

Chapter Four

Readiness Challenges

After the catastrophic circumstances of the Vietnam War, the Army as a whole suffered from “low morale, popular distaste for military service, low self-esteem, and a tarnished public image.” Additionally, severe budget and personnel reductions left the organization a hollow Army—that is, an institution with an intact shell but a significantly diminished core that was seriously deficient in facilities, funding, manpower, and materiel.¹ The Army, at low ebb, was compelled to recreate itself. A critical period of innovation, modernization, and reform materialized. Important components of the Army’s renaissance were the upgrading of the Table of Organization and Equipment (TO&E) units and field equipment and the improving of individual and unit readiness, the ability to respond quickly and competently to achieve the mission.²

A major factor in field nursing and the state of readiness was the evolution of field units, including their staffing, physical facilities, and configurations. In 1975, the Army Medical Department (AMEDD) began a large-scale conversion of the Evacuation Hospitals (EVACs) and Mobile Army Surgical Hospitals (MASHs) from tentage into Medical Unit, Self-contained, Transportable (MUST) facilities and equipment.³ The MUST concept entailed “inflatable shelters, together with a power package [to support] heat, light, air-conditioning, hot and cold water, and other utility requirements.” The surgeon general directed that EVACs and MASHs be reconfigured into the modern Combat Support Hospitals (CSHs). A further change in doctrine dictated that divisions would be supported in future combat operations by a matrix of two CSHs that were 200-bed MUSTs and one EVAC. Previously, division medical assets included one surgical and two EVACs.⁴ The doctrine changed once again in 1982 when the configuration of combat divisional support evolved into one MASH, one CSH, and one EVAC. This change raised combat division allocation from 800 to 1,060 beds and increased operating tables from 14 to 20. The AMEDD then terminated the MUST program and began preparations to develop the Deployable Medical System, which would enhance

AMEDD's capability "to provide the soldier with timely, state-of-the-art medical and surgical care in a combat environment."⁵

In the mid-1970s, the commander of Forces Command ordered all TO&E units to achieve and maintain a level of operational readiness so they might clearly meet their mission. He also directed that unit training be the highest priority. Before that, Army policy had restricted the full-time assignment of professional caregivers to Modified Table of Organization and Equipment (MTO&E) units, the deployable wartime hospital units. This limitation resulted from the extreme staff shortages in the Table of Distribution and Allowances (TDA) hospitals, referred to as the fixed facilities or the Army medical centers and Army Medical Department Activities (MEDDACs). Thus, stringent ceilings were set for Army Nurse Corps participation in MTO&E units, and the Corps assigned only a minimal number of such officers to ensure that training needs were met and operational readiness was maintained. The Army Nurse Corps assigned only six Army nurses full-time to the 18 existing MTO&E units. They served as staff officers and advised on training matters related to nursing and the other allied health fields.⁶

After the new policy mandating increased readiness levels went to the field, the Army Nurse Corps selected officers from its meager supply and placed them in all the MTO&E hospitals, by then 17 in number.⁷ These nurses were responsible for improving readiness and assisting with a transition to CSH configuration and MUST equipment. They implemented the required changes in "SOPs, procedures, ward layouts, sterile loads, packing and loading plans, plus a total training program for all patient care personnel."⁸ However, certain aspects of the utilization of Army nurses in MTO&E units remained problematic.

Generally speaking, the Army Nurse Corps considered the manner in which Medical Service Corps commanders used Army nurses in MTO&E units to be "very poor" in 1973. The commanders had the latitude to use their personnel as they saw fit, and many decided to send their Army Nurse Corps officers to the local military treatment facility, usually the nearby MEDDAC, because there was "nothing for a nurse to do in the unit." Male nurses assigned to MTO&E units frequently were given administrative, nonnursing responsibilities such as training officer or as supply officer, which required signing and being responsible for the entire unit's training or equipment. This allowed them little if any time to focus on nursing issues. Colonel Madelyn Parks, the Continental Army Command chief nurse, observed that the male nurses seemed to fall into this trap more readily, wanting "to be one of the fellows." Rarely did any "female ANC's find themselves in this situation." Support and consultation for these Army Nurse Corps officers—usually captains—from the local TDA or MEDDAC chief nurse often was not forthcoming. A few TDA chief nurses resented the MTO&E nurses, viewing their assignments as a foolish waste of personnel when nursing resources in the TDA hospital were so scarce. Others backed the MTO&E nurse "to the hilt" and consistently went "to bat for them when they [had] a problem." At times, however, the TDA chief nurse was hamstrung by insufficient command support and a lack of understanding. Many of the MEDDAC commanders were consumed by the daily

demands of their TDA hospital and had neither the time nor interest to devote to the MTO&E unit assigned to them and usually co-located on their post.

To mitigate some of these difficulties, Parks recommended that all newly assigned MTO&E chief nurses undergo an orientation with an exemplary unit, such as the 41st CSH at Fort Sam Houston, with an outstanding chief nurse such as the 41st's Captain Grace Squires. She also suggested that all MTO&E nurses meet annually to exchange ideas, set standards, and acquire current information. Moreover, Parks asserted that Health Services Command should direct MEDDAC commanders to exercise active involvement in the ongoing activities of their MTO&E unit. Parks added some comments that reflected the state of MTO&E unit readiness in 1973:

"The state of the readiness of the medical MTO[&]E units is terrible now. We know this. The ANC [Army Nurse Corps] effort has been tremendous in getting nurses in all of these units to try to upgrade their patient care capability. They can't do it alone."⁹

In another move to improve readiness, the Army developed guidelines for weapons training for female soldiers and distributed them to the field. In January 1976, Headquarters, Department of the Army established a policy that all female officers participate in individual weapons training on the same level as their male complement. The rationale was that all personnel, including female soldiers, should be capable of defending "themselves and their unit regardless of their location on the battlefield."¹⁰ The existing unwillingness on the part of the rank and file of the Army to allow women to handle firearms was a reluctance rooted in tradition. In the past, the Army rarely authorized women or nurses to participate in weapons training or to carry or discharge arms even for their own personal protection.

By the mid-1990s, the bearing of arms such as the 9-mm pistol or the M16 rifle with ammunition while on deployments became mandatory for all Army nurses, regardless of gender. At a minimum, Army Nurse Corps officers attended weapons familiarization sessions annually but most were fully qualified on their weapon. When traveling off the hospital compound while deployed, the Army nurse carried the weapon that—upon return to the hospital—was secured in a weapons room or on a weapons rack on the hospital unit. Sometimes pepper spray also was issued as a less lethal option for self-defense. Lieutenant Colonel Charlotte Scott recalled that by the late 1990s, Army nurses carried a weapon at all times while on deployed status, on duty in hospital wards, at the mess hall, and even on trips to showers and latrines. When traveling, the weapons were loaded but kept on "safe." Scott added that a "clearing barrel" filled with sand sat at every hospital entrance. Both hospital personnel and visitors were "required to remove ammo, perform a safety check, and 'dry' fire their weapon . . . prior to entry into the hospital." This safety check helped to prevent an unintended weapon discharge within the hospital perimeter.¹¹

Over the period of two decades, regulations and policy transitioned from almost totally banning weapons for Army nurses to fully mandating their use in

the theater of combat. This transition mirrored the slightly slower assimilation of Army Nurse Corps officers from a segregated, separate status within the Army into nearly full integration as Army commissioned officers.

The more stringent adherence to weight control and physical fitness standards was an additional strategy used by the Army to enhance individual soldier readiness to go to war. The introduction of the new expedients affected Army nurses as it did virtually all members of the officer corps and the enlisted ranks. Headquarters, Department of the Army distributed the revised Army Regulation 600-9, "The Army Weight Control Program," to the field late in 1976. Its intent was to foster weight control awareness and thus improve physical fitness and individual readiness. The newly established weight standards contained within the regulation were much more stringent than previous parameters. The earlier guidelines based on civilian life insurance height and weight tables dated back to 1945.

The new program defined in the regulation also recommended physical fitness requirements for every soldier and directed commanders to conduct year-round fitness programs. Eventually, all soldiers younger than age 40 were to be weighed and tested annually according to the new physical fitness standards. The Health Services Command commander cautioned that "soldiers who consistently fail to comply may well earn poor ratings on efficiency reports, bars to re-enlistment and finally involuntary separations. In short, they must measure up."¹²

Before 1976, the Army as a whole virtually ignored the dictates of Army Regulation 600-9. However, over time, commanders paid increasing attention to this regulation. Army Nurse Corps officers who—for one reason or another—could not or would not meet the weight standards paid a penalty in the long run. They were not promoted, not selected to attend service or civilian schools, passed over for the choice assignments, and ultimately many were eliminated from the service. Their commanders and peers harassed many Army Nurse Corps officers about their inability to comply. Ironically, a significant number of these individuals who did not meet the fitness requirements were among the brightest, most diligent, and dedicated officers on the Army Nurse Corps rolls. Their elimination unquestionably represented a significant loss for the Army. Nonetheless, there was no question that soldiers had to be physically fit to survive in modern combat and contribute meaningfully to the mission. Colonel Carol Reineck shared her thoughts about the contradictions in the system:

"... certainly the military force needs to be strong and healthy and capable. But there is also . . . a benefit from wisdom in whatever body size it comes in. That's what I saw lost was the wisdom, the experience, and the commitment. How could we have a value system that would actually place those qualities as less valuable than the stature of the individual physically. I couldn't imagine a system like that, but I accepted it, and figured that there may be something that I didn't know that drove it."¹³

The weight control program was a bitter pill to swallow, but an essential undertaking for the Army in its quest for improved fitness and readiness.

Although the weight and fitness standards were consistent across the width and breadth of the Army, one noteworthy discrepancy did exist between the AMEDD

and the Army line. For instance, readiness to deploy carried radically different implications for the tactical units, the combat arms, and the AMEDD. In situations of rapid mobilization, the AMEDD and the Army Nurse Corps were at a distinct disadvantage. When committed to a deployment, the line units shifted into a higher gear, moving from training to operational status. Skeleton units performed garrison duties while the main force deployed. The AMEDD, conversely, had to support—simultaneously and fully—both garrison and field responsibilities because the population at the home base who needed health care simply did not disappear when units went to war. Thus, in times of mobilization, Army Nurse Corps officers were required to be in two places simultaneously, which affected the Army Nurse Corps response to such emergencies. Factors affecting this response included the available numbers of active duty, reserve, and National Guard Army Nurse Corps officers; the ability to retain officers on active duty and to activate the reserve component; the authority to draft nurses; the effectiveness of existing recruitment and training programs; and public opinion of the military by the profession of nursing at large.¹⁴ To improve its state of readiness, the Army Nurse Corps recognized that it had to study and deal with these issues. It also had to increase its participation in field exercises.

In September 1978, 20 Army nurses participated in the Return of Forces to Germany exercises.¹⁵ Their participation signified a recognition of the imperative for Army Nurse Corps involvement in such exercises to enhance overall readiness and improve deployment proficiency. Likewise, in January 1979, three Forces Command and 11 Health Services Command Army nurses deployed to this large-scale winter training exercise. That same year, Lieutenant Colonel Betty Brice, the obstetrics/gynecology nursing consultant, deployed with the 1st Infantry Division to evaluate health care needs of the division's women.¹⁶

Brice's assignment was a public acknowledgment by the Army that female soldiers had unique health care issues. Female soldiers by then carried out combat support and combat service support responsibilities in unprecedented numbers. Furthermore, there was a greater percentage of women in the active military as a whole. In 1970, 41,479 women, or 1.3 percent, were serving in the total active duty military force of 3,066,294. By 1980, the number of women in all the U.S. armed forces totaled 71,418, or 3.5 percent of the entire force of 2,050,627.¹⁷

This revolution represented a major change for women, the Army, and the Army Nurse Corps. In the 1980s, women's opportunities grew and the Army devoted extensive time and effort to developing policies to cope with the influx of women and their new military roles. The Army Nurse Corps correspondingly faced challenges such as caring for the distinctive needs of female patients in the field setting. As a predominantly female organization, it also benefited from the greater presence of women in the military, which forced the Army to augment facilities for women, treat women in an equitable manner, enhance women's medical support, and improve uniforms and equipment.

Although the state of individual and unit readiness for mobilization was still unsatisfactory by 1979, it had improved during the 1970s. Junior and senior Army

Nurse Corps officers worked alike to get the Army where it needed to be. A large portion of the readiness picture was the part played by the Reserve and National Guard components.

The Ready Reserve was composed of three elements in the early 1970s. The U.S. Army Reserve (USAR) Army Nurse Corps officers could potentially belong to one of the three elements. The first element, the Troop Program Units (TPUs), consisted of various hospitals and medical detachments in locations across the United States. Army nurses in TPUs drilled for one weekend per month at military or civilian hospitals or at Army Reserve Centers with their unit. They also served two weeks of active duty for training or annual training per year with their unit at selected active military installations. The second element, the USAR School members, had to participate in class for one evening per week for about nine months each year. They might also attend a USAR School for two weeks annually. The third element, the Annual Training Control Group, could be assigned to a TPU with a possibility of two weeks of active duty for training.¹⁸

The USAR and the Army National Guard (ARNG) faced a number of challenges in the post-Vietnam era. Few nurses were interested in joining or maintaining their status in the reserves. In 1971, only 10 percent of Army Nurse Corps billets in reserve units were filled.¹⁹ In the summer and fall of 1976, a mere 25 percent and then 35 percent of requirements, respectively, were filled. By spring of 1977, only 36 percent of Army Nurse Corps authorizations in the reserves were occupied. To fill vacancies, the Office of The Surgeon General used various strategies, including some that potentially degraded the quality of the reserve component while improving personnel numbers. Among these new policies was a relaxation of standards to make reserve service more attractive, which included eliminating certain military education standards viewed as mandatory for promotion, allowing and sometimes funding attendance at professional conferences in place of annual training, and permitting Army Nurse Corps reservists and guard personnel to remain in service up to age 64. To augment procurement efforts, new policies permitted and even encouraged certain reserve units to recruit above and beyond their authorizations whenever possible to compensate for under-strength units, to use “proven marketing techniques” such as widespread advertising in a variety of media, and to accept registered nurses regardless of their educational level.²⁰ All of these strategies slightly improved the strength of the USAR and ARNG. Nonetheless, these components remained seriously shorthanded, and the USAR and ARNG situation would worsen before it improved significantly.

In early 1976, the Army Nurse Corps reserve component picture suddenly became more challenging and complex. The USAR increased authorizations in TPUs from about 1,900 Army Nurse Corps officers to more than 5,100 officers. This change happened because, as General Madelyn N. Parks wrote, the “readiness posture of the . . . Corps to meet its primary mission during a contingency is critical.” By April 1977, there still were only 1,911 Army nurses in these units. Acknowledging that there were far too few Army nurses, the USAR leadership liberalized appointment criteria for Army Nurse Corps officers and thus gave a

“broader and clearer interpretation” to the existing standards to boost numbers of reserve nurses.²¹ At that time, the AMEDD Personnel Support Agency selected applicants with specific educational credentials or with a combination of educational background plus certain amounts of professional experience. For example, applicants with a bachelor’s of science degree in nursing and six months’ clinical practice within the preceding year or those with a hospital school diploma or an associate degree in nursing plus 24 months of experience were allowed to apply for a commission in the USAR.²² Other criteria for a USAR or ARNG appointment included graduation from a nationally accredited nursing program and a license to practice as a registered nurse.²³ By January 1978 the Army Nurse Corps had procured more than 2,000 officers to fill the TPU vacancies.²⁴

Nevertheless, attracting quality applicants into the USAR remained a challenge. USAR recruiters could not cast their nets “in the most obvious and fruitful sources—universities and schools of nursing.” These sites represented the “preserves of the active Army recruiters,” and there was neither coordination nor a “central organization” for USAR recruiting. Every activity was “strictly on its own.”²⁵ Efforts to end this fragmentation and decentralization began in 1978 when the vice chief of staff of the Army directed that the responsibility for recruiting Active, Guard, Reserve officers would be combined outside of USAR command channels. The surgeon general subsequently ordered that all AMEDD recruiting occur under his aegis, with the exception of Army Nurse Corps recruiting. All Active, Guard, Reserve Army Nurse Corps officers’ recruitment was vested—as it had been traditionally—in the U.S. Army Recruiting Command. This new system consolidating all AMEDD Active, Guard, Reserve recruitment was fully operational by July 1980.²⁶ With the dawning of the decade of the 1980s, the picture was somewhat brighter. By then, the Army Nurse Corps Reserve and National Guard reported filled authorizations at a much improved 59 percent level.²⁷

Another important issue linked to the expanded reliance on the USAR and ARNG was the mandate to improve their state of readiness. In 1972, a private think tank, the Research Analysis Corporation, examined this question. Its final report noted that the intent of the USAR system was “to provide . . . units and individuals that can be made combat ready faster, on mobilization, than can newly organized units composed primarily of untrained personnel.”²⁸ The investigators concluded that the USAR system “succeeded only marginally” in achieving this end “in the partial mobilizations” that occurred after World War II. They attributed the failures to flawed national policies that affected the USAR’s and ARNG’s recruitment and manpower practices; deficiencies in equipment, training locations, and amenities; and “improper organization of Reserve component units.”²⁹

By the end of the decade, the AMEDD had incorporated certain parts of the study’s findings into its planning. The Office of The Surgeon General, like the rest of the Army, pre-positioned equipment overseas for use by mobilized reserve hospital units, in line with Army-wide policy. Additionally, it sought ways to improve supplies and equipment for deploying units. The Office of The Surgeon General also arranged for priority units designated for early deployment to be filled to



Before her retirement in 1981, Colonel Garnet I. Willow served as Mobilization Designee to the Chief of the Army Nurse Corps.

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

the maximum or even to over strength manning levels.³⁰ Moreover, the AMEDD expanded opportunities for training both at the unit level and at the Academy of Health Sciences.³¹

Furthermore, the AMEDD adopted a comprehensive approach to promote overall readiness, inclusiveness, and cohesiveness. Lieutenant Colonel Garnet Willow of the 2290th U.S. Army Hospital in Rockville, Maryland, articulated the problematic, widely held opinion of reservists in regard to the Total Army Concept:

Under the “One Army” concept the USAR has been with us for years. Yet many reservists feel, not entirely without justification, that they have been left at home crouching in the ashes while their more favored stepsisters (and stepbrothers) of the active forces dance at the ball. We sympathize with their viewpoint.³²

To bridge the gulf and unify the components, the AMEDD used several strategies. For example, the AMEDD expanded its Mobilization Designee program, included USAR and ARNG representation at the Department of the Army level whenever feasible, and reminded all involved in the process of policy making to keep in mind “What is the impact on the reserve components?”³³ Finally, the Army Nurse Corps assigned an officer full-time to U.S. Army Reserve Components Personnel and Administration in St. Louis, Missouri. In October 1977, the Corps selected Lieutenant Colonel Margie O. Burt, Army Nurse Corps-USAR, to assume responsibilities for the integration of the Officer Personnel Management System in the USAR. She also managed personnel activities such as Specialty Skill Identifier changes for Army Nurse Corps USAR officers.³⁴ After implementing these measures, the AMEDD was closer to achieving its goal of improved reliance on the USAR and ARNG components and was in better compliance with the expectations of the Total Army Concept.

The opening of the Reserve Officers’ Training Corps (ROTC) program to future Army Nurse Corps officers was another milestone that produced several beneficial effects. One of those positive outcomes for Army nurses who participated in this program was greater readiness to function in the combat setting. Although the contemporary Army ROTC originated with the National Defense Act of 1916, women were first allowed to participate in the program in the 1972–1973 academic year.³⁵ Although it is true that not all potential Army Nurse Corps officers were women, nonetheless the elimination of the bar that limited ROTC participation to men opened the door for all baccalaureate nursing students—regardless of gender—to apply for this program.

At this time, ROTC became the preferred choice for future accessions to the Army Nurse Corps. As years passed, the Army customarily prized and valued—to an increasingly greater extent—professional military traits in Army Nurse Corps officers. Thus, the institution favored nurses who were ROTC graduates because this basic preparation developed leadership attributes and soldiers’ skills. Additionally, it cultivated military proficiencies and promoted a professional demeanor and military bearing. The program also provided a comprehensive orientation to the Army as an organization, its goals, values, and mores. Finally, ROTC fostered a sense of esprit de corps among its members and other Army officers.³⁶

New incentives also attracted collegiate nursing students to ROTC. Financial advantages included the potential to be awarded a two- or three-year scholarship with full payment of tuition, books, supplies, and specific fees along with a maximum \$1,000 annual subsistence allowance. Cadets who did not qualify for the full scholarship benefit could still receive the \$1,000 annual allowance in their junior and senior years of school. ROTC graduates also enjoyed expedited participation in advanced and/or specialized educational programs. Moreover, ROTC cadets could choose either the Cadet Troop Leadership Program or the six-week Alternative

Advanced Summer Camp specifically designed for nurse cadets during their summer. While attending these programs, cadets had transportation and room and board furnished; they also were paid about a \$500 subsistence allowance.³⁷

As early as 1978, ROTC chief nurses discussed forming an Army Nurse Corps summer camp for ROTC cadets to augment or replace the traditional Cadet Troop Leadership Program, an all-branch Army summer camp. Both advantages and disadvantages were implicit in the Army Nurse Corps branch-specific program. Although the nurse-specific option would undoubtedly hone the cadets' clinical skills and enhance their preparation for a future career as an Army nurse, it would not offer as much exposure to the rest of the Army world.³⁸ Texas Christian University cadet Teresa Parsons participated in the traditional ROTC summer camp and favored that option. She felt that it was "one of the few times that we . . . had the opportunity to . . . actually be a part of the main body of the military." Parsons recalled that while at the Cadet Troop Leadership Program, she "had to write operation orders, and place land mines, and conduct patrols, and all that lieutenants did in the rest of the Army all the time."³⁹ Outgoing chief of the Corps, Parks, opposed the Army Nurse Corps-specific plan on that very basis, reasoning that "the present structure" should not be disturbed, because it offered "some of our best Nurses with much better insights into the Army as a whole."⁴⁰ Nonetheless, by the summer of 1981, Brigadier General Hazel Johnson, the subsequent chief of the Army Nurse Corps, approved the concept and implementation of a special summer camp for ROTC nurse cadets.⁴¹ A total of 24 cadets participated that first year at four sites, one in each ROTC region.⁴² The overall objective of the camp was "to provide a realistic leadership experience in the clinical setting" and to furnish "firsthand knowledge of the duties, responsibilities and living conditions of the junior ANC [Army Nurse Corps] officer in the Army."⁴³ As prerequisites for attendance at the camp, cadets had to volunteer for the special camp, have completed three years of their nursing curriculum, and be eligible to graduate with a baccalaureate degree in nursing in the spring of 1982.⁴⁴ Cadet volunteers who attended the six-week summer program actually shadowed an Army Nurse Corps junior officer, who served as their preceptor. The students participated in other selected hands-on experiences and also spent some time in the field with a CSH.⁴⁵

Each year the program evolved and improved. Based on 1981 camp participants' suggestions, ROTC leaders decided to incorporate common military proficiencies and skills into the summer 1982 camp program of instruction. Accordingly, exposure to subjects such as physical training; weapons qualification; nuclear, biological, and chemical protection; day and night land navigation skills; field first aid and sanitation; and individual tactical training was added to the experience in 1982.⁴⁶

By the summer of 1983, the entire program had grown exponentially, testifying to the idea's success and value. A total of 121 cadets participated in the ROTC Nursing Advanced Camp (ROTCNAC). In addition, 61 more ROTC nursing cadets participated in Cadet Troop Leadership Training, the traditional Advanced Summer Camp that focused exclusively on military skills.



First Lieutenant Monica Scheibmeir of the U.S. Army Medical Department Activity, Fort Riley, Kansas, mentors ROTC Cadet Pam Olson from the University of Kansas, Kansas City, as she prepares a medication for a patient on 8 July 1987.
Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

In 1983, 82 deans of university schools of nursing visited the ROTCNAC sites.⁴⁷ In succeeding years, the deans' visits became an annual ritual. ROTC nurse leaders conceived and implemented the familiarization program to more fully convince the civilian academic administrators of the value of the ROTC experience. They hoped that the deans' exposure to the program would influence them to encourage further student participation. Such was the case in 1989 with Dr. Lea Acord, the director of the University of Maine School of Nursing. That summer, Acord accepted the invitation to visit the Fort Bragg ROTCNAC for two days. While there, she decided to attempt rappelling off a wall and also to participate in the slide of life. Her success with these two maneuvers and other experiences there led Acord to declare that "she was impressed by the organization and motivational techniques employed . . . and would encourage students . . . to try it." Acord added that she "always thought of the service as rigid." However, her ideas were transformed when she "found instead during her visit that positive reinforcement was widely used to encourage improvement."⁴⁸

The ROTCNAC program continued to evolve. By 1983, 32 collegiate nursing programs had begun to award academic credit for ROTCNAC. Another 15 nursing schools were considering granting academic credit for ROTCNAC from their institutions.

Various problems needing additional attention surfaced and were resolved as ROTCNAC was regularly put into practice on an annual basis. These concerns revolved around issues such as standardization of field training, appropriate billeting, and adequacy of transportation.⁴⁹ By 1984, 27 Army hospitals were hosting ROTCNAC for a total of 162 cadets.⁵⁰ In 1985, the camp's title was changed to the Nurse Summer Training Program.⁵¹

The use of ROTC as a procurement source got underway very slowly. In fiscal year (FY) 1976, the first two nurses graduated from ROTC and entered the Army Nurse Corps.⁵² In the following FYs 1977, 1978, and 1979, ROTC claimed two, 32, and 29 accessions, respectively, to active duty.⁵³ By FY 1980, the number of new accessions procured through ROTC recruiting channels had gradually increased to 35 new officers of a total of 425 accessions.⁵⁴ In FYs 1981, 1982, and 1983, ROTC produced 58, 46, and 50 new Army Nurse Corps officers annually.⁵⁵ The modest growth in ROTC accessions reflected the greater attention and increased assets channeled into ROTC as a recruiting tool.

To improve recruitment and coordination of ROTC cadets, the Army Nurse Corps undertook several measures. It selected and assigned ROTC chief nurses to the four ROTC regions in the early 1980s. These Army Nurse Corps officers met a variety of expectations. They served as the region commander's nursing staff officer and developed plans for accomplishment of the mission. They identified and visited promising sites of recruitment, implemented staff visits to summer camps and accredited colleges of nursing, and produced publicity information. They also interfaced with the U.S. Army Recruiting Command recruiters and shared information and leads.⁵⁶ Additionally, the ROTC chief nurses advocated for the cadets vis-à-vis professors of military science assigned to the universities. Nursing

cadets carried heavy class loads between their traditional collegiate courses, nursing classes that involved many extra hours of clinical experience, and their ROTC classes. “The PMS [professor of military science] was not always willing to make allowance for [the intense demands made on the time of] nursing students.” Also, on occasion, no ROTC programs existed on the nurse cadets’ campuses, which necessitated time-consuming travel to another institution with a ROTC program.⁵⁷ Nonetheless, ROTC continued as a mainstay for recruitment and a key producer of high-quality Army Nurse Corps officers for the rest of the 20th century.

Airborne training was another option for certain nursing ROTC cadets as the 1970s ended, and it too served to improve readiness in those nurse paratroopers who achieved that mark of distinction. Cadet Teresa Parsons competed against all other ROTC cadets at Texas Christian University for one of two slots to attend jump school at Fort Benning, Georgia. The university’s ROTC unit decided that the two cadets—regardless of gender—that earned the highest physical training test scores would attend. To make the competition among the Texas Christian University cadets fair, Parsons volunteered to compete using the men’s more stringent parameters for the two-mile run and push-ups. She won the competition, was chosen to attend the course, and successfully achieved airborne status.⁵⁸

Participation in airborne training was grueling but definitely worthwhile for those who qualified for jump wings. Cadet Jimmie Keenan participated in the training in 1983 right after her freshman year at Henderson State University in Arkansas. She explained:

Jump school was a defining moment for me. . . . Airborne School really tested me and made me understand how a soldier really felt. I believe . . . having to buff the floors, clean the toilets, march everywhere, do more pull-ups, push-ups and side straddle hops than I thought possible, broke me down and built me up. . . . I knew that if I could make it through Airborne school I could do anything. I finally felt like a soldier. Now almost 20 years later, when I have on my BDUs [battle dress uniforms] or my class A’s I always stand a little straighter because I went through Airborne school . . . it has also helped me to take care of my patients. They knew when they looked at my uniform that I understood what they had been through. It helped establish instant credibility with the line officers that I have worked with in Recruiting, AMEDD C&S, CAS3, Resident CGSC, and as the Chief Nurse in Kosovo, going head to head with the Line guys fighting for space to set up the combat support hospital.⁵⁹

In the 1950s, a handful of Army Nurse Corps male nurses—many of whom were anesthetists—became jump-qualified. Some of these officers were attached to Special Forces units. Second Lieutenant Robert M. Stauffer and Captain Patrick J. Ferry were among the first Army Nurse Corps officers to qualify for this demanding role. The twosome, assigned to the 101st Airborne Division at Fort Campbell, Kentucky, attended Airborne School in 1956.⁶⁰

Lieutenant Colonel Susan McCall was 43 years old when she attended jump school. Since she was directed to help design an airborne/airdroppable unit, she decided that she “needed to know what the capabilities were of the personnel” in the proposed unit. Hence, she went to “airborne school to see what was involved.” Still later McCall chose to participate in jump master school with the 82nd Airborne Division at Fort Bragg, North Carolina. She was the only female



Lieutenant Colonel Susan McCall, sitting on the “Green Ramp” at Fort Bragg, North Carolina, was waiting to board the aircraft to jump in 1988. Her main parachute was on her back and her reserve parachute was on her front with the bag to stow her chute strapped under the reserve. After jumping she would gather her chute and stow it to carry it off the drop zone. To the left of Lieutenant Colonel McCall on the tarmac is her full Alice pack.

Photo courtesy of Susan McCall, Houston, TX.

in the class and one of the oldest of all the students. Faculty informed her “that the pass rate [was] about 40% but our class [ultimately] had about a 90% pass rate.” McCall surmised that “those guys were not about to let some little old lady out do them.”⁶¹ Thus, possessing the elite Airborne School qualification proved to be an advantageous distinction not only for key Army Nurse Corps officers but also for a selected few ROTC cadets.

Another Army nurse, Captain Jose F. Rivera, pioneered the way for Army Nurse Corps participation in air assault training with the 101st Airborne Division in 1978. While assigned to Fort Campbell, Kentucky, Rivera was among 77 of a class of 136 to earn the coveted air assault badge by rappelling from a tower and later from a helicopter, completing a strenuous road march with full pack and weapon, and integrating various other air assault techniques and acumen into his armamentarium.⁶² The acquisition of these advanced military proficiencies enhanced the quality of the contributions made by Army Nurse Corps officers to the Army mission.

Notes

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2. Quinn H. Becker, Interview by Gary Sadlon, 121–123, 129, 9, 10, and 11 February 2000, Research Collection, OMH.

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31. “United States Army Health Services Command,” Printed Brochure, n.d.; Amie Modigh, “Historical Background for Nursing Service 3274th Army Hospital (1,000 Bed),” 7 August 1976; and Major Jones, “Reserve Components—AMEDD,” Information Paper, 12 November 1973 (all in ANCC, OMH). Richard R. Taylor, “Team Work Needed for Army Medicine,” *U.S. Medicine* 10 (15 January 1974): 60.

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33. A Mobilization Designee (MOB DES) was “any officer, warrant officer or enlisted person in a Ready Reserve status who [was] preselected, trained, and available to fill a key authorized augmentation position in a selected Active Army TDA unit as required during early mobilization.” DA HQ USA HSC, HSC Regulation 140-1, “Army Reserve, Individual Reserve Training, Mobilization Designee Program,” 2, 5 October 1977. Individual Mobilization Augmentees (IMAs) were USAR officers not assigned to a reserve unit but instead assigned to “an active Army organization or Staff Agency” in Individual Ready Reserve (IRR) status. The Army required the IMA to have “premobilization experience and training.” A number of Army Nurse Corps positions, such as the assistant chief of the Army Nurse Corps, had IMAs assigned. U.S. Army Reserve Components Personnel and Administration Center, “Information Pamphlet for Officers of the United States Army Reserve,” 1, January 1975. By 1983, there were 81 IRR Army nurses participating in this program. Charles J. Reddy, “Nursing Newsletter Number 83-2,” 3, 1 November 1983, Office of Medical History, Army Nurse Corps Collection. Normally, IMAs trained in their active component assignment for at least 12 days a year. James H. Carter, “Mutual Support and Mobilization Preparedness: The Method of an Army Reserve Hospital,” *Military Medicine* 155 (August 1990): 379–81. Major Jones, “Reserve Components—AMEDD,” Information Paper, 12 November 1973, ANCC, OMH.

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40. Unidentified Author to Colonel McCarthy, “ROTC for Nurses,” Routing and Transmittal Slip, 26 June 1978, ANCC, OMH.

41. Brigadier General Parks retired in 1979 and by 1981 the new senior leadership supported the establishment of a nurse-specific summer camp.

42. These four sites were situated in Army hospitals at Fort Bragg, North Carolina, where

eight cadets were involved; Fort Knox, Kentucky, where seven cadets participated; Fort Riley, Kansas, where three cadets were assigned; and at Madigan Army Medical Center in Washington state, where six cadets took advantage of the program. Eugenia A. Vineys, "ROTC Alternative Advanced Camp," TD, 4, 17 February 1981, ANCC, OMH. Denise Boucher, "Experimental Advanced Camp," *The Cadet, Fort Bragg, North Carolina* 3 (2 July 1981): 1–2. Laura Elder, "Trial Nurse Program Conducted," *ROTC Leader, Ft. Knox, Kentucky* 7 (16 July 1981): 1. Jeff Behuniak, "Student Nurse Program in Full Swing," *Kaleidoscope, Ft. Riley, Kansas* 8 (8 July 1981): 1. Myrna Hall, "New ROTC Program Designed for Nurses," Unidentified Newspaper Clipping, n.d., ANCC, OMH.

43. Jeff Behuniak, "Student Nurse Program in Full Swing," *Kaleidoscope, Ft. Riley, Kansas* 8 (8 July 1981): 1. Eugenia A. Vineys, "ROTC Alternative Advanced Camp," TD, 1, 17 February 1981, ANCC, OMH.

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