, "PROFIS Puts Providers There When Needed," *The Mercury* 24 (May 1997): 12. Cleo Brennan "PROFIS Soldiers Offer Two-For-One Service," *The Mercury* 26 (January 1999): 12. By 1982, the system had slotted 3,600 physicians and nurses into vacancies for combat roles. "Medical Readiness of the Armed Services, Hearings before the Subcommittee on Manpower and Personnel of the Committee on Army Services, United States Senate, 97th Congress, 2nd Session, May 4, 26, 1982" (Washington, DC: U.S. Government Printing Office, 1982), 25.

33. Fuertes Caminos ("strong roads" in Spanish) was an annual Army Reserve and National Guard rotation that implemented nation-building projects, such as the planning and paving of roads, the construction of schools, the distribution of clothing, and medical outreach in Central and South America. John D. Sherwood, "U.S. Army Operations Other Than War since 1989," 5–6, 7 April 1995, ANCC, OMH.

34. 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), 61.

35. Frank F. Ledford, "Army Medicine Balancing Needs with Resources," *Army* 40 (October 1990): 180–83, 185.

36. "Medics Train in New Field Hospital," *HSC Mercury* 14 (October 1987): 12.

37. "Operation Desert Shield/Storm, Lessons Learned—DEPMEDS," TD, n.d., ANCC, OMH. Kevin Ropp, "Review Hits DEPMEDS Shortages," *HSC Mercury* 17 (June 1990): 10.

38. "Medics Train in New Field Hospital," *HSC Mercury* 14 (October 1987): 12.

39. "Standard Field Equipment Coming This Year," *HSC Mercury* 14 (April 1987): 1.

40. An organic vehicle is a piece of equipment permanently assigned to a unit based on the Table of Organization and Equipment (TO&E) for that type of unit. Richard V.N. Ginn, *The History of the U.S. Army Medical Service Corps* (Washington, DC: Office of the Surgeon General and Center of Military History, United States Army, 1997), 435. United States General Accounting Office, *Military Personnel and Compensation, Committee on Armed Services, House of Representatives, Operation Desert Storm, Full Army Medical Capability Not Achieved*, GAO/NSIAD-92-175 (Washington, DC: GAO, August 1992), 4, 40–43.

41. Colonel Jerome V. Foust, Interview by Captain Donald Hall, March 29, 1991, Type-written Transcript, 10, 22, Richard V.N. Ginn Collection, OMH. "Army Identifies 'Lessons Learned' from Desert Storm," *U.S. Medicine* 28 (February 1992): 1, 3, 26, 27. Frank Best and Nancy Tomich, *Medicine in the Gulf War* (Washington, DC: U.S. Medicine, 1991), 6, 8, 9. Ingeborg Sosa, "The Journal Interviews—MG Michael J. Scotti, Jr., MC, Commanding General, 7th Medical Command, Europe," *The Journal of the US Army Medical Department*, PB8-92-1/2 (January/February 1992): insert between pages 34 and 35. Ingeborg Sosa, "The Journal Interviews—LTG Frank F. Ledford, Jr., Surgeon General, United States Army," *The Journal of the US Army Medical Department*, PB8-92-3/4 (March/April 1992): insert between pages 30 and 31. William R. Smith and Philip Lisagor, "Experience of the 31st Combat Support Hospital in Operation Desert Shield and Desert Storm, A Commander's Story," *The Journal of the US Army Medical Department*, PB8-92-11/12 (November/December 1992): 4–10.

42. "Operation Desert Shield/Storm, Lessons Learned—DEPMEDS," TD, n.d., ANCC, OMH.

43. "Medics Train in New Field Hospital," *HSC Mercury* 14 (October 1987): 12. Academy of Health Sciences, *Deployable Medical Systems Users' Manual, Final Draft* (Fort Sam Houston, TX: 1989), 1–3, Smith Collection, U.S. Army Medical Department Museum.

44. The Defense Medical Standardization Board became the Joint Readiness Clinical Advisory Board in the 1990s. Kathryn L. Boehnke, "Slot Authorization for Army Nurse Corp [sic] Officer at JRCAB/(DMSB)," Typewritten Letter, 16 June 1998, ANCC, OMH.

45. Connie L. Slewitzke, Interview by Beverly Greenlee, 354, n.d., USAWC/USAMHI Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

46. Eily P. Gorman, "Joint Services Nursing Advisory Group (JSNAG)," Typewritten Memorandum, 10 March 1988; John W. Funk, "Joint Services Nursing Panel of Clinical Experts," Typewritten Letter, 22 February 1988; Alcide M. Lanoue, "Request for Additional Health Care Planning Factors," Typewritten Memorandum, 13 January 1988; Walter F. Johnson, "Request for Additional Health Care Planning Factors," Typewritten Memorandum, 15 January 1988; Alcide M. Lanoue, "Request for Additional Health Care Planning Factors," Typewritten Memorandum, 30 October 1987; and Susie Sherrod to Author, E-mail Correspondence, 26 March 2003 (all in ANCC, OMH).

47. Bernhard T. Mittemeyer, "Quality Assurance: Major Army Focus," *U.S. Medicine* 20 (15 January 1984): 55–59. As well as austere but adequate, the new U.S. Army's Deployable Medical System was intended to be "affordable, maintainable, and relocatable." Acad-

emy of Health Sciences, *Deployable Medical Systems Users' Manual, Final Draft* (Fort Sam Houston, TX: 1989), 1–2, Smith Collection, U.S. Army Medical Department Museum.

48. Connie L. Slewitzke, Interview by Beverly Greenlee, 346, 349, n.d., U.S. Army War College/U.S. Army Military History Institute Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

49. Connie L. Slewitzke, Interview by Beverly Greenlee, 355, n.d., U.S. Army War College/U.S. Army Military History Institute Senior Officer Oral History Program, Project No. 88-8; and Susie Sherrod to Author, E-mail Correspondence, 26 March 2003 (both in ANCC, OMH).

50. Connie L. Slewitzke, Interview by Beverly Greenlee, 360, n.d., U.S. Army War College/U.S. Army Military History Institute Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

51. Nancy R. Adams, "Coordination Draft Manpower Requirements Criteria (MARC) Study Document (MSD) for Hospital Ward Nursing (AOC 66J/H, MOS 91B/C), MCN SO4," Memorandum for DASG-HCD-O, TD, 14 January 1992; and Jeannette S. James, "Manpower Requirements Criteria (MARC)," Briefing Slides, n.d. (both in ANCC, OMH).

52. Terris E. Kennedy, "Coordination Draft MARC for Hospital Ward Nursing," Memorandum for DASG-HCD-D, TD, 8 March 1993, ANCC, OMH.

53. Connie L. Slewitzke, Interview by Beverly Greenlee, 354–55, n.d., USAWC/USAMHI Senior Officer Oral History Program, Project No. 88-8, 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), 55.

54. Connie L. Slewitzke, Interview by Beverly Greenlee, 343, 344, 345, n.d., U.S. Army War College/U.S. Army Military History Institute Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

55. "ANC Annual Historical Report FY 85," 3, ANCC, OMH.

56. Connie L. Slewitzke, Interview by Beverly Greenlee, 345, 347, 372, n.d., U.S. Army War College/U.S. Army Military History Institute Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

57. "Army Nurse Corps (ANC) 1986 Annual Historical Report," 16–17; and Elizabeth Wanersdorfer, "ANC Highlight Update," Typewritten Memorandum, 11 July 1990 (both in ANCC, OMH).

58. Connie L. Slewitzke, Interview by Beverly Greenlee, 373, n.d., U.S. Army War College/U.S. Army Military History Institute Senior Officer Oral History Program, Project No. 88-8.

59. "Nurses Work to Respond to Readiness," *HSC Mercury* 8 (March 1981): 5.

60. 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), 56. Charles D. Matthews, "Memorandum for RC Chief Nurses," Information Paper, 26 September 1983, ANCC, OMH; Bernhard T. Mittermeyer, "Army Total Fitness Program a Success," *U.S. Medicine* 19 (15 January 1983): 29–34. Bernhard T. Mittermeyer, "Quality Assurance: Major Army Focus," *U.S. Medicine* 20 (15 January 1984): 55–59.

61. Lynne T. Connelly to Author, E-mail Correspondence, 1 July 2003, ANCC, OMH.

62. Lewis H. Seaton, "Navy Medical Department," *Military Medicine* 148 (November 1983): 842. J. William Cox, "Navy Transition Brings Progress," *U.S. Medicine* 19 (15 January 1983): 73, 74, 76.

63. Max B. Bralliar, "Air Force Medical Service," *Military Medicine* 148 (November 1983): 850. 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), 38–39.

64. Office of the Assistant Secretary of Defense (Health Affairs), “Plan for Expanding the Combat Casualty Care Course,” TD, 2, December 1987, ANCC, OMH. Dale C. Smith, “Military Medicine,” in *Encyclopedia of the American Military*, ed. John E. Jessup and Louise B. Ketz (New York: Charles Scribner’s Sons, 1994), 1625.

65. Jim Markiewicz, “Course Teaches Medical Leadership,” *HSC Mercury* 13 (November 1985): 12.

66. Office of the Assistant Secretary of Defense (Health Affairs), “Plan for Expanding the Combat Casualty Care Course,” TD, 3, December 1987, ANCC, OMH.

67. Office of the Assistant Secretary of Defense (Health Affairs), “Plan for Expanding the Combat Casualty Care Course,” TD, 2, December 1987, ANCC, OMH.

68. 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), 55. Barbara J. Smith, Interview by Constance J. Moore, Transcript, 2 March 1995, Army Nurse Corps Oral History Collection, OMH, 12.

69. Connie L. Slewitzke, “Memorandum for the Chief, US Army Nurse Corps,” 4, July 1986, ANCC, OMH; and Connie L. Slewitzke, Interview by Beverly Greenlee, 470, n.d., U.S. Army War College/U.S. Army Military History Institute Senior Officer Oral History Program, Project No. 88-8 (both in ANCC, OMH).

70. The Mobilization Designees “were usually Reservists and National Guard . . . who were activated as backfill and to fill existing vacancies created by [the] mission.” Frank Metcalf to Author, E-mail Correspondence, 25 April 2003, ANCC, OMH. Bruce Aron, “All You Ever Wanted to Know about the Reserves,” *HSC Mercury* 9 (October 1982): 7.

71. “1980 ANC Professional Development Workshop,” in Hazel W. Johnson, “Information for All ANC Officers,” 7 November 1980, Inclosure 2, ANCC, OMH.

72. Connie L. Slewitzke, “Memorandum for the Chief, US Army Nurse Corps,” 10–11, October 1984; and Connie L. Slewitzke, “Memorandum for the Chief, US Army Nurse Corps,” 11, December 1986 (both in ANCC, OMH).

73. Mark O. McMorris, “Nurse Training,” Letters to the Editor, *HSC Mercury* 16 (May 1989): 2.

74. Christine E. Cobb, “Nurse Training,” Letters to the Editor, *HSC Mercury* 16 (July 1989): 2.

75. M. Denise Palmer, “USAR Nurse Comments on Training,” Letter to Editor, *HSC Mercury* 16 (October 1989): 2.

76. Sharon Bystran, “Deployment Checklist,” 1986; and Connie L. Slewitzke, “Memorandum from the Chief, US Army Nurse Corps,” 8, December 1986 (both in ANCC, OMH).

77. Charles J. Reddy, “Nursing Newsletter Number 83-2,” 1 November 1983; Hazel W. Johnson, “Notes from the Chief U.S. Army Nurse Corps,” 3, March 1983; and Terris M. Kennedy, Interview by Constance J. Moore, Transcript, 217–19, 24 October 1995 (all in ANCC, OMH).

78. Connie L. Slewitzke, Interview by Beverly Greenlee, 40–42, n.d., USAWC/USAMHI Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

79. Connie L. Slewitzke, Interview by Beverly Greenlee, 353, n.d., USAWC/USAMHI Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

80. Connie L. Slewitzke, “Memorandum from the Chief US Army Nurse Corps,” 1, October 1984, ANCC, OMH.

81. Connie L. Slewitzke, Interview by Beverly Greenlee, 41–42, n.d., USAWC/USAMHI Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

82. The Army issued some officers, upon their retirement, hip pocket orders that assigned them to a particular duty at a specific post in the event of a national emergency. The hip pocket orders included a Unit Identification Code that specified a mobilization station.

83. Terry R. Misener, Martha R. Bell, Hedy Mechanic, and Valerie P. Biskey, "Mobilization Readiness of Retired Army Nurse Corps Officers," Report #HR86-002 (Fort Sam Houston, Texas: United States Army Health Care Studies and Clinical Investigation Division, 1986), ii-iii.

84. The Surgeon General Lieutenant General Quinn Becker reiterated that 70 percent of the Army's medical support was destined to come from the Army Reserve and National Guard. "U.S. Army Medicine, from the Ferment, Profound Changes," *Army* 36 (March 1986): 43. "TSG Meeting with CSA, 2 July 1987," Typewritten Outline, ANCC, OMH.

85. Another result of this survey was the 1986 establishment of a policy barring reserve nurse promotions above the rank of major without a baccalaureate degree in nursing. General Slewitzke was able to implement this standard because educational funding was available to support reservists in their pursuit of the degree. Connie L. Slewitzke to Author, Typewritten Comments, 29 September 2003; and "Army Nurse Corps (ANC) 1986 Annual Historical Report," 20 (both in ANCC, OMH).

86. Connie L. Slewitzke, Interview by Beverly Greenlee, 464-65, n.d., U.S. Army War College/U.S. Army Military History Institute Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

87. Charles J. Reddy, "Nursing Newsletter Number 83-2," 3, 1 November 1983, ANCC, OMH. "ARPERCEN and RCPAC, What Do They Do?" *Army Reserve Magazine* (Winter 1985): 10-11.

88. COL Blake, "Practice Requirements for USAR Nurse Corps Officers," Typewritten Memorandum, 4 January 1988, ANCC, OMH.

89. "Program Boosts Reserve Readiness," *HSC Mercury* 13 (December 1985): 5. Jerry Harben, "Competition for Nurses Gets Tough," *HSC Mercury* 16 (August 1989): 6.

90. Connie L. Slewitzke, Interview by Beverly Greenlee, 393-94, n.d., U.S. Army War College/U.S. Army Military History Institute Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

91. Connie L. Slewitzke, Interview by Beverly Greenlee, 396, n.d., U.S. Army War College/U.S. Army Military History Institute Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH. Wesley G. Byerly, "A Mutual Support Program between a 1,000 Bed TDA Augmentation Reserve Hospital and an Active Component Army Community Hospital," *Military Medicine* 149 (October 1984): 565-69. James H. Carter, "Mutual Support and Mobilization Preparedness: The Method of an Army Reserve Hospital," *Military Medicine* 155 (August 1990): 379-81.

92. The officer in OTSG was Lieutenant Colonel Marie P. Alire. Marie P. Alire, "Input to Readiness Issue on ANC Strategic Plan," Typewritten Memorandum, June 1988, ANCC, OMH. Connie L. Slewitzke, Interview by Beverly Greenlee, 466-68, n.d., U.S. Army War College/U.S. Army Military History Institute Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH. Clara L. Adams-Ender and Amelia J. Carson, "Capabilities of Army Nurse Corps Officer Graduates of the United States Army War College," *Medical Bulletin of the US Army, Europe* 43 (September/October 1986): 27-29.

93. Donna F. Owen, "Annual Historical Report," Typewritten Memorandum, 2 December 1989, ANCC, OMH.

94. Lorraine Mirabella, "Army Reserve General Wears One Star but Two Hats," *Howard County Sun* (6 August 1989): 4.

95. "Nurse Named Brigadier General," *Army Times* 50 (21 August 1989): 2.

96. Dorothy Pocklington to Author, E-mail Correspondence, 3, 22 August 2003; and Dorothy Pocklington to LTC Mittelstaedt, Typewritten Letter, 13 January 1995 (both in ANCC, OMH).

97. Dorothy Pocklington, "BG Pocklington's OER Support Objectives & Contributions," TD, March 1988–June 1991, ANCC, OMH.

98. Dorothy Pocklington to Author, E-mail Correspondence, 4, 22 August 2003, ANCC, OMH.

99. Michael J. Foster, "Minutes of the Army Nurse Corps Staff Meeting on 2 April 1993," TD, 5, 5 May 1993, ANCC, OMH.

100. Sonnie Scarlett, "Academy, FORSCOM Develop a Smart Training Plan," *HSC Mercury* 15 (January 1988): 1.

101. Diane Corcoran to Author, Telephone Conversation, 9 April 2003.

102. "Reserve Training Program," Information Paper, 2 July 1985, Enclosure 5, in Connie L. Slewitzke, "Memorandum from the Chief, US Army Nurse Corps," April 1986, ANCC, OMH.

103. Connie L. Slewitzke, "Memorandum from the Chief, US Army Nurse Corps," 10, October 1984, ANCC, OMH.

104. Connie L. Slewitzke, Interview by Beverly Greenlee, 471, n.d., USAWC/USAMHI Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH.

105. The AMEDD termed this notion of pre-positioning a hospital the "warm-base concept." It involved "the remote storage of a general hospital set at the intended site of its wartime use. As a minimum, the hospital core [was] established, including the operating rooms, central material service, laboratory, radiology and 100 intensive care beds. The remainder of the equipment [was to be] stored contiguously to facilitate expansion to the full 1,000 bed capacity." Quinn H. Becker, "Medical Readiness: Army's Top Priority," *U.S. Medicine* 24 (January 1988): 45–46.

106. Barbara Jo Foley and Joseph E. Foley, "On Worldwide Call to the Army," *American Journal of Nursing* 89 (October 1989): 1310.

