

## *Chapter Sixteen*

# New Frontiers for Army Nurse Corps Officers

**B**efore the 1990s, the notion that Army nurses might advance beyond traditional nursing roles and cross unprecedented command boundaries into areas of new responsibility rarely warranted mention. On the rare occasions that the idea did surface, it was summarily dismissed. For instance in 1972, the surgeon general, Lieutenant General Hal B. Jennings, “erased any doubts” about his “adamant” stance on assigning other than Medical Corps (MC) officers to command Army hospitals. Jennings confidently promised that the physician “would remain the quarterback of the medical team.”<sup>1</sup> A few years later, Lieutenant General Charles C. Pixley, surgeon general from 1977 to 1981, reiterated that physicians were the only officers capable of commanding the Army Medical Department (AMEDD) units, submitting:

... that if we had not had Medical Corps officers who were interested in leadership positions and who had not seized the opportunity to be leaders in various roles, such as high level medical staff and command positions over the past 200 years, then many of the great advances of military medicine would never have transpired.<sup>2</sup>

Pixley acknowledged that he had “no quarrel with permitting MSC [Medical Service Corps] officers becoming commanders of TO&E [Table of Organization and Equipment] units where patient care is not being performed. These are training situations.”<sup>3</sup>

Lieutenant General Frank F. Ledford, surgeon general from 1987 to 1991, also rejected the notion of command for nurses. During her tenure as chief of the Army Nurse Corps, Brigadier General Clara L. Adams-Ender broached the subject with then Deputy Surgeon General Major General Alcide LaNoue, who “had absolutely no problem with it. His belief was that a leader is a leader, regardless of gender or profession.” When LaNoue promised to discuss the question with Ledford, Adams-Ender recalled, “I quietly groaned.” She was keenly aware of Ledford’s stance on command for nurses. Later, LaNoue related his conversation with the

surgeon general on the topic and drolly recalled that after Ledford “broke out all the windows in his office and threw all the books from his bookcase on the floor, I got the feeling he didn’t favor nurses being in command.”<sup>4</sup> Time proved all of these resolute viewpoints wrong.

For several decades, the Defense Advisory Committee on Women in the Services (DACOWITS) was an important voice advocating for command for Army nurses. Adams-Ender recalled that when she was post commander at Fort Belvoir, Virginia, in 1992, the DACOWITS vice chair visited her to discuss the possibility of Army Nurse Corps officers commanding hospitals. Of course, Adams-Ender endorsed the idea. The vice chair subsequently interviewed the commander and a number of staff at Fort Belvoir’s DeWitt Army Community Hospital. Adams-Ender revealed that the vice chair:

... in her outbriefing with me, . . . shared the reactions that she had received to nurses commanding MTFs [military treatment facilities]. I got a real chuckle out of one of them. The vice chair was interviewing a female physician and asked her if nurses should command hospitals. The physician replied, “Absolutely not!” When queried as to why not, the physician responded, “Nurses run everything else in the hospital now. If you give them command, they’ll run the whole hospital!”

As an aside, Adams-Ender remarked, “I didn’t know that physicians noticed—that was a pretty perceptive comment.”<sup>5</sup>

Although the idea of Army Nurse Corps officers holding command positions generally was a taboo subject in certain quarters, there were a few instances where Army nurses commanded hospital units, usually when dictated by expedience. In 1976, Captain Diane Corcoran was chief nurse at the 86th Combat Support Hospital (CSH) at Fort Campbell, Kentucky, when the unit was awaiting the assignment of a new commanding officer. The commander of the 101st Airborne Division intervened and directed Corcoran to assume command of the 86th CSH, stating that he knew she had made many of the decisions in the past while on field maneuvers with the 101st. Corcoran responded that it was traditional for the ranking Medical Service Corps (MSC) officer in the unit to assume command. The 101st commander insisted, overruled the objections of disgruntled MSC officers postwide, cleared his intentions with Brigadier General Madelyn Parks, chief of the Army Nurse Corps, and scheduled a change of command ceremony to take place within two days with 10 battalions participating in the ritual.

With some trepidation but with significant excitement and pride, Corcoran began immediate preparations to lead the pass and review formation. She conferred with the Fort Campbell hospital chief nurse, Colonel John B. Garlick, a former infantry officer, who took Corcoran to the parade grounds and gave her a crash refresher course in drill and ceremonies. Corcoran remembered praying fervently before the ceremony and proceeding through the parade in a “trance mode.” During the change of command ceremony, she managed to accept command, passed the reviewing stand under the watchful eyes of Major General James A. Wickham, the post commander, and reached her assigned position on the drill field. She started to relax when several of the infantry commanders in the audience gave



Captain Diane Corcoran, Army Nurse Corps officer and Commander of the 86th Combat Support Hospital at Fort Campbell, Kentucky, confers with officers of the 101st Airborne Division in 1976. The division staff was visiting while the 86th was setting up its hospital during a field exercise. Photo courtesy of Colonel Diane Corcoran, Durham, NC.

her a thumbs-up signal. Corcoran subsequently received all the accoutrements of command, including official orders and command epaulets for her uniform. For three months she successfully commanded the 86th CSH before leaving Fort Campbell to attend the University of Texas at Austin for her doctorate.<sup>6</sup>

The belief that only male officers could command was so firmly entrenched in the Army's culture that it had been codified into U.S. law and Army regulations. Both 10 USC 3579 and Army Regulation 600-20 specifically prohibited the predominantly female Army Nurse Corps and Army Medical Specialist Corps officers from assuming command positions. In 1980, however, Congress amended §3579 to lift the outdated ban.<sup>7</sup>

Notwithstanding, a decade elapsed before possibility became reality in the AMEDD because segments of the MC, the MSC, and the hierarchy of line officers opposed command for the two mainly female AMEDD branches. In 1990, for

example, the MC recommended as a part of the AMEDD Officer Leader Development Action Plan to “not establish a branch immaterial [BI] designator for the AMEDD.” The MC “definitely opposed” such an action and “in contradistinction” to the Air Force and the Navy, the AMEDD had many field hospitals that, upon mobilization, male MC officers would have to command. It posed a rhetorical question: “If not afforded the opportunity to be a TDA [Table of Distribution and Allowances] commander, how then to train [MC officers] for a TOE (wartime) command.”<sup>8</sup> Other MC officers also firmly believed that only officers of their branch were capable of command or entitled to general officer rank.<sup>9</sup>

Comments emerging from a December 1995 survey directed by Brigadier General Bettye H. Simmons focused on the concerns and ideas of Army Nurse Corps officers also revealed some ill will toward nurses from MSC officers. One Army nurse’s response spoke of the “lack of respect from other branches (especially MSC) and the potential threat we pose with the surge of branch immaterial talk” as a current issue affecting the Corps.<sup>10</sup>

General Gordon Sullivan, chief of staff of the Army (CSA), disapproved General Nancy Adams’ assignment as commander of the Fitzsimons Health Service Support Area and vetoed the inclusion of nonphysician/nondentist AMEDD officers on select AMEDD General Officer Promotion Boards.<sup>11</sup> The active Army seemingly lagged behind the U.S. Army Reserve (USAR) and Army National Guard (ARNG) and its sister services in implementing the attitudinal change that led to equal command opportunity for all AMEDD branches.

Unlike the Active component, the USAR and ARNG had no prohibitions regarding command for nurses. Brigadier General Dorothy Pocklington, the first female and nurse to be promoted to brigadier general in the USAR, knew this and worked to open command opportunities for USAR and ARNG nurses. The surgeon general, Lieutenant General Frank Ledford, however, did not support her efforts, and numerous MSC officers vehemently opposed her campaign. Both MC and MSC officers likely viewed the potential intrusion of Army nurses into command roles as a threat to their opportunities to achieve such positions. Pocklington still placed the issue on the agenda for the Surgeon General’s Reserve Component Medical Advisory Board and challenged the notion that nurses could not command. She testified before other Department of Defense (DoD) policy-making bodies and, in her travels to USAR and ARNG units nationwide, advised nurses to prepare themselves for command and work toward this career goal. She recalled that on one occasion, an Army nurse captain confided that she had commanded a training unit but the unit purposefully kept it “quiet.” Pocklington added that she “would not be surprised if there were a few other instances of this happening and no one was supposed to know about it,” because the USAR and ARNG in general were laboring under the misapprehension that nurses were banned from command.

Pocklington actively promoted the campaign for command for nurses in the USAR and ARNG. She presented her case across all echelons of the Army from the highest policy-making levels all the way down to the barracks soldiers. Her enthusiasm heightened awareness, and in the late 1980s, her efforts achieved re-



After her change of command ceremony, new commander Colonel Flora Sullivan (right) met with Lieutenant Colonel Dorothy Allbritten (left), who was Sullivan's replacement as chief nurse of the 338th Medical Group.

Photo courtesy of Colonel Flora Sullivan, Glenolden, PA.

sults. Colonel Florence Sullivan, an Army Nurse Corps officer, publicly assumed command of a Pennsylvania USAR hospital unit.<sup>12</sup>

Meantime, the Navy already had selected nurses for command roles, choosing the best-qualified individual for the job regardless of the chosen one's professional discipline or gender. In 1975 a Navy nurse, Captain Harriet A. Simmons, became the officer in charge of the Mayport, Florida, Naval Station Dispensary. Simultaneously, Captain Bernadette A. McKay assumed command responsibilities at the Naval Submarine Medical Center, New London, Connecticut, as director of administrative services. Next, in 1980, Rear Admiral Frances T. Shea accepted command responsibilities at the Naval Health Sciences Education and Training Command.<sup>13</sup> In 1983, Captain Mary F. Hall became the first Navy nurse to command a Naval Hospital, when she took full charge of the facility at Guantanamo Bay, Cuba. There she oversaw health care for 7,000 beneficiaries representing all services, with a staff of 186 officers and enlisted sailors in a 50-bed hospital. Another more challenging assignment two years later furnished testimony to Hall's success in her first command, when she subsequently assumed command at Naval Hospital, Long Beach, California, with its six clinics, 170 beds, and a staff of 1,300.<sup>14</sup>

The Air Force Nurse Corps also had an established history of command. In 1987, the Air Force Medical Service opened the competition for positions as medical group commander to nurses. Most of these command billets were then physician dominated, but the Air Force Nurse Corps had approximately two to three of its officers in command at any one time.<sup>15</sup> During this initial period, the Air Force nurses commanded air evacuation facilities and units only. In 1990, however, an Air Force nurse assumed command of the base clinic at Pope Air Force Base, North Carolina. Colonel Judith Hunt was the first Air Force nurse to assume this level of command at a Medical Treatment Facility. Then Air Force nurse Colonel Gloria K. Kamoureux began her assignment as hospital commander at Loring Air Force Base, Maine, in 1992.<sup>16</sup> As of 1996, many Air Force nurses were commanding at the squadron and group levels. Three officers served as Medical Group commanders while four others served as group commander. Additionally, 39 nurses were squadron commanders within medical groups, and two Air Force Nurse Corps officers were commanders of aeromedical evacuation squadrons.<sup>17</sup>

By 1993, the AMEDD was slowly edging forward with the branch immaterial (BI) concept for command slots, though lagging well behind the Navy and Air Force, which had used a comparable system for some 20 years.<sup>18</sup> In reaction to the inherent problems with the Professional Officer Filler System (PROFIS) commander program, the strong recommendations made by DACOWITS, probing questions posed by members of Congress, and the need for better utilization of general officers within the context of the AMEDD reorganization, the surgeon general, Lieutenant General Alcide LaNoue, announced his support for opening selected opportunities for command for all AMEDD officers.<sup>19</sup> At the behest of General Sullivan, the CSA, LaNoue established a Leader Development Decision Network process in February 1994 to study the issue of BI AMEDD commands. This network ultimately proposed a new policy to select the officer best qualified for command of a unit and retain that officer in command upon mobilization.<sup>20</sup> Secretary of the Army Togo West approved the Leader Development Decision Network process on 14 January 1997.<sup>21</sup> In March 1997, the surgeon general, Lieutenant General Ronald R. Blanck, demonstrated his wholehearted approval by deciding “to open BI fully at the earliest opportunity.”<sup>22</sup>

Meanwhile, the AMEDD Command Leader Development Action Plan identified related issues and made corresponding recommendations. It suggested revision of Army regulations and AMEDD policies to facilitate AMEDD Immaterial (AI) commands, designation of selected command positions as AI (thus eliminating the PROFIS command system), identification and utilization of certain AMEDD criteria (i.e., skills, knowledge, and behaviors necessary for officers to qualify for command), reengineering of AMEDD Professional Military Education to support the AI concept, and integration of AI command positions into the Department of Army Command Designated Position List process.<sup>23</sup>

Sullivan supported opening more seats for Army Nurse Corps officers at Command and General Staff College and at the Senior Service Schools and advocated recoding specific AMEDD General Officer positions to BI status.<sup>24</sup> Although no

Army nurses were considered for command at the time, Colonel Doris S. Frazier was the first Army nurse to matriculate at the Army War College in 1973. Immediately after her graduation, only a few Army Nurse Corps officers sporadically participated in the program. By 1986, for instance, only six additional Army nurses had graduated from the Army War College. Despite their lack of command opportunities at the time, the nurse graduates prepared for senior leadership positions by refining their skills in “self-assessment, organizational dynamics, leadership, ethics, and professionalism.” The curriculum also provided them with the knowledge and abilities needed to successfully function in diverse staff positions in “major Army commands or at Department of the Army level.”<sup>25</sup> Still later, when more seats were allocated, attendance at the Army War College prepared Army Nurse Corps officers for senior-level command.

The Army Nurse Corps leadership worked diligently to justify command positions for Army nurses. They explained how professional leader development advanced within the corps and how it encompassed every phase of the Army Nurse Corps Life Cycle Model, or career plan.<sup>26</sup> Adams asserted:

The scope of responsibility and accountability of each nursing position increases in every phase of the Army Nurse Corps Life Cycle Model. Each position prepares AN [Army Nurse] officers for more advanced leadership roles. The only difference is that AN leadership positions are not entitled “command.” The reality is AN officers have the same military and civilian education and similar leadership experiences as their counterparts/colleagues in other AMEDD Corps who compete for command. Essential and key positions in the AN require the same education that leads to the skills, knowledge, and attitudes that would qualify AN officers for advanced leadership positions as identified in the other AMEDD Corps Life Cycle Models.<sup>27</sup>

As 1995 drew to a close, Army Nurse Corps hopes and efforts were coming to fruition as the Army relaxed policies and opened AI command positions to nurses. After her four-year tenure as chief, Adams assumed command of the Southwest Health Service Support Area located at Fort Bliss, Texas, and in 1997, accepted the flag of command at William Beaumont Army Medical Center. Adams became the first female and first nonphysician to command an Army Medical Center, a watershed event in AMEDD history.<sup>28</sup> Following her command at Beaumont, she was promoted to major general and assumed command of Tripler Army Medical Center in Honolulu, Hawaii. Her additional responsibilities included serving as the U.S. Army, Pacific, surgeon, as commander of the Pacific Regional Medical Command, the TRICARE Pacific lead agent, and the PROFIS commander for Korea’s 18th Medical Command. She was the first Army Nurse Corps officer to receive a second star and fulfill these challenging responsibilities.<sup>29</sup> Army Nurse Corps officers also took command of three of five AMEDD Recruiting Detachments at this time, with responsibility for all AMEDD recruiting for every AMEDD enlisted soldier and all AMEDD officer corps.<sup>30</sup> At the AMEDD Center and School (C&S) Brigade, Army Nurse Corps officers assumed new roles as company commanders.<sup>31</sup> The first Army Nurse Corps officer who competed and was selected for an AMEDD C&S training company command was Captain Bethany Alexander. In January 1995, she assumed command of Company D, 232nd Medical Battalion.<sup>32</sup>

In 1995, Colonel William Bester commanded the Advance Party of the 67th CSH in Hungary and Croatia. The next year, the surgeon general requested approval from the secretary of the Army for an interim change to the policy of restricting command of medical treatment facilities to MC officers. The secretary granted the request in January 1997, clearing the way for Colonel Bester to serve as commander of Moncrief Army Community Hospital at Fort Jackson, South Carolina, in 1998.<sup>33</sup> In March of that same year, Colonel Kristine V. Campbell commanded the 396th CSH in Bosnia-Herzegovina, becoming the first female officer and first USAR Army nurse to deploy and command a field hospital overseas in a peacekeeping operation.<sup>34</sup> Campbell led the 450-strong hospital unit and fostered a positive work environment, facilitated a smooth unit operation, and provided resources. She recalled that the command experience was demanding, adding that she managed by focusing on “what I knew I was good at. I knew how to take care of patients”; by concentrating on that strength, she succeeded in her command.<sup>35</sup>

The AMEDD BI Colonel Command Board that convened in January 1998 under the direction of the Army Secretariat represented the first time that Army Nurse Corps colonels were eligible for consideration to command Medical Groups, Scientific/Technical units, Level 1 Medical Treatment Facilities, and Level 1 TO&E hospitals. Army Nurse Corps officers still could not compete for command of larger Level 2 Medical Department Activities or Medical Centers, considered Level 3 commands. After gaining Level 1 TO&E/MTF command experience, these officers would become eligible for consideration in subsequent boards.<sup>36</sup> The AMEDD BI Lieutenant Colonel Command Board that convened in December 1997 selected lieutenant colonels for battalion-level command in BI positions such as TDA Training Commands at the AMEDD C&S, in TDA Scientific/Technical Battalion Equivalents such as at the Center for Health Promotion and Preventive Medicine (CHPPM), and in TO&E Medical Treatment Battalions in Area Support Medical Battalions.<sup>37</sup> The names of those officers selected by the lieutenant colonel and colonel command boards later appeared on a Command Designated Position List, which became known as the Command Selection List (CSL) in 1998.<sup>38</sup> The AMEDD CSL for fiscal year (FY) 1999 designated four Army nurses for command.<sup>39</sup> By FY 2000, seven Army Nurse Corps colonels appeared on the AMEDD CSL.<sup>40</sup>

Other BI opportunities for command materialized during this time. These non-CSL clinic command opportunities operated under a slightly different format. The MC, MSC, Army Nurse Corps, and Army Medical Specialist Corps each nominated two officers for available clinic commander positions.<sup>41</sup> The regional medical commander then would select the best qualified officer—regardless of branch—for the command position within that region.<sup>42</sup>

By 1998, participants at a chief nurse conference elaborated the Army Nurse Corps philosophy relating to BI command and positions. They believed that company grade BI positions such as company command were simply alternative leader development options analogous to traditional branch-based leadership opportuni-

ties such as those found in head nurse positions. Furthermore, they acknowledged that all AMEDD branches could develop leaders comparably within their core disciplines. Finally, they stressed that the discipline of nursing must remain the core competency within the Army Nurse Corps.<sup>43</sup> Brigadier General Bettye Simmons expanded on this philosophy:

As Branch Immaterial opportunities emerge for us, it will be critical that we never lose focus on our core responsibilities of providing, managing and leading the delivery of nursing care to soldiers and their families. Our real value in all arenas is the perspective of the discipline of nursing. If we lose sight of this or lose sight of our primary responsibility, we have lost the whole point of working to get “to the table.”<sup>44</sup>

General Clara Adams-Ender shared her insights on the intermingling of nursing and command roles. She wrote that, “if anything, being in command positions sharpens your skills as a nurse and reinforces the specific skills that nurses bring to the table.” Adams-Ender revealed that her unceasing prayer while in command was:

... “Thanks, God that you made me a nurse first.” Nursing provided me with three unique skills that I used often while in command and in bringing order to my often chaotic life today. [First,] through nursing, I learned about human behavior. Through the behavioral sciences and in the labs, nurses learn that there are some personalities in the world and some real characters—we learn how to cope with them all. [Second,] we learn as nurses how to manage many activities at once on a 24-hour clock. I never thought I’d learned anything of value on the 11-7 shift, but I did learn how to organize activities independently and how to get my staff organized. I would never have learned that as well on the day shift with someone else in charge. [And finally,] nursing taught me a process.<sup>45</sup> Sometimes we don’t even value that process much as nurses. However, I’ve come to realize and value the nursing process because it is just a systematic way of getting things done and it keeps me on the road to successful mission accomplishment.<sup>46</sup>

Adams-Ender recognized that the most important knowledge, values, and skills she contributed to the overall picture were inherent to the discipline of nursing.

Nurses faced other dilemmas in the introduction of command opportunities. After an Army nurse completed a command assignment, the question of a follow-on assignment surfaced. For instance, after commanding a hospital, was it an appropriate career move for an Army Nurse Corps officer to revert to a hospital chief nurse position? Another quandary focused on budgeted end-strength issues. If a hospital had just enough nurses to carry out the existing workload, was it appropriate to pull resources away for command opportunities? In other words, if staffing was tight, was it proper to release a head nurse or a staff nurse to fill a company commander post? The final decision often came down to a choice between offering nurses upward mobility versus providing adequate staff to proffer high quality nursing care.<sup>47</sup> There were no simple answers to these complex questions.

Command positions for Army nurses finally gained sufficient momentum during the 1990s to become a reality. But Army Nurse Corps officers’ opportunities to contribute in BI capacities were not only restricted to command roles. They also could participate in a variety of other BI positions.

Early in 1990, the trend of making not only command slots but also other key AMEDD positions into BI billets gained impetus. This movement centered on the idea that certain roles could be efficiently and successfully assumed by any competent officer, irrespective of gender, branch, or specialty. During her tenure as chief of the Army Nurse Corps, Adams-Ender's actions were an expression of this trend. She realized that the AMEDD had to upgrade the position of director of personnel for the surgeon general, elevating it from that of a colonel to the general officer level. This, she believed, would enhance the position's authority and influence when dealing with other elements of the Army and guarantee that AMEDD issues were seriously addressed. Accordingly, Adams-Ender approached Lieutenant General Frank Ledford, the surgeon general, with her idea and he in turn responded, "Clara, if you are crazy enough to volunteer for this position, I am crazy enough to appoint you." Over time, several advantages accrued from the change.

Adams-Ender's personnel staff welcomed their newfound ability to utilize what she called their "referent power." When differences of opinion arose, for example, the personnel officers would announce that the "general said this is the way it is going to be so I would suggest that your general get together with my general and see if they can't work it out." Using some version of this approach made the disagreements by and large disappear. Another beneficial effect of the dual-hatting was the fact that Adams-Ender met often with the deputy chief of staff for personnel (DCSPER) of the Army and the assistant secretary of defense for manpower and reserve affairs (ASD M&RA). At such sessions, she could speak about nursing concerns. She recalled, "General Ono [DCSPER] was always interested in what was happening in nursing and I had convinced Mr. Spurlock [ASD M&RA] that he ought to be interested. It didn't matter, I was going to tell him anyway." Thus, she was able to not only advance the concerns of the AMEDD but also surface matters of interest to the Army Nurse Corps.<sup>48</sup>

As successive chiefs accepted their responsibilities for the Army Nurse Corps, they too assumed other BI roles. As noted, Adams also became the director of AMEDD Personnel and later, commander of CHPPM while serving as chief of the Army Nurse Corps. Simmons commenced her tenure as chief of the Army Nurse Corps in 1996 while simultaneously beginning an assignment as the deputy commandant at the AMEDD C&S.<sup>49</sup> A year later, she moved from the AMEDD C&S to become the Forces Command command surgeon, noting:

This is a great opportunity for Army Nursing . . . it gives us an opportunity to prove the ability of Army Nurses in nontraditional roles to our line counterparts and to show the value-added of our discipline in working the issues impacting the Army.<sup>50</sup>

In 1999, Simmons relinquished her role at Forces Command and assumed command of the CHPPM.<sup>51</sup> Bester succeeded Simmons as chief of the Army Nurse Corps in 2000 and, like his predecessors, wore two hats. Initially he served as the assistant surgeon general for force projection and subsequently as the CHPPM commander.<sup>52</sup>

In 1993, a small contingent of Army Nurse Corps officers were functioning in a



During this period, Major Mary E.V. Frank was the Army Nurse Corps historian, assigned to the U.S. Army Center of Military History. During her tenure in that assignment, she conducted a number of historical analyses of contemporary issues.  
Photo courtesy of Colonel Mary E.V. Frank, St. Michaels, MD.

number of critical positions previously reserved only for other AMEDD officers. In most cases, the respective division/directorate chief specifically requested these Army nurses, whom the Army Nurse Corps then approved to assume these billets (several of which were crucial positions at senior leadership levels).<sup>53</sup> Similar positions held by Army nurses, such as chief, Family Health Clinic, chief, Primary Care, or executive or administrative officer, involved leadership at a local level and existed in various settings.<sup>54</sup> As Army Nurse Corps officers moved into BI command and staff positions in greater numbers, attention turned to expanding horizons even further. Questions emerged about the possibility of opening promotions for Army nurses, indeed for all AMEDD officers, beyond the one-star level.

Since 1967, 10 U.S. Code 3069 limited the tenure of the Army Nurse Corps officer selected to be the chief of the Army Nurse Corps to no more than four years.<sup>55</sup> After the four-year incumbency, chiefs traditionally retired from active duty.<sup>56</sup> The assignment was a terminal position that offered no opportunity to compete for further promotions.<sup>57</sup>

In 1985, Major Mary Frank wrote that the Army Nurse Corps advancement to rank parity paralleled the grueling path nursing took in its quest for professional development and it also echoed the progression of the women's rights movement. She added that advancements came in the guise of "minimally threatening increments" against the backdrop of the AMEDD's, the Army's, and most of the legislators' "gender phobias." Frank also noted that, in the past, progress toward rank parity always required special legislation that, in turn, perpetuated the myth of the Army Nurse Corps as a disparate, atypical branch. This misperception always rendered efforts to move ahead all the more complex, protracted, and costly. Finally, she concluded that every step forward has "been in response to well-documented crises in authority, recruitment and retention and . . . been based on the irrefutable logic of superior performance."<sup>58</sup> The arduous, century-long journey from no rank and little status to relative rank, begrudgingly bestowed on Army nurses in 1920, to the comprehensive opportunities available in 2004 was an epic tale of struggles fought by the senior leadership with the unflagging support of a few enthusiastic benefactors.

Many had long recognized that chiefs of the Army Nurse Corps had the potential to provide further, valuable service to the AMEDD and the Army after their four-year term and Corps-specific responsibilities. In 1991, when Adams became chief of the Army Nurse Corps and the concept of AMEDD BI positions gained more currency, the notion of opening the upper echelons of the AMEDD for all eligible senior officers became a possibility.

Senator Daniel Inouye, long a supporter of the Army Nurse Corps, believed Congress should enact legislation to make the chief of the Corps position a major general billet.<sup>59</sup> Adams privately disagreed with this position and instead favored allowing the chiefs of the Army Nurse Corps to compete for promotion to major general with their AMEDD contemporaries.<sup>60</sup> She believed that fulfilling the Corps chief's responsibilities justified the brigadier general officer position but it also enfranchised the chief of the Army Nurse Corps to compete on equal terms with her contemporaries for other senior leadership positions that no longer were reserved exclusively for the MC. As assistant surgeon general for personnel,

she subsequently articulated this option, garnered the surgeon general's support, worked to implement it, and ultimately made this concept the next stage in the evolving process of change.<sup>61</sup>

After her tenure as chief, Army Nurse Corps, Adams had two years remaining on active duty before her mandatory retirement date of 1997 and continued on active duty serving in a BI general officer position. During this time, she became eligible for consideration for promotion to major general by the FY 1998 General Officer Promotion Board that convened in the fall of 1997. The board selected Adams for promotion to major general.<sup>62</sup>

In the interim, however, the campaign waged to open consideration of Army Nurse Corps officers for the AMEDD General Officer Promotion Board turned into another challenging odyssey. In July 1994, Surgeon General LaNoue requested approval from Sullivan, the CSA, to establish a corps immaterial competitive category for promotion to AMEDD brigadier and major general.<sup>63</sup> Sullivan disapproved the request while acknowledging that his decision caused a "disproportionate promotion opportunity for the medical [physician] GOs [General Officers]." <sup>64</sup>Inouye became involved and urged the Chief of Staff of the Army "to reconsider the Army's decision to deny nurses and other qualified AMEDD officers the same opportunities that the physicians and dentists" enjoyed.<sup>65</sup> In April 1995, the surgeon general again sought approval to include all AMEDD branches for consideration in the competitive category for promotion to AMEDD brigadier and major general, this time addressing his request to a new Chief of Staff of the Army, General Dennis J. Reimer.<sup>66</sup> After clarifying several minor details, Reimer approved the surgeon general's proposal and expanded the AMEDD major general promotion competitive category to include all brigadier general officers of the AMEDD regardless of branch in June 1997.<sup>67</sup> That same year the FY 1996 Department of Defense Authorization Act eliminated the legislative restrictions that narrowly limited the three-star position of surgeon general to MC officers only in all three services.<sup>68</sup> These decisions opened the door for Army Nurse Corps officers to compete with their peers in the AMEDD and ensured a relatively level playing field for leadership opportunities for all branches.

While this was taking place, Inouye sponsored legislation to authorize the one-star rank for all three Nurse Corps chiefs and directors (Army, Navy, and Air Force) and the rank of colonel for the assistant chiefs. In practice, this had been the case for decades but had not been previously mandated by law. Inouye explained that he was "concerned that without this official designation, these positions [were] vulnerable to being downgraded or even eliminated." He added:

In recent years, downsizing mandates and new ways of providing health care have led to many reorganization efforts. Unfortunately, reorganization has become a euphemism for eliminating positions—and health care reorganization has too often become an excuse to eliminate nursing positions. . . . Military nurses hit two glass ceilings: one as a nurse in a physician-dominated health care system and one as a woman in a male-dominated military system. The simple fact is that organizations are best served when the leadership is composed of a mix of specialty and gender groups—of equal rank—who bring their unique talents to the corporate table. For military nurses, the general officer chief nurse position is the only way for nurses to get to the corporate executive table.<sup>69</sup>



Pictured is Major General Gale Pollock, who served as the 22nd Chief of the Army Nurse Corps from 2004 to 2008.

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



Pictured is Major General Patricia Horoho, who served as the 23rd Chief of the Army Nurse Corps from 2008 to 2012.

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

Congress passed the legislation 30 July 1996 and removed any doubt that henceforth the Army Nurse Corps and the Air Force Corps director positions would be the one-star rank, and their assistants would hold the rank of colonel.<sup>70</sup> The rank of the director of the Navy Nurse Corps had already been guaranteed by Public Law 97-22 in 1981. As a part of Public Law 97-22, the Defense Officer Personnel Management Act, §6, specified that the director of the Navy Nurse Corps would serve in the rank of commodore admiral.<sup>71</sup>

Inouye also continued his efforts to enact legislation to make the chief of the Army Nurse Corps a two-star billet. His justification was based on the fact that the Dental Corps chief position was a two-star billet, while the chief of the Army Nurse Corps wore only a single star. Inouye reasoned that if the two-star Dental Corps chief position carried a scope of responsibility for 1,253 Dental Corps officers, why should the chief of the Army Nurse Corps, who managed 4,207 Army Nurse Corps officers, not carry equal rank?<sup>72</sup> When Sullivan testified before Congress in 1994, Inouye raised the two-star issue:

Well, I have been talking about this for 20 years now. They [the Nurse Corps] went up to one star, and I think it is about time they went up to two stars. Maybe I am a bit too biased because I spent 21 months of my life in an Army hospital and 95 percent of the time I saw nurses, and maybe 5 percent a physician, including minor surgery.

And so, as far as being autonomous and independent and professional, I have no question about that. And if we want to recruit the best, we better give them opportunities. So I am not doing it just for the Army, I am doing it for the Navy and the Air Force, and hoping that they will come to their senses. And I hope you will seriously consider this matter—not ten years from now.<sup>73</sup>

Sullivan responded, “Can I come back to you on that Senator? . . . I would request you not mandate it yet. . . . we are doing some things for the nurses. And I appreciate personally your views.”<sup>74</sup>

It was not until December 2002 that Congress passed Public Law 107-314, which amended Title 10, §3069(b). This legislation authorized the appointment of the chief of the Army Nurse Corps to the rank of major general. In 2004, Colonel Gale S. Pollock was nominated to be the 22nd chief of the Army Nurse Corps. She also was promoted to major general and assumed her assigned duties as chief of the Army Nurse Corps, commander of Tripler Army Medical Center, U.S. Army, Pacific, surgeon, and commander of the Pacific Regional Medical Command.<sup>75</sup>

Over the relatively short period of a decade from 1990 to the birth of the new century, an unprecedented world order evolved and formed a unique context that shaped the Army Nurse Corps. The Cold War ended, the military underwent a stringent retrenchment, and the AMEDD and the Army Nurse Corps reinvented themselves. As this major transformation was coming to pass, the Army and the Army Nurse Corps simultaneously was taking part in a number of large scale, challenging combat operations.

## Notes

1. "Surgeon General Wants MDs to Head Hospitals," *The Stripe* (8 June 1972): n.p., Newspaper Clipping in Army Nurse Corps Collection (ANCC), Office of Medical History (OMH).

2. Charles C. Pixley, Interview by John N. Bogart, Transcript, 65, 1985, Office of Medical History.

3. Ibid.

4. Clara L. Adams-Ender with Blair S. Walker, *My Rise to the Stars, How a Sharecropper's Daughter Became an Army General* (Lake Ridge, VA: Cape Associates, Inc., 2001): 228.

5. Clara L. Adams-Ender, Handwritten Notes on Draft Manuscript, 28 September 2005, ANCC, OMH.

6. Diane Corcoran to Author, E-mail Correspondence, 19 June 2002, ANCC, OMH.

7. "Army Nurses Light 75th Candle, Chief Takes Corps' Pulse," Spotlight, U.S. Army Command Information, No. 142, 2, 29 April 1976; Frank A. Bartimo, "Exercise of Command by Members of the Army Nurse Corps," Memorandum, 16 January 1974; and T.R. Byrne, "Request for Clarification of Definitions and Policies Relating to Assumption of Command by AMEDD Officers," Memorandum, Tab B, Legal References, 29 September 1992 (all in ANCC, OMH).

8. Chief, Medical Corps Affairs, "Do Not Establish a Branch Immaterial Designator for the AMEDD," n.d., Recommendation Number 35, attached to James J. James, "AMEDD Officer Leader Development Action Plan," Memorandum, 12 April 1990; Lieutenant Colonel Christopher, "Command of AMEDD Units," Information Paper, 18 March 1992; AMEDD Center and School, "AMEDD Leader Development," Briefing Slides, n.d.; AMEDD Center and School, "AMEDD Command Leader Development Action Plan," 4, n.d.; and Dorothy B. Pocklington, "My IMA Experiences," E-mail Correspondence, 22 August 2003 (all in ANCC, OMH).

9. Colonel Robert Claypool, M.C., staff officer at OTSG at the time, subscribed to these beliefs. Nancy R. Adams, "Thoughts for MG Tempel," n.d., ANCC, OMH.

10. "Army Nurse Corps Transition Survey," 13, n.d., ANCC, OMH.

11. Nancy R. Adams to Gordon Sullivan, Draft, Unsent Letter, 1992; Nancy R. Adams, "Thoughts for MG Tempel," n.d.; Allan C. Brendsel, "AMEDD Branch Immaterial General Officer Positions," Memorandum, 27 July 1994; and Daniel K. Inouye to General Gordon R. Sullivan, Typewritten Letter (TL), 6 February 1995 (all in ANCC, OMH).

12. Dorothy A. Pocklington, Interview by Joseph Frechette, Transcript, 24–26, 26 May 2000, Army Nurse Corps Oral History Collection. Dorothy A. Pocklington to Author, 7 January 2005; Dorothy A. Pocklington to Author, 12 May 2005 (both E-mail Correspondence, in ANCC, OMH).

13. Susan H. Godson, *Serving Proudly, A History of Women in the U.S. Navy* (Annapolis: Naval Institute Press, 2001), 244. Connie L. Reeves, “Invisible Soldiers, Military Nurses,” in *Gender Camouflage, Women and the U.S. Military*, ed. Francine D’Amico and Laurie Weinstein (New York: New York University Press, 1999), 23. Doris M. Sterner, *In and Out of Harm’s Way, A History of the Navy Nurse Corps* (Seattle, WA: Peanut Butter Publishing, 1996): 380.

14. J. K. Herman, “A Conversation with RADM Hall,” *Navy Medicine* 79 (May–June 1988): 8–11.

15. “Statement of Brigadier General Linda J. Stierle, Director of Medical Readiness and Nursing Services, Office of the Surgeon General,” Department of the Air Force, Presentation to the Committee on Appropriations, Subcommittee on Defense, United States Senate, 3, April 1998, 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), 41.

16. 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), 45, 47.

17. “Statement of Brigadier General Linda J. Stierle, Director Nursing Services, United States Air Force,” Presentation to the Committee on Appropriations, Subcommittee on Defense, United States Senate, 1, June 1996, ANCC, OMH.

18. The terms Branch Immaterial (BI), Corps Immaterial (CI), and AMEDD Immaterial (AI) were used interchangeably. Jerry Harben, “Policy Change Offers All Officers Chance to Command,” *The Mercury* 24 (May 1997): 1–2.

19. The existing policy that dictated change of command from the MSC commander in garrison to the PROFIS medical commander upon deployment had a significant potential to “compromise a unit’s cohesiveness and mission capability.” AMEDD Center and School, “AMEDD Command Leader Development Action Plan,” 3, n.d. G.E. Willis, “Policy Changes Open Medical Commands,” *Army Times* 38 (14 April 1997): 4. In its Fall 1973 conference, DACOWITS recommended that DoD “prepare a legislative proposal to amend section 3579, title 10, U.S. Code to provide the opportunity for officer [sic] of the Army Nurse Corps and the Army Medical Specialist Corps to exercise command within the Army Medical Department. “DACOWITS 2000 Spring Conference, History of Recommendations, 1951–1999,” 74, n.d., ANCC, OMH. G.E. Willis, “Panel Wants Nurses to Command Military Hospitals,” *Army Times* 53 (2 November 1992): 11. Evelyn D. Harris, “New DACOWITS Leader Wants Women to Command Hospitals,” *The Mercury* 21 (February 1994): 4. Daniel K. Inouye to Gordon R. Sullivan, TL, 6 February 1995, ANCC, OMH. General LaNoue qualified his support, stating that he believed “hospitals should be commanded by physicians, but other commands do not require Medical Corps leadership.” Jerry Harben, “Surgeon General Seeks ‘Best Qualified’ Leaders,” *The Mercury* 22 (January 1995): 12. AMEDD Center and School, “AMEDD Command Leader Development Action Plan,” 3–7, n.d.

20. “Initiatives, New AMEDD Command Policy,” Briefing Slide, in “1993 Army Medical Department Functional Review, Army Medical Department (AMEDD) Overview,” TSG Briefing, 25 October 1993; William L. Moore, “Leader Development Decision Network (LDDN) to Study Implementation of Branch Immaterial Army Medical Department

(AMEDD) Commands,” Memorandum, 13 December 1993; Daniel K. Inouye to Gordon R. Sullivan, TL, 6 February 1995; and Gordon R. Sullivan to Daniel K. Inouye, TL, 6 March 1995 (all in ANCC, OMH).

21. G.E. Willis, “Policy Changes Open Medical Commands,” *Army Times* 38 (14 April 1997): 4. Ronald R. Blanck to Secretary of the Army, “Command of Medical Units—Action Memorandum,” 23 October 1996; Colonel Hammerbacher, “Army Medical Department (AMEDD) Corps Immaterial Command Leader Development Decision Network (LDDN),” Information Paper, 19 February 1997; and Alice Demarais, “AMEDD Center & School Personnel Proponent Directorate, Branch Immaterial,” Memo from the Chief, Army Nurse Corps (March 1997): 4 (all in ANCC, OMH).

22. Alice Demarais, “AMEDD Personnel Proponent Directorate, Branch Immaterial (BI),” Memo from the Chief, Army Nurse Corps (April 1997): 2, ANCC, OMH.

23. AMEDD Center and School, “AMEDD Command Leader Development Action Plan,” 1–13, n.d.

24. Jeffery L. Heslop “Army Nurse Corps (ANC) Leader Development,” Typewritten Document, 26 April 1994; Barbara K. Penn, “Army Medical Department (AMEDD) Seats in Command and General Staff College (CGSC) and Senior Service College (SSC),” Executive Summary, 9 May 1994; Roy A. Bryan, “Assignment of Army Nurse Corps (ANC) Officers to ARSTAF Positions, (U) (DASG-PTZ),” Executive Summary, 9 May 1994; and Roy A. Bryan, “AMEDD Branch Immaterial General Officer Positions, (U) (DASG-PTZ),” Executive Summary, 9 May 1994 (all in ANCC, OMH).

25. 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 U.S. Army, Europe* 43 (September/October 1986): 27–29.

26. Colonel Kathleen Roehr explained that the ANC Life Cycle Model accurately portrayed “career development opportunities and responsibilities, both institutional and personal.” She added that its “three-pronged approach to a successful career clearly identifies the available structured training and the personally designed, developmental opportunities, tied into the appropriate and supportive assignments.” Kathleen Roehr, “Taking Command,” *The Army Nursing Newsletter* (April 1999): 1, ANCC, OMH.

27. Nancy R. Adams, “The U.S. Army Nurse Corps Professional Leader Development,” Printed Document, 16 February 1994, ANCC, OMH.

28. Nancy R. Adams, Memo from the Chief, Army Nurse Corps (November 1995): 1, ANCC, OMH. Jim Conley, “Fort Bliss Welcomes 1st Woman General,” *El Paso Times* (29 November 1995): 1A–2A. Leticia Zamarripa, “Woman General a First for Bliss,” *El Paso Times* (14 December 1995): 1A–2A. Jerry Harben, “Nurse Takes Command at Medical Center,” *The Mercury* 24 (May 1997): 1–2. G.E. Willis, “A Different Kind of First Lady,” *Army Times* 38 (14 April 1997): 4.

29. Kathy Titchen, “The General Is a Nurse,” *MidWeek* (6 January 1999): 22, 35. Carol Reineck, “Nancy R. Adams,” in Dorothy Pocklington, ed., *Heritage of Leadership, Army Nurse Corps Biographies* (Ellicott City, MD: ALDOT, 2004), 115–19.

30. The three were lieutenant colonels Constance Scott, Lenore Enzel, and John Beus, who commanded the newly formed 1st, 2nd, and 6th AMEDD Recruiting Detachments, respectively, and, for the most part, achieved their recruiting missions. Lenore Enzel to Cynthia Brown, E-mail Correspondence, 20 June 1999; and Nancy R. Adams, Memo from the Chief, Army Nurse Corps (August 1995): 2 (both in ANCC, OMH).

31. “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,” Record

Version, 11, 13 June 1995, ANCC, OMH.

32. Harry Noyes, "Nurse to Command Training Company," *The Mercury* 22 (February 1995): 6. 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), 68.

33. Bettye H. Simmons, "Nurse Progression," n.d., ANCC, OMH. Bettye H. Simmons, "Message from the Chief, Army Nurse Corps," *The Army Nursing Newsletter* (August 1998): 1; and Untitled Chronological List of Command by Army Nurse Corps Officers, n.d. (both in 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), 71.

35. Campbell's subsequent promotion to brigadier general was testament to her successful command. Karen Schmidt, "Brig. Gen. Kristine Campbell, On Being an Army Nurse," *NurseWeek* 14 (November 14, 2001): 11–12.

36. Examples of Medical Groups were the 1st Medical Group, Fort Hood, Texas, and the 55th Medical Group at Fort Bragg, North Carolina. Scientific/Technical units suitable for Army nurses' first command experiences were the CHPPMs in Europe and Japan. Level 1 MTFs were installations such as the MEDDACs at Heidelberg, Germany, Fort Sill, Oklahoma, and Fort Drum, New York. A typical TO&E unit that Army nurses were eligible to command was the 21st Combat Support Hospital. Carolyn Bulliner, "PERSCOM Update," *Army Nursing Newsletter* (November 1997): 2; Bettye H. Simmons, "Branch Immaterial," Memo from the Chief, Army Nurse Corps (March 1996): 5; and Alice Demarais, "AMEDD Center & School Personnel Proponent Directorate, Branch Immaterial," Memo from the Chief, Army Nurse Corps (March 1997): 4 (all in ANCC, OMH).

37. Michele Kohl, "PERSCOM Update, LTC AMEDD Command Board," Memo from the Chief, Army Nurse Corps (1 September 1997): 3; and Caroline Bulliner, "PERSCOM Update," Memo from the Chief, Army Nurse Corps (1 October 1997): 3 (both in ANCC, OMH). By mid-1997, the Navy Nurse Corps had 11 nurses in command, with 13 serving as executive officers or chiefs of staffs at Navy MTFs, lead agent staffs, and educational commands. "Statement of Rear Admiral Joan Engel, Nurse Corps, United States Navy, before the Subcommittee on Defense of the Senate Appropriations Committee, April 23, 1997, Concerning Medical Issues," Typewritten Draft, 14, 17 April 1997, ANCC, OMH.

38. Carolyn Bulliner, "PERSCOM Update," *The Army Nursing Newsletter* (August 1998): 3, ANCC, OMH.

39. The four included Colonel William T. Bester, who commanded the MEDDAC at Fort Jackson, South Carolina, Colonel Alice O'K. DeMarais, who commanded the MEDDAC at Fort Sill, Oklahoma, Colonel Patricia A. Saulsbery, who commanded the Heidelberg MEDDAC, and Colonel Patricia B. Wise, who chose to retire from active duty. When Colonel Wise declined the opportunity, Colonel Gale Pollock took her place and commanded the MEDDAC at Fort Drum, New York, in 1999. "FY 99 Colonel Command Principal List, Army Medical Department," n.d.; and Carolyn Bulliner, "PERSCOM Update," *The Army Nursing Newsletter* (June 1998): 3 (both in ANCC, OMH).

40. They included these colonels and their commands: Joan P. Eitzen (Japan CHPPM), Lark A. Ford (Fort Irwin, California, MEDDAC), Jeri I. Graham (Fort Leonard Wood, Missouri, MEDDAC), Deborah A. Gustke (Fort Leavenworth, Kansas, MEDDAC), Eileen B. Malone (Fort Belvoir, Virginia, MEDDAC), Barbara J. Scherb (West Point, New York, MEDDAC), and Arthur P. Wallace (Fort Riley, Kansas, MEDDAC). "FY 00 Colonel Command Principal List, Army Medical Department," n.d.; and Untitled Chronological List of Command by Army Nurse Corps Officers, n.d. (both in ANCC, OMH).

41. The clinic non-CSL command positions available for nominees to fill during the

summer of 1999 included those at Fort Lee, Virginia; Fort Myer, Virginia; Fort Buchanan, Puerto Rico; Fort Huachuca, Arizona; White Sands, New Mexico; Schofield Barracks, Hawaii; Camp Zama, Japan; Schweinfurt, Germany; Stuttgart, Germany; SHAPE, Belgium; and Vicenza, Italy. Carolyn R. Bulliner, "Non-CSL Clinic Commander Positions," 14 October 1998, ANCC, OMH.

42. Carolyn Bulliner, "PERSCOM Update," *The Army Nursing Newsletter* (November 1998): 6, ANCC, OMH.

43. "Army Nurse Corps Issues FY 96–99," 11, n.d., ANCC, OMH.

44. Bettye H. Simmons, Memo from the Chief, Army Nurse Corps (February 1997): 1, ANCC, OMH.

45. The nursing process is the standard method nurses use to diagnose and treat a patient's needs. Its components are fivefold—patient assessment, problem identification, planning a course of action, implementation of care, and evaluation of effectiveness. *Stedman's Medical Dictionary*, 27th ed. (Philadelphia: Williams and Wilkins, 2000), 1245. *Taber's Cyclopedic Medical Dictionary*, 19th ed. (Philadelphia: F.A. Davis, 2001), 1484. *Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health*, 7th ed. (Philadelphia: Saunders, 2003), 1234.

46. Clara L. Adams-Ender, Handwritten Notes on Draft Manuscript, 28 September 2005, ANCC, OMH.

47. Bonnie M. Jennings, "Chapter Five Comments," August 2005, ANCC, OMH.

48. Clara L. Adams-Ender, Interview by Virginia Ruth Cheney, Project 92-3 U. S. Army Military History Institute, Senior Officer Oral History Program, 77–89, 1992, ANCC, OMH.

49. Nancy R. Adams, Memo from the Chief, Army Nurse Corps (November 1995): 1, ANCC, OMH.

50. Jerry Harben, "Simmons to FORSCOM," *The Mercury* 24 (May 1997): 2. Bettye Simmons, "My Reassignment," E-mail Correspondence, 17 February 1997, ANCC, OMH. Bettye H. Simmons, Memo from the Chief, Army Nurse Corps (February 1997): 1, ANCC, OMH.

51. Debora R. Cox, "Army Nurse Corps Annual Historical Report, Calendar Year 1999," Typewritten Report, 2, 9 June 2000, ANCC, OMH.

52. Evelyn B. Riley, "BG William T. Bester Becomes USACHPPM Commander," Press Release, 15 March 2002, ANCC, OMH.

53. The Army nurses filling the BI positions were Colonel Barbara Penn as chief of the AMEDD Education and Training Division, Lieutenant Colonel Rhonda Graves as chief of Program, Policy and Analysis Branch, Major Christie Smith as program analyst in Coordinated Care, Lieutenant Colonel Patricia Buzonas as process action team leader in Procurement, and Lieutenant Colonel Barbara Scherb as combat developments staff officer. Terri Kennedy, "Branch Immaterial Officers/Positions," Information Paper, 2 August 1993, ANCC, OMH.

54. Bettye H. Simmons, "Nurse Progression," n.d., ANCC, OMH.

55. The law directed that the officer be selected by a DA Secretariat Promotion Board, then be appointed by the secretary of the Army on recommendation of the surgeon general. Mary V. Frank, "Historical Review of ANC Efforts to Achieve Rank Parity 1898–1985," Memorandum, 33–37, 1985; Colonel Sierra, "AMEDD General Officer/Corps Chief Authorization," Information Paper, 1 September 1992; and Iris J. West, "Origin of General Officer Billet, Army Nurse Corps," Memorandum, 10 January 1994 (all in ANCC, OMH).

56. Two exceptions to the rule were Colonel Ruby F. Bryant, who reverted to lieutenant colonel and became chief of the Nursing Branch and nursing consultant in Europe, and

Brigadier General Clara L. Adams-Ender, who assumed command of Fort Belvoir, Virginia. These assignments followed Colonel Bryant's and General Adams-Ender's tenures as chiefs of the Army Nurse Corps.

57. Nancy R. Adams, "GO Potential: Chief, Army Nurse Corps," Briefing Slide, n.d., ANCC, OMH.

58. Mary V. Frank, "Historical Review of ANC Efforts to Achieve Rank Parity 1898–1985," 3, 28 February 1985, ANCC, OMH.

59. Patrick DeLeon, Senator Inouye's office chief of staff, also provided significant support and espoused the cause of military nursing.

60. Terris E. Kennedy, Interview by Constance J. Moore, Transcript, 404, 31 October 1996, ANCC, OMH.

61. Nancy R. Adams to Author, E-mail Correspondence, 5 November 2004, ANCC, OMH.

62. Nancy R. Adams, "Thoughts for MG Tempel," n.d.; Nancy R. Adams, "Mandatory Retirement Date (MRD)," Memorandum, 28 January 1994; "Current and Potential Branch Immaterial GO Positions," 4 March 1994; and Nancy R. Adams to Author, E-mail Correspondence, 17 November 2004 (all in ANCC, OMH).

63. Alcide M. LaNoue to Chief of Staff, Army, TL, 8 July 1994, ANCC, OMH.

64. Allan C. Brendsel, "AMEDD Branch Immaterial General Officer Positions," Memorandum, 27 July 1994, ANCC, OMH.

65. Daniel K. Inouye to General Gordon R. Sullivan, TL, 6 February 1995, ANCC, OMH.

66. Alcide M. LaNoue, "Army Medical Department (AMEDD) Branch Immaterial General Officer Positions—Action Memorandum," 20 April 1995, ANCC, OMH.

67. Dennis J. Reimer, "AMEDD General Officer Branch Immaterial Promotion Selections," Memorandum for the Surgeon General of the Army, 20 June 1996; and "CY 96 Zone of Consideration for Promotion to Major General, Army Medical Corps Competitive Category, Promotion Selection Board," MILPER Message NR 97-117, 30 June 1997 (both in ANCC, OMH).

68. Dennis J. Reimer, "AMEDD General Officer Branch Immaterial Promotion Selections," Memorandum for the Surgeon General of the Army, 20 June 1996; Department of the Air Force, "Statement of Brigadier General Linda J. Stierle, Director of Medical Readiness and Nursing Services, Office of the Surgeon General," Presentation to the Committee on Appropriations, Subcommittee on Defense, United States Senate, 4, April 1998; "Promotion Opportunities," n.d., Set of questions with background data posed by Senator Inouye in "SAC DEF 1 April Medical Questions," 7 April 1998; and "CY 96 Zone of Consideration for Promotion to Major General, Army Medical Corps Competitive Category, Promotion Selection Board," MILPER Message NR 97-117, 30 June 1997 (all in ANCC, OMH).

69. Congressional Record—Senate, S6425–S6426, 19 June 1996.

70. Congressional Record—Senate, S6424, 9 June 1996, 104th Congress, 2nd Session, Vol. 142, No. 91, National Defense Authorization Act for 1997, Amendment 4050, Title 10.

71. Iris J. West, "Origin of General Officer Billet, Army Nurse Corps," Memorandum, 10 January 1994, ANCC, OMH.

72. These figures represent FY 1995 officer end strength. "AMEDD General Officer Position Descriptions," n.d. ANCC, OMH. "Army Nurse Corps and Medical Service Corps Rank Structure," Insert for the Record, 15 March 1994, Documenting dialogue between Senator Inouye and General Sullivan; and Nancy R. Adams to Author, E-mail Correspondence, 4 November 2004 (both in ANCC, OMH).

73. "Army Nurse Corps and Medical Service Corps Rank Structure," Insert for the Re-

cord, 15 March 1994, Documenting dialogue between Senator Inouye and General Sullivan, ANCC, OMH.

74. *Ibid.*

75. Dorothy Pocklington, "Gale S. Pollock," in Dorothy Pocklington, ed., *Heritage of Leadership, Army Nurse Corps Biographies* (Ellicott City, MD: ALDOT, 2004), 133.

