

## *Chapter Five*

# Administrative Questions

A number of administrative questions arose during the 1970s. Although some were unprecedented concerns, others were age-old dilemmas that had been addressed in the past and recurred later in a climate of new and changing circumstances. Foremost among the administrative challenges were concerns that dealt with the augmentation of the Army Nurses Corps personnel strength; the quest for quality in the provision of health care; and the search for appropriate, comfortable, and appealing uniforms for Army nurses.

Despite predictions that the Army Nurse Corps would have no trouble in maintaining an adequate nurse force during the 1970s, shortages of nurses remained a pressing concern. The grim deficits resulted from at least two conditions. At first, the primary causal factor was the classic postwar retrenchment in resources following the Vietnam War. As the size of the standing Army was cut, the Army Medical Department (AMEDD) also was on the wane, and Army Nurse Corps authorizations correspondingly regressed.<sup>1</sup> Often these cuts seemed exorbitant and inexplicable. Although the active duty troop strength declined, its decrease was more than offset by the ever-increasing number of other beneficiaries. This population included additional family members linked to the all-volunteer army and the rising numbers of retired military personnel and their dependents, all of whom required health care.<sup>2</sup> At the same time, in-hospital care needs had become increasingly complicated, with more acutely ill patients and new technological modalities, thus requiring a higher professional nurse-to-patient ratio to provide adequate, safe care.<sup>3</sup> Also, after several years passed and the surgeon general increased the authorized strength, the Corps faced formidable challenges in its efforts to recruit sufficient applicants amid a national nurse shortage. Clearly, the Army Nurse Corps was in a tight spot.

Authorizations in the post-Vietnam War Army Nurse Corps steadily declined for several years. The authorized year-end strength was 4,752 in the early days of fiscal year (FY) 1972 but quickly plunged. For FY 1972 and FY 1973, year-end

strengths were 4,107 and 3,597, respectively.<sup>4</sup> The year-end quota was 3,830 for FY 1974.<sup>5</sup> The actual year-end strength for FY 1975 was 3,706.<sup>6</sup> For FY 1976, the Army Nurse Corps was allowed to fill only 3,510 authorizations. General Madelyn N. Parks reassured the Corps that she was “fighting” to obtain “some relief from this impossible ceiling.”<sup>7</sup> But the steady decline continued and the actual FY 1976 year-end strength remained at 3,510 as projected.<sup>8</sup> The trend began reversing in 1977 when the surgeon general authorized 98 additional slots “directly related to support of the new Walter Reed Army Medical Center.” This increase brought the Corps to a strength of 3,608, and Parks rightfully noted that year-end strength might be expanded further “as a result of making our manpower shortages widely known.”<sup>9</sup> By April 1977, the FY 1977 year-end strength rose to 3,710. Parks also predicted that the intense, painful summertime nursing shortfall—so typical in the past when the Corps would cut desperately needed active duty nurses to bring actual numbers into compliance with fiscal year-end strength limits—would not be repeated in the summer of 1977. Congress had shifted the beginning of the FY from 1 July to 1 October, which meant more nurses could be carried on the books for three months longer.<sup>10</sup> Authorized year-end strengths for FY 1978 and FY 1979 were 3,886 and 3,727 each.<sup>11</sup> The latter figure reached 3,759 by November 1979.<sup>12</sup> By FY 1980, the authorized year-end strength had partially recovered to 3,801 slots.<sup>13</sup>

Although illogical and baffling, the painful cuts imposed on the Army Nurse Corps in a decade when it was launching a major new program, the Army Nurse Clinician Program, and assuming even greater responsibilities probably were a part of an overall military force reduction. When a task force met in 1977 to assess the program’s past accomplishments and plan future directions, participants noted that between 1971 and 1977, the strength of the Army Nurse Corps had dropped from 4,495 to 3,608, a total loss of 887 slots. At the same time, the strength of the Medical Corps had “remained relatively constant.” When no physicians could be found or recruited to fill the empty general medical officer authorizations, the Medical Corps converted these billets into medical specialty or physician assistant spaces. Simultaneously, the “Medical Service Corps also remained at a relatively stable strength.”<sup>14</sup> This meant a shrinking Army Nurse Corps was assuming the responsibilities of other health care providers as well as its own when its own resources were steadily declining and the strengths of the other branches remained virtually unchanged. The inability of the Army Nurse Corps to defend against reductions in the face of power and politics probably played a large part in this conundrum.

The Army Nurse Corps implemented measures to bring actual numbers into compliance with the proposed drastic downsizing that occurred in the Army after the Vietnam War. One strategy was to curtail new accessions to the Corps.<sup>15</sup> By 1973, a “zero-procurement objective” was in effect. In other words, the Corps was recruiting almost no nurses, which produced an unwelcome consequence—“a 30% shortfall” in the Army Nurse Corps Contemporary Practice Program courses. Senior Army Nurse Corps leaders then predicted that under these conditions they

would “be forced to place less prepared nurses on independent duty, and quality,” consequently, would be jeopardized. This would cause “anger, frustration and apathy” among patients, nurses, and doctors. In the final analysis, patients, it was predicted, would become “the victims.”<sup>16</sup> The chief of the Corps, General Lillian Dunlap, anticipated the crisis and formally briefed the Surgeon General (TSG), Lieutenant General Hal Jennings, on its implications. When faced with the critical state of affairs, TSG initiated measures designed to increase Army Nurse Corps authorizations by 300 spaces. These authorizations were to be subsequently distributed to the field. The Army Nurse Corps designated 260 of these nurse clinician slots for the continental United States, 25 for the U.S. Army, Europe, and approximately 15 for the U.S. Army, Pacific. However, the recommendations for distribution of the 300 nurse clinician spaces were not included with the Budget Manpower Guidance that went forward to the Health Services Command (HSC).<sup>17</sup> Later in 1977, Colonel Edith Nuttall, assistant chief of the Army Nurse Corps, reiterated that the “300 never appeared as . . . ANC [Army Nurse Corps] spaces on manpower documents in the field in 1972.” Nuttall again attributed the failure to a “lack of specific guidance by OTSG [Office of The Surgeon General] in PBG [Program Budget Guidance].”<sup>18</sup> The entire episode probably was a slipup that inadvertently happened in a busy, complex time when many pressing concerns claimed the attention of Army Nurse Corps leaders. Subsequently, the phantom 300 slots were lost in the vast, confusing collection of manpower numbers and were dispersed elsewhere.<sup>19</sup>

In addition to curtailing new accessions, the Army Nurse Corps reluctantly implemented even more problematical measures to reduce numbers, knowing that these measures would be detrimental to esprit de corps. The Corps had no choice but to impose more stringent ceilings on all promotions.<sup>20</sup> As a result of the slower promotions and longer time in grade, the morale of many Army nurses suffered.

Furthermore, in FY 1972, the Army Nurse Corps released 579 officers from active service. In FY 1973, it forced another 404 officers to leave.<sup>21</sup> A change in Army policy dictated this reduction in forces. In November 1971, the Army, “in contrast to previous fiscal years,” made “established year-end strengths . . . mandatory.”<sup>22</sup> By FY 1976, the Department of the Army constrained the Army Nurse Corps to release “approximately 328 fine young officers.”<sup>23</sup> Many Army nurses affected by the reduction in forces left embittered, resolving never to recommend a career in the Army Nurse Corps to friends or associates. Many vowed never to return to the Army, swearing never again to respond in time of national need.

Another solution regularly proposed to deal with the Army’s inability to recruit new personnel for the Army Nurse Corps—albeit rarely implemented—involved converting additional existing military authorizations to civilian registered nurse billets. In FY 1974 and FY 1975, military installations were employing 2,447 and 2,221 civilian nurses, respectively.<sup>24</sup> On a recurring basis during the 1970s, civilian and military leaders and professionals suggested additional civilianization to increase numbers. The Army Nurse Corps regularly rejected the option because it hampered its flexibility to use nursing resources and hindered stabilizing



Colonel Edith Nuttall served as assistant chief of the Army Nurse Corps from 1974 to 1978. Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

assignment tours for Army nurses. Furthermore, the excessive employment of civilian nurses was thought to result in a chronic failure to fulfill teaching requirements and enforce discipline for enlisted corpsmen and patients.<sup>25</sup> Evidently, the leadership held the opinion that the authority vested in an Army Nurse Corps officer was a prerequisite for dealing with these responsibilities. It also was essentially impossible to convert the civilianized slots back to military billets when needs and circumstances changed in the future. Most recognized that civilianization was a flawed short-term fix with long-term ramifications.

In the immediate post-Vietnam period, Army Nurse Corps leaders were unwaveringly assured—albeit erroneously—that authorizations would not be reduced. Thus, with confidence in a stable future, the leaders focused on creative strategies to fill existing authorizations. One option posed was the Volunteer Army Student Nurse Program, a collegiate variation of the Army Student Nurse Program. Broached in 1971 but never implemented, the plan suggested offering three-year subsidies annually to 150 baccalaureate nursing students who had already completed one year in an approved university nursing program. The students would be reimbursed for tuition and certain expenses and receive the pay and allowances of an enlisted soldier. At the time, the Army Nurse Corps received more than 1,000 applications each year for the Walter Reed Army Institute of Nursing (WRAIN) program. Of these 1,000, only 170 potential WRAIN students were selected. Planners hypothesized that the balance of the remaining “outstanding applicants who could not be selected” for WRAIN would constitute a ready, motivated pool for the Volunteer Army Student Nurse Program.<sup>26</sup> The program demonstrated significant potential for not only supplementing Army Nurse Corps numbers but also for expanding the proportion of Army nurses with a baccalaureate degree. Sadly, it too fell victim to fiscal restraints.

A different perspective on the causes of the cyclically recurring shortages has affirmed that the deficits were not only supply shortages. The demands for nurses also burgeoned. In this regard, Joan E. Lynaugh reiterated the “lesson of the unintended outcome.” Although the creation and blossoming of the innovative practice realms of critical care and primary care nursing were strategies at least partially used in this era to “conserve” personnel resources, they had unintended consequences.<sup>27</sup> The unprecedented successes of the advanced practice movement within the Army filled the primary care provider void but also created a demand for more nurse practitioners. A 1973 report verified that there existed an “increasing number of requests by Army medical facility commanders for nurse clinicians in every specialty area.”<sup>28</sup> Additionally, the intensive care nurses “made it possible to deploy technology successfully and to try more vigorous treatments.” Finally “more progressive therapy made nurses even more in demand as well as more expert.”<sup>29</sup> Thus, the solutions generated a new demand and a new imbalance between requirements and resources. Regardless of whether a decreased supply or an increased demand or a combination was at fault, the reality was that there were too few nurses both in the civilian and the military workforces during the 1970s.<sup>30</sup>

As the decade progressed and the authorizations picture improved, a blend of both adverse and auspicious signs appeared. Finally, those who controlled manpower resources heard the persistent message of a critical need for more nurses. Attention shifted from a climate of tense, active conservation of personnel resources to a state of intense procurement. After several years spent dismissing those who wished to serve in the Army Nurse Corps, recruiters suddenly welcomed high-quality candidates and were pressed to find even more applicants who met its rigorous standards.

From a pessimistic vantage point, the Army had discontinued both the hugely successful Army Student Nurse Program and Registered Nurse Student Program in 1975, and WRAIN closed in 1978.<sup>31</sup> The Reserve Officers' Training Corps program for nurses and women, the only available subsidized program for attracting nurses to the Army, was in its infancy in the mid-1970s and not yet a significant source of new nurses. Therefore, the Army Nurse Corps had to refocus the burden for recruiting new accessions to finding and capturing the interest of graduate nurses with baccalaureate degrees, an onerous challenge.<sup>32</sup> In the main, direct commissions and—to a lesser extent—voluntary recalls of reservists filled the active duty rolls.<sup>33</sup> However, since not all reservists had a bachelor of science in nursing, a necessary requirement for active duty, the U.S. Army Reserve and Army National Guard did not represent a highly productive source for accessions.<sup>34</sup>

During the 1970s, yearly recruitment goals steadily declined from 325 in FY 1974, 100 in FY 1975, to a nadir of 80 in FY 1976. Only in 1976 was the recruiting goal achieved, with a 101 percent mission attainment. It also marked the beginning of a recovery period. In FY 1977, the recruiting mission was 414 and in FY 1978 through FY 1980 the mission goals were 920, 500, and 468, respectively.<sup>35</sup> To help meet the enormous FY 1978 mission of 920 accessions, the Corps decided to offer qualified reservists, those with a bachelor of science in nursing and at least 24 months of prior active duty, the option to return to active duty for a period of 12, 18, or 24 months.<sup>36</sup> Similar reserve recall opportunities surfaced in later years.<sup>37</sup> However, such recruiting strategies were tantamount to robbing Peter to pay Paul. The active component, U.S. Army Reserve, and Army National Guard numbers all were equally dismal. Appropriation of nurses from the reserve components to augment the active component profited the latter but seriously constrained the former. Recruitment of officers for the U.S. Army Reserve was an even greater challenge because, in FY 1976 for instance, there was a “shortfall of over 800 Army Nurse Corps officers in . . . Reserve Units.”<sup>38</sup>

With limited recruiting prospects in 1975, the U.S. Army Recruiting Command (USAREC) proposed to transfer Army Nurse Corps recruiting responsibilities from USAREC to OTSG, which recruited most other branches of the AMEDD.<sup>39</sup> The Army Nurse Corps did not favor the move from the USAREC to OTSG because it never got its “fair share of [procurement] support from OTSG.” Nor did the Army Nurse Corps think OTSG accorded it with equitable funding. At USAREC, the Army Nurse Corps concluded that it received a fair “share of dollars and resources.”<sup>40</sup> Ultimately, the Army Medical Department Personnel Support

Agency rejected the USAREC proposal because of insufficient personnel, funds, and logistical elements for OTSG to assume the added task of procuring Army Nurse Corps officers.<sup>41</sup>

A number of factors ultimately combined to improve the overall numbers of the Army Nurse Corps. Among these was the retention of pregnant women on active duty after 1975.<sup>42</sup> This decision expanded the pool of nurses readily available. Furthermore, after 1975 no new accessions were accepted in the Army Student Nurse Program, and after 1978, WRAIN ceased operation. Although these two decisions were primarily based on fiscal considerations, they had secondary effects. The personnel slots previously occupied by those attending school in these programs became available to the Army Nurse Corps and thereafter were filled by nurses on duty in Army facilities.<sup>43</sup> A number of military treatment facilities also closed permanently, freeing more nurses for assignments elsewhere. For example, in 1974, the hospital at Fort Wolters, Texas, and the Valley Forge General Hospital in Phoenixville, Pennsylvania, ceased operations.<sup>44</sup> In 1977, the Army transferred responsibility for staffing the health care facilities in Okinawa to the U.S. Navy.<sup>45</sup> That same year HSC began the reduction of the U.S. Army Medical Department Activities (MEDDAC) at Carlisle Barracks, Pennsylvania, into a U.S. Army Health Clinic. It also modified the status of the MEDDACs at Aberdeen Proving Ground, Maryland; Fort Benjamin Harrison, Indiana; and Fort McPherson, Georgia, into U.S. Army Health Clinics.<sup>46</sup> These closures somewhat reduced the demands imposed on the overworked and understaffed Army Nurse Corps.

Meeting the recruitment mission during the 1970s was difficult. The requirement specifying that all active component Army Nurse Corps officers have earned a baccalaureate degree in nursing from a program accredited either by the National League for Nursing or the secretary of education was strictly enforced and effectively decreased the available applicants for commissioning. In 1972, 80.5 percent of all employed registered nurses had *less* than a baccalaureate degree in the United States. Only 12.1 percent of working nurses had a baccalaureate degree. Those with credentials higher than a baccalaureate degree represented 3.4 percent of the national nurse workforce. Thus, the Army Nurse Corps was able to recruit from only 15.5 percent of the marketplace.<sup>47</sup> By 1974, those numbers improved slightly. Approximately 15.2 percent of employed registered nurses held a bachelor's degree in nursing, while about 3.3 percent had earned a master's degree or higher.<sup>48</sup> The Army Nurse Corps then had a somewhat expanded recruiting pool, roughly 18.5 percent of the available population of employed registered nurses. From 1977 to 1978, 18.1 percent of the registered nurse population had a baccalaureate degree and 4.0 percent claimed a master's or a doctoral degree. At this point, the pool of eligible applicants for a commission in the Army Nurse Corps had risen to a significantly improved 22.1 percent of all employed registered nurses.<sup>49</sup> Civilian health care organizations faced similar challenges but were able to hire those registered nurses with less than a bachelor's degree and could offer a few enticements that the Army Nurse Corps could not match.<sup>50</sup> In 1976, a second lieutenant's salary was \$839.70 and a first lieutenant's monthly

base pay was \$973.80. The Army also paid housing and subsistence allowances. Starting salaries in civilian institutions ranged from \$800 to \$1,075 monthly. Civilian hospitals also variously offered “fully paid comprehensive health insurance, 3 weeks vacation, . . . tuition reimbursement, . . . shift differentials, time and a half for overtime, ten paid holidays and/or travel and moving allowances.”<sup>51</sup> The Army’s benefits were almost comparable to those offered by civilian institutions. The major difference was the extra pay awarded by civilian hospitals for working undesirable shifts (usually evening and nights) and overtime. After the FY 1976 low was reached and long-standing educational subsidies were discontinued, the Army Nurse Corps faced a perplexing dilemma about how best to encourage future accessions. Soon thereafter, the Nursing Reserve Officers’ Training Corps program emerged as the ideal answer.

Concerns about adequate numbers of nurses persisted throughout the 1970s. These worries about quantity soon were complicated by questions about the quality of nursing care.<sup>52</sup> After the Vietnam War, the AMEDD faced major personnel and budget cuts, rapidly escalating expenses, and a deteriorating reputation. Many beneficiaries perceived the AMEDD as an inept institution that was difficult to access, inadequately staffed, poorly equipped, and usually providing only minimally acceptable care.<sup>53</sup>

During this challenging time, Army Nurse Corps officers tested and implemented various strategies and nursing care delivery models to improve the quality of care. A task force initiated a preliminary study to identify what nurses were doing, what factors had an impact on “maximum utilization” of nurses, and what nurses ideally should be doing to meet patient care needs. This investigation examined 10 components: (1) staffing ratios, (2) workload distributions, (3) absentee rates, (4) nursing activities, (5) tasking time, (6) personnel trade-off time, (7) escort services, (8) personnel turbulence, (9) patient acuity, and (10) the ratio of nursing care hours to patient care requirements. Among their findings, investigators discovered that nurses “filled the gap between the patient or his environment and the centralized areas of resources.” Study results also indicated that excessive non-nursing demands prevented “nursing personnel from accomplishing their primary mission of patient care.” Administrative tasks, for example, consumed about 40 percent of nurses’ time and detracted from quality service.

Although these studies were being conducted, nurses in U.S. Army Medical Centers and U.S. Army Medical Department Activities were planning and subsequently implementing additional efforts to monitor quality of care. These undertakings involved establishing requirements that directed caretakers involved in unusual occurrences such as patient falls or medication errors to complete a written report, initiate active and retrospective audits of nursing documentation, and carry out patient and staff satisfaction questionnaires. One outcome of all these efforts was the development of the Pri-Team concept.<sup>54</sup>

Previously, patient care services were delivered in the case, the functional, or the team method of staff assignment, or in a combination of several such nursing delivery models.<sup>55</sup> The intent of the newly conceived Pri-Team delivery model

was to focus “authority, responsibility, and accountability at the operational level,” to capitalize on available resources, and to create “a holistic and unified approach to patient care.”<sup>56</sup> Pri-Team involved having one professional nurse responsible for the patient’s care from admission to discharge. However, a team of caregivers provided the nursing care for the patient, which involved the nursing process of “assessing, planning, implementing, and evaluating the nursing care of a group of patients.”<sup>57</sup> The Pri-Team consisted of a clinical coordinator accountable for quality, supervision, and coordination of patient care activities; a senior clinical nurse tasked with monitoring total nursing activities; the Pri-Team leader responsible for delivering nursing care for a specific group of patients; the clinical nurse who offered direct patient care and clinical support for paraprofessional nursing staff; the clinical specialist (91C), or licensed practical nurse; and the ward specialist (91B), or nursing assistant. An associate team cared for the patient when the patient’s Pri-Team was off duty. Among all members of the team, the patients themselves were spotlighted as the most important component.<sup>58</sup> Planners pilot-tested the system at the Walter Reed Army Medical Center and the Dwight David Eisenhower Army Medical Center.<sup>59</sup> Those who initially evaluated Pri-Team reported that the various care providers and support personnel could “be made complementary to each other.” In their opinion, Pri-Team had the potential to utilize staff more efficiently, better define roles and responsibilities, enhance personalization of patient care, and improve personnel performance.<sup>60</sup> As it moved into a new, more modern facility in 1978, the Walter Reed Army Medical Center concurrently implemented this delivery model.<sup>61</sup> Lieutenant Colonel Mary Messerschmidt served on a female medical ward at the new Walter Reed Army Medical Center when the Department of Nursing implemented Pri-Team. She noticed a “180° turn” for the better in the quality of care provided within the framework of this new model.<sup>62</sup>

The AMEDD implemented another innovation, the Hospital Unit Dose Drug Distribution System (HUDS), to improve quality of care. Both the civilian health care environment and Letterman Army Medical Center pilot tested HUDS with positive results. This led the Government Accountability Office and the U.S. Army Audit Agency to recommend it for implementation in virtually all Army hospitals. Before the 1970s, most nursing units maintained a bulk supply of medications on the ward in a locked medicine cabinet. When a physician ordered a drug, the nurse filled in a small medication card with details such as patient’s name, bed number, drug, dosage, and route and times of administration. At the time specified on the card for the drug’s administration, the nurse selected the preparation from the bulk supply, placed it in a medication cup, and administered it to the patient. With HUDS, the central hospital pharmacy prepared and delivered the medication in a “packaged, labeled and ready-to-administer form.” Proponents thought that such a system would decrease medication errors, improve patient safety, and increase staff productivity. Advocates also predicted that the system would control theft and abuse of medications, an important consideration in an era when drug abuse was rampant.<sup>63</sup> HUDS grew to be the standard for medication administration in all health care facilities, both military and civilian.

For many years, the Army Nurse Corps worked on developing, publishing, and implementing its own distinctive, comprehensive Standards of Nursing Practice in another effort to improve quality. The intent of this credo was to establish basic guidelines for professional nursing practice in the Army in accordance with the nursing profession's responsibility "to assess, provide, evaluate, and improve nursing practice." The standards set the stage for the introduction of a quality assurance program for the Army Nurse Corps.<sup>64</sup> They also served as a "yardstick" by which the Corps evaluated its professional commitment in terms of safety and competence in areas such as "licensure, certification, accreditation, quality assurance, peer review, and . . . policy."<sup>65</sup> The Army Nurse Corps published the first draft of the standards in 1979, and then it evaluated, revised, and implemented the standards in every Army hospital and—in due course—published them in pamphlet form in 1981.<sup>66</sup>

The Physician-in-Charge (PIC) Program was an undertaking addressing quality of care. Colonel Robert J.T. Joy, an Army physician, originally conceived the idea at the request of Surgeon General Richard Taylor, who was concerned that "young MC [Medical Corps] officers had no training or practice in leadership or administration" and virtually no preparation for future command roles. Joy recommended that the PIC plan be cautiously pilot-tested on a limited, experimental basis at one Class I hospital such as the U.S. Army Medical Department Activities at Fort Benning, Georgia, or Fort Bragg, North Carolina.<sup>67</sup>

The PIC Program sought to return the Medical Corps officer to greater involvement with "ward administrative and property accountability activities" after a hiatus of some 30 years. There had been few or no Medical Corps officers implementing the ward officer role since the days of post-World War II Army medicine.<sup>68</sup> The model's intent was to strengthen "the authority and influence of Medical Corps officers . . . at the ward and clinic level." An additional aim was "to improve patient care and professional satisfaction, and to ensure that the ethical, moral and legal implications of the practice of medicine" were achieved to "the fullest extent."

In March 1974, TSG instructed the HSC commander, Major General Spurgeon Neel, to put PIC into practice.<sup>69</sup> Neel then delegated the responsibility for initiation of a six-month evaluation trial of PIC to the HSC chief of staff, Brigadier General Philip A. Deffer. In May 1974, Deffer handpicked six military treatment facilities to serve as sites for an initial evaluation phase of the PIC Program and directed these installations to develop comprehensive implementation plans.<sup>70</sup> The staff at Brooke Army Medical Center fleshed out a road map intended "to assist [the] PIC in asserting his leadership role." It detailed specific responsibilities for the PIC, some of which seemed reasonable and advantageous and others that appeared to intrude on the domains of independent nursing practice. Among these were meeting "daily with head nurse to discuss ward/clinic activities," reviewing "nursing care plans with head nurse once a week," acting "as control or regulator for limiting patient census when staffing requirements cannot be met," auditing the "medical record/nursing record on an ongoing basis," reviewing and approv-

ing “all work orders and supply requisitions pertaining to his ward/clinic,” and “assisting in the orientation of all new staff members on ward/clinic. He [the PIC] will set the standards of care.”<sup>71</sup> Another aspect of the program designated the PIC as the officer efficiency report rater of the head nurse with the endorsement section to be completed by nursing superiors. This changed the rating chain for the clinical head nurse’s officer efficiency report, the duty performance appraisal.<sup>72</sup>

The introduction of the PIC proposal came when American women were increasingly rejecting sexism, subjugation, and paternalism. It also coincided with widespread attempts by American nurses to gain greater autonomy and control over their unique professional practice. The nation’s professional nurses also were attempting to identify the exclusive domains of nursing.<sup>73</sup> For these reasons, the reaction of the majority of Army Nurse Corps officers to the PIC Program was overwhelmingly one of “indignation, frustration and betrayal.” On the positive side of the ledger, a few agreed that the notion “of having a primary physician in each nursing unit . . . for health care planning and for . . . leadership [was] an appealing one,” and they also acknowledged that “the PIC *could* produce very real improvement in the quality and depth of care.” But, most Army nurses believed “that the PIC would . . . evaluate the performance of the head nurse against a single criterion—how well and how directly does the nurse respond to his medical orders and his wishes.” Finally, a large segment of Army Nurse Corps officers

. . . remarked that they truly believe . . . the motivation of today’s physician. . . is solely toward medical care of his patient, accomplished in a disease-centered care orientation. These nurses believe the physician cannot and should not be burdened with ward management, logistic problems, personnel and training problems, coordination of support services and the myriad of other activities of the nursing unit. (The Army physician now complains of paperwork and the pressure of time—one has but to review. . . the declining quality of physicians’ progress notes in clinical records to clearly perceive the pressures already placed on him resulting in his slighting even clinically—essential, administrative records.)<sup>74</sup>

One of the most promising senior leaders of the Corps of that era, Colonel Doris S. Frazier, collated the points summarized above. She wrote the preceding letter, observing that the PIC Program disregarded precepts of effective organizational leadership, would fragment professional and military authority, and would “hopelessly burden” the PIC “with despised, non-clinical paper work.” Frazier predicted that PIC would “result in duplication of effort” and would cripple “the Department of Nursing as a viable force in AMEDD hospitals.” Finally, she prophetically observed that PIC would “force out of the Army Nurse Corps its best administrators . . . [and] its most highly skilled and empathetic clinical practitioners as well.” Frazier concluded that professional “nurses will not remain where they are not permitted to think or to control nursing practice and nursing personnel.”<sup>75</sup>

Frazier shared the letter’s contents with several Army Nurse Corps officers, who subsequently “leaked” it to the American Nurses Association at its convention in San Francisco, California, in June 1974. ANA members were outraged by the PIC concept and, in response, resolved to prevent its implementation. Accordingly, American Nurses Association members sent letters of protest to TSG and

to Dunlap expressing their disapproval and displeasure concerning the notion of physicians encroaching on nursing's turf.<sup>76</sup>

The Army viewed this whole debacle as a violation of an unwritten but cardinal rule proscribing the airing of any internal AMEDD business outside the institution. Subsequently, Frazier saw her career truncated, regardless of her significant past contributions and seemingly exceptional potential.<sup>77</sup> Known for her perception and integrity, she courageously voiced her convictions and paid the penultimate price. Sadly, hers was the regrettable fate of rejection that commonly awaits those who take a brave stand on a sensitive public issue.

Although skeptical about the wisdom and viability of PIC, Dunlap was in the awkward and conflicted position of needing to demonstrate loyalty to the vision of her immediate superior, the surgeon general, and her allegiance to the Corps. Accordingly, she did not take a strong stand on the matter. Instead, Dunlap chose an approach marked by an openness to try and test the program and allow it to sink or swim on its own merits. The final word on PIC ultimately belonged to Dunlap. She wrote that "over a period of time, the whole project withered on the vine."<sup>78</sup>

The Army Nurse Corps has invested intense interest and copious time and attention on the subject of women's uniforms throughout its history.<sup>79</sup> This issue has numerous roots. Critics pointed to the Army Nurse Corps all-female past and the questionable notion that women display an inordinate focus on clothes. However, male uniforms also have changed. Others ascribe the fascination to the fact that women in the military had an ever-present need to be comfortable, project an attractive image, and appear professional. Another consideration was recruiting, that is, presenting an appealing role model for potential Army nurses. Whenever worries about nursing shortages were paramount, leaders in the Army Nurse Corps quickly recognized that the quality, styles, and colors of uniforms influenced the recruiting mission's success. Attractive uniforms were a major selling point. In the 1970s, with the pervasive and acute nursing shortage, uniform issues became even more important.

Many uniform changes—some subtle, some conspicuous—emerged in the 1970s and affected the Army Nurse Corps. In 1972, regulations authorized Army women to wear patent leather shoes with their Class A uniforms and to carry and use black umbrellas when in uniform.<sup>80</sup> That same year, the Army allowed women in the Army to wear a prescribed white shirt with a black tab centered under the rounded collar along with the Army green uniform as a replacement for the similarly styled tan shirt. Army Regulation 670-30 authorized the wearing of a white neck scarf year-round under the uniform topcoat. It also set the standard for uniform gloves, permitting the wearing of white gloves for summer and gray-beige gloves for other seasons. A regulation change phased out the gray-beige gloves by the end of 1975. By 1977, uniform regulations authorized a black raincoat of "London Fog" style for purchase by both men and women from commercial retailers. It was to be worn in place of the Army green raincoat or double-breasted Army green overcoat with a zip-out liner as an outer garment.<sup>81</sup>

By 1974, the Army added more refinements to the wearing of the uniform. The

chief of the Army Nurse Corps directed that in most instances the handbag should be carried over the arm rather than the shoulder. Moreover, the Army Nurse Corps leadership cautioned women Army nurses to tailor their uniform skirts in accordance with standards of good taste and informed them that an acceptable skirt length was no shorter than two inches above or no longer than one inch below the middle of the knee. Regulations also authorized plain black civilian mid-calf boots for wear with the uniform in inclement weather.<sup>82</sup>

In 1974, the Department of the Army initiated a far-reaching study of Army women's uniforms. As a part of the study process, the Army Natick Research and Development Command asked the Women's Uniform Board to study the options and recommend uniforms for women. Members of this board included both the director of the Women's Army Corps and the chief of the Army Nurse Corps, two women with divergent needs and preferences. By December 1976, the study group had surveyed female troops, solicited ideas from civilian dress designers and manufacturers, and carried out a historical review of women's uniforms. They recommended adoption of a "year-round uniform . . . to make men and women look like soldiers of one Army, without sacrificing the femininity of the women; and to use . . . versatile components, such as shirts, slacks, and skirts."<sup>83</sup>

The black beret for Army women made its debut in the clothing line in 1973, several years before the completion of the large-scale study. Its appearance was accompanied by extensive controversy. The director of the Women's Army Corps, Brigadier General Inez Bailey, an acknowledged fashion plate, promoted the semi-rigid, formed black felt hat. Her Army Nurse Corps counterpart, Dunlap, however, found the beret to be "terrible." Dunlap recalled that it was "plopped every which way" on women's heads and in no way "was complimentary to the rest of the uniform." Dunlap found it politically expedient to accept the black beret because "when you have two people . . . representing two different views, you can't have women fighting women. That's what the men love." The laws for social interactions varied depending on gender. Although it seemingly was unladylke for women to actively disagree or strenuously air conflicting views, it was not unusual for men to differ passionately and insist on the primacy of their ideas. Dunlap ultimately agreed to the adoption of the black beret, but initially restricted its wear to the green cord or hospital white duty uniforms, not the green Class A uniform.<sup>84</sup> At that time, the latter was to be worn only with the traditional visor cap.<sup>85</sup> Bowing to pressure by 1975, the chief of the Corps approved the black beret for wear with the Army green uniform "on informal occasions," such as when traveling. Essentially, the Army perceived the black beret as a replacement for the garrison or overseas cap.<sup>86</sup> General, across-the-board discontent with the black beret led to the trial of another felt Class A hat in 1975. Efforts at testing soon were abandoned because, as Parks said, "We thought it looked like the 'Keystone Cops' hat—tall, domed crown and a narrow brim! It was awful!"<sup>87</sup>

Another ill-advised uniform item that had a short life was the mint green outfit, officially known as the "Women's Summer Uniform, Warp Knit." It replaced the green-and-white cord uniform—a summer-weight, short-sleeved, two-piece skirt

and top set—that was comfortable and cool but easily wrinkled. The green-and-white cord's replacement uniform soon became known as the Jolly Green Giant outfit. Its mint green polyester fabric construction and various mix-and-match options such as a dress, jacket, skirt, long-sleeved and short-sleeved blouses, and a vest became available in the summer of 1977.<sup>88</sup>

Also during 1977, the Army wear tested a durable press fatigue (utility) uniform for women similar to the men's version.<sup>89</sup> It was intended to replace the Vietnam era women's fatigue uniform and was part of a larger movement toward a combined male/female uniform. However, the Army cancelled plans to authorize the women's adaptation in 1979 because of other far-reaching plans. Instead, the Army announced it would design a new combat, camouflage, utility uniform, or what would become the battle dress uniform. In the meantime, the quartermaster expanded the available sizes of the men's durable press fatigue uniform to fit the smaller dimensions needed by many women. The Army then instructed female servicemembers to wear the unisex durable press utility uniform in the field until the battle dress uniform was available.<sup>90</sup>

The women's Army green pantsuit was a comfortable, practical, and welcome addition to the clothing bag in 1976. Planners intended it initially as a Class B uniform for such duties that involved air travel or assignments in Table of Organization and Equipment or field units. The uniform was a loosely fitted long-sleeved jacket and pants of 100 percent polyester. It was to be worn either with a light green knit turtleneck overblouse or a white woven shirt with black neck tab. The Women's Uniform Board approved it for year-round wear.<sup>91</sup>

During the 1970s, the Army Nurse Corps female white duty uniform also changed. The heavily starched white cotton long-sleeved dress, which was replaced by a short-sleeved version and later a synthetic and then a cotton-synthetic-mix short-sleeved dress, subsequently became a polyester short-sleeved pantsuit. The wearing of trousers by women had by then become accepted—indeed, it was an international fashion trend that was both modest and practical. Nonetheless, Dunlap was reluctant to adopt the duty pantsuit. When forced by the majority opinion to do so, Admiral Alene Duerk, director of the Navy Nurse Corps, advised her not to “adopt one that opens in the front because no matter how many regulations you write, you will have a lot of Brigitte Bardots on your staff who will want to open it at the top button.” After a small-scale trial of the Navy's pantsuit proved successful, the Army Nurse Corps subsequently adopted the polyester pantsuit with a high neck and back zipper. The Army restricted the wear of the white pantsuit, a duty uniform, to the patient care duty site only.<sup>92</sup>

The white hospital duty uniform worn by male Army Nurse Corps officers had only one major change from the time when men were first authorized commissions in the Corps in 1955 up to the present. Originally, male Army nurses wore a high-necked, heavily starched, cotton uniform top that had cloth knots as buttons across the shoulder and up the collar. Lieutenant John T. Pack found this uniform extremely irritating because the stiff “collar often ended up chaffing your neck so you had to soften it with a bar of soap on the inside.”<sup>93</sup> Captain Eugene Cudnohuf-

sky experienced comparable problems with the uniform. He was allergic to the brass that was pinned to the collar in direct contact with the skin of the neck. The brass “would turn [his] neck green and [he] would break out in horrible sores.”<sup>94</sup> The collar had a notch centered at the middle of the throat. The men positioned insignia denoting rank and the Army Nurse Corps caduceus on the collar on either side of the notch. Males wore the smock with white cotton drill pants. After 1968, regulations mandated the replacement of the uncomfortable high-necked smock with a more professional look, a white cotton open-necked shirt that buttoned up the front.<sup>95</sup>

By 1972, the women’s white duty uniform could also be worn with a green acrylic sweater.<sup>96</sup> At that same time, the Army Nurse Corps was searching for a suitable sweater for male Army nurses to wear on clinical duty. It proved a challenge to find one that looked professional and fit appropriately over the male nurses’ smock that was worn loose over the waist.<sup>97</sup> By 1974, regulations allowed men to wear a white cardigan with their hospital duty uniform when cold weather dictated warmer clothing.<sup>98</sup> In 1975, regulations authorized a green acrylic cardigan sweater for wear by male Army Nurse Corps officers.<sup>99</sup> However, few male Army nurses wore this sweater.

Another change in the duty uniform occurred in the 1970s with the evolution of the white starched nurse’s cap worn by Army Nurse Corps female officers in the clinical setting. This original headpiece, whose shape was maintained with a white shoelace, was secured to the nurse’s head with a bobby pin. In 1972, a button-backed cap replaced the older laced version.<sup>100</sup> As time passed, its wear while on duty became optional. Many civilian nurses were no longer wearing nursing caps with their uniforms, and many civilian collegiate schools of nursing no longer claimed a distinctly styled cap for their individual schools.<sup>101</sup> As a practical matter, with technology moving to the bedside with its attendant bulky equipment such as multiple monitors, ventilators, drainage systems, and infusion pumps, there simply was not enough room to navigate with a cap-covered head. Moreover, the increasing numbers of male nurses in the ranks likely influenced a merging of all nurses’ outward physical appearance regardless of gender. In the final analysis, the lines separating nursing practice from medical practice were blurring to some degree. Nurses were undertaking many responsibilities formerly considered the exclusive domain of physicians. As the old demarcations became more obscured, female nurses began to don their traditional starched white garb less frequently. Gradually, the distinctive nurse’s cap of the Army Nurse Corps became optional and, with time, disappeared.

Another uniform transformation involved the placement of insignia on the uniform. Previously, female Army Nurse Corps officers had positioned their insignia on the Army green cord, the mint green, and the hospital duty uniforms in a distinctive manner. The rank was pinned on the center of the right collar and positioned perpendicular to the floor. The branch insignia was centered in the same position on the left collar.<sup>102</sup> Army officials questioned this style of brass placement—unique to the Army Nurse Corps—in 1978. At that time, the chief



Crisply starched uniforms and Army Nurse Corps caps were the uniform of the day when Lieutenant Colonel Rita Geis (left) promoted First Lieutenant John T. Pack (far right) to captain at the 106th General Hospital in Kishine Barracks, Yokohama, Japan, in the summer of 1967. Photo courtesy of Major John T. Pack, Fairfield, OH.

of staff of the Army directed the Army Nurse Corps members to reposition their insignia consistent with the rest of the Army—that is, with the insignia positioned parallel with the floor. With characteristic candor, Parks wrote:

General Rogers, Chief of Staff, has made the decision on how we (all women officers) will wear our brass on the *summer dress and suit* and the white hospital *dress and pantsuit*. An effective date will be announced later for these changes. Then we will all be wearing our brass like the “WAC’s” do now. I fought against this change for 18 months. I lost when the Chief of Staff made his decision.<sup>103</sup>

The nuances in Parks’ comments expressed her distress at being forced to implement the new order. It was difficult to dictate such a change to an enduring custom that was long grounded in tradition. The uniform, however, was intended to unify and make all service personnel appear homogeneous. That likely was the rationale for the imposition of the unwelcome change to the Army Nurse Corps insignia placement.

Once regulations allowed pregnant women to remain in service, questions arose about appropriate pregnancy uniforms. A Department of the Army message published in 1975 directed pregnant Army Nurse Corps officers to purchase and wear white commercial maternity dresses or pantsuits as hospital duty uniforms. If the pregnant officer’s duty assignment took her away from the AMEDD military treatment facility, such as for a temporary duty assignment, any commercial maternity outfit, “color and style unspecified,” was to be worn. The civilian maternity garment was to have no insignia attached. Only a name tag was allowed; it was to include the rank, last name, and the pregnant service member’s full, unabbreviated Corps (presumably “Army Nurse Corps” but not “ANC”). These uniforms were expected to be “in good taste” and were to be “approved by the commander.” The nurses had to pay for these uniforms.<sup>104</sup>

Change seemed to be among the few constants in the Army Nurse Corps uniform picture in the 1970s. However, more changes loomed on the horizon.

## Notes

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1975 (Washington, DC: Office of the Surgeon General, U.S. Army, 1975), 60.

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9. Madelyn N. Parks, "Information for All ANC Officers," 2, 19 August 1976, ANCC, OMH.

10. Madelyn N. Parks, "Information for All ANC Officers," 1, 29 April 1977, ANCC, OMH.

11. Madelyn N. Parks, "Information for All ANC Officers," 2, 27 March 1978; Madelyn N. Parks, "Information for All ANC Officers," 2, 29 January 1979; and Madelyn N. Parks, "Information for All ANC Officers," 1, 14 August 1979 (all in ANCC, OMH).

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13. *Report of the Surgeon General United States Army Fiscal Years 1976-1980* (Washington, DC: Office of the Surgeon General, Department of the Army, 1988), 39.

14. Madelyn N. Parks, "Recommendations of the Working Conference for Nurse Clinicians," Disposition Form, Inclosure 4, 18-19, 9 March 1977, ANCC, OMH.

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18. Edith M. Nuttall, "AMEDD Health Care Extenders," Memorandum for the Record, 1-2, 19 May 1977, ANCC, OMH.

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70. The six test sites were Brooke and Letterman Army Medical Centers and Martin, Cutler, Raymond Bliss, and Womack Army Hospitals. Philip A. Deffer to Commanders, HSC Installations and Activities, TL, 2 May 1974, ANCC, OMH.

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74. Doris S. Frazier to Lillian Dunlap, TL, 29 May 1974, ANCC, OMH.

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76. "New Resolution Rejects Physician-in-Charge," *Convention Journal* (11 June 1974): n.p., Newspaper Clipping; and Frazier to Author, E-mail Correspondence, 21 January 2002 (both in ANCC, OMH).

77. Many acknowledged that Frazier was the foremost candidate to become General Lillian Dunlap's successor as chief of the Army Nurse Corps. Most believed that this incident curtailed her career and forced her into an early retirement. Frazier to Author, E-mail Correspondence, 5 February 2002, ANCC, OMH.

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80. Men in the Army were and are not allowed to use umbrellas while in uniform.

81. "New Beret in the Future for Women?" *Medcom Examiner* (May 10, 1973): 3. Lillian Dunlap, "Uniforms," *U.S. Army Medical Department Newsletter* 3 (Fall 1972): 23–24; Rose V. Straley, "Questions Pertaining to Uniform," 21 May 1974, in Barbara R. Costello for Virginia L. Brown, "Nursing Information Letter 3-74"; Edith M. Nuttall, "Information on Uniforms," in Madelyn N. Parks, "Information for Key ANC Officers," 24 September 1975; and Marjorie J. Wilson, "Nursing Information Letter 1-77," 3, 1 April 1977 (all in ANCC, OMH). Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 304.

82. Rose V. Straley, "Questions Pertaining to Uniform," 21 May 1974, in Barbara R. Costello for Virginia L. Brown, "Nursing Information Letter 3-74"; and Edith M. Nuttall, "Information on Uniforms," in Madelyn N. Parks, "Information for Key ANC Officers," 24 September 1975 (both in ANCC, OMH).

83. "Women in the Army and Sexual Harassment, Historical Milestones," TD, 5, n.d., ANCC, OMH.

84. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 225–26.

85. Rose V. Straley, "Questions Pertaining to Uniform," 21 May 1974, in Barbara R. Costello for Virginia L. Brown, "Nursing Information Letter 3-74," ANCC, OMH.

86. Edith M. Nuttall, "Information on Uniforms," in Madelyn N. Parks, "Information for Key ANC Officers," 24 September 1975, ANCC, OMH.

87. Madelyn N. Parks, "Information for Key ANC Officers," 1, 24 September 1975, ANCC, OMH.

88. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps,

2001), 226–27, 304. Edith M. Nuttall, “Information on Uniforms,” in Madelyn N. Parks, “Information for Key ANC Officers,” 24 September 1975; and “Wear Policy for the Army Green Pantsuit,” DA-TWX Message 181518Z, November 1976, in Madelyn N. Parks, “Information for All ANC Officers,” December 1976 (both in ANCC, OMH).

89. “Status of Women’s Uniform Items,” 11 April 1977, Inclosure 13, in Madelyn N. Parks, “Information for All ANC Officers,” 29 April 1977, ANCC, OMH.

90. Patrick R. Lowrey for W.F. Ulmer, “OG 507, Durable-Press, Utility (Fatigue) Uniform for Female Soldiers,” 10 January 1979, Inclosure 5, in Madelyn N. Park, “Information for Key ANC Officers,” 3, 16 March 1976, ANCC, OMH.

91. Edith M. Nuttall, “Information on Uniforms,” in Madelyn N. Parks, “Information for Key ANC Officers,” 24 September 1975; “Wear Policy for the Army Green Pantsuit,” DA Message, June 1976, in “Nursing Information Letter, 2-76,” 8 July 1976; and “Status of Women’s Uniform Items,” 11 April 1977, Inclosure 13, in Madelyn N. Parks, “Information for Key ANC Officers,” 29 April 1977 (all in ANCC, OMH).

92. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 227–28. Virginia L. Brown, “Newsletter to All CONUS Chief Nurses,” 2, 4 March 1974, ANCC, OMH.

93. John T. Pack to Author, E-mail Correspondence, 13 December 2002, ANCC, OMH.

94. Eugene Cudnohufsky to Author, E-mail Correspondence, 14 December 2002, ANCC, OMH.

95. Unidentified Chronology of Uniforms, n.d., ANCC, OMH.

96. While acknowledging the need for a sweater for use in cool duty environments, many nurses had reservations about its wear. Some considered the green sweater as a source for transmitting infections from patient to patient in the clinical setting. The white duty uniform was to be changed daily and washed between wearings. But the green sweater, while washable, clearly was not laundered daily. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 255–56. In 1974, Army nurses were cautioned that sweaters were “not to be worn with the white uniform when photographs are taken for publicity purposes.” Virginia L. Brown, “Newsletter to All CONUS Chief Nurses,” 2, 4 March 1974, ANCC, OMH. It was a functional but not very attractive uniform component.

97. Lillian Dunlap, “Uniforms,” *U.S. Army Medical Department Newsletter* 3 (Winter 1972): 29, ANCC, OMH.

98. Rose V. Straley, “Questions Pertaining to Uniform,” 21 May 1974, in Barbara R. Costello for Virginia L. Brown, “Nursing Information Letter 3-74,” ANCC, OMH.

99. Edith M. Nuttall, “Information on Uniforms,” in Madelyn N. Parks, “Information for Key ANC Officers,” 24 September 1975, ANCC, OMH.

100. Lillian Dunlap, “Uniforms,” *U.S. Army Medical Department Newsletter* 3 (Winter 1972): 29; and Lillian Dunlap, “Uniform Items,” *U.S. Army Medical Department Newsletter* 3 (Spring 1972): 27 (both in ANCC, OMH).

101. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 228.

102. Madelyn N. Park, “Information for Key ANC Officers,” 3, 16 March 1976, ANCC, OMH.

103. Madelyn N. Park, “Information for All ANC Officers,” 1, 18 October 1978, ANCC, OMH.

104. “Authorization of Appropriate Maternity Uniforms for Army Pregnant Female Personnel-Officers and Enlisted,” n.d., Inclosure 9, in Virginia L. Brown, “Nursing Information Letter 1-75,” 7 March 1975; and Marjorie J. Wilson, “Nursing Information Letter 1-77,” 5, 1 April 1977 (both in ANCC, OMH).