

Part Two

A Decade of Change

Chapter Eight

New Leadership and Expanding Horizons

Having navigated the troubled waters of the 1970s with fair success, the Army Nurse Corps entered into an even more complex decade in the 1980s as it dealt with both traditional and unprecedented issues of equal intensity. A blend of new and familiar perplexities also confronted the Army and the Army Medical Department (AMEDD).

The 1980s was a time of difficult transitions. Most of the evolving issues had their roots in the 1970s and amplified with the new decade. The shortage of nurses was the most obvious challenge, but improving quality of care and readiness also consumed much time and energy. Army Nurse Corps leaders were creative and innovative when dealing with these dilemmas.

At the same time that the Army Nurse Corps was coping with these demands, it also was slowly expanding its practice frontiers. Increasing numbers of Army nurses were accepting nontraditional assignments and pushing back long-established boundaries. They were bellwethers of the paradigm shift from strictly traditional roles to unprecedented command positions for Army nurses. From the Cuban Relief Mission reminiscent of 1970s field missions, to the checkered campaign of Operation Urgent Fury, to the more streamlined execution of Operation Just Cause, the AMEDD and the Army Nurse Corps advanced out of the post-Vietnam War doldrums into the era of the all-volunteer army. The 1980s represented sweeping change, reform, and modernization for the U.S. Army. Conversely, growth in numbers of women in the active Army slowed in relation to the prior decade.¹

A total of 12,542 female officers and soldiers served in the active force during fiscal year (FY) 1960.² Ten years later, during FY 1970, the numbers remained constant, with 12,500 women in active service.³ Across the 1970s, however, a large number of women joined the Army and, by FY 1980, the Army counted 68,966 officer and enlisted women in its ranks.⁴ After the 1980s, a decade of comparatively minimal growth for the Army, some 83,600 women were on ac-

tive duty, as of FY 1989.⁵ Feminist scholars specializing in military women's issues posit that the senior Army and Air Force hierarchy encouraged the Reagan administration early in 1981 to put a damper on the numbers of women in military, who they believed hindered military efficiency. This movement became known as "womanpause."⁶ The entry of large numbers of women soldiers into the Army was not issue-free. Fierce debate over topics such as degraded unit readiness because of pregnancies, women's failure to complete their enlistments, and a lack of physical endurance and upper extremity strength led to the formation of a Policy Review Group on Women in the Army in April 1981.⁷ In November 1982 this task force recommended that enlisted women be restricted to service in 93 percent of all enlisted military occupational specialties (MOSs), basing the decisions on the Direct Combat Probability Coding system. To set up this system, a team scrutinized and graded each MOS on a scale of P1 to P7, with P1 indicating the greatest probability of involvement in direct combat.⁸ The Army banned female soldiers from any MOS that fell into the category of P1, essentially the combat arms, which also offered career soldiers the best opportunities for promotion, command, and awards. Controversy and challenges led to minor modifications to the Direct Combat Probability Coding rating system in the following years.⁹ The changes, interestingly enough, did not liberalize standards, perhaps because a mostly male backlash followed the large-scale introduction of women into the military.¹⁰ The reaction may also have represented another illustration of womanpause. By 1989, Army enlisted women were eligible for only 86 percent of MOSs, although the Army deemed female officers eligible for 95 percent of all officer specialties. Women could also qualify for 91 percent of all warrant officer roles. The Army's official attitude was that the Direct Combat Probability Coding system reflected the implied intent of the Congress.¹¹ This meant Army policy, not congressional legislation, dictated the service's utilization of women. The Navy, however, relied on statutes, not policy, to prohibit the permanent service of Navy women on combat ships and aircraft. Similar restrictions applied to women serving in the Marine Corps. Legislation likewise proscribed Air Force women's presence on combat aircraft. However, the law exempted Air Force women in the medical professions and the chaplaincy from the prohibition. Of all the uniformed services, women in the Coast Guard enjoyed the greatest latitude. They had no restrictions or embargoes imposed. Every role in that service was open to women.¹² Perhaps this liberal stance could be traced to the fact that the Coast Guard was a small service, not an element of the Department of Defense, but under the Treasury Department, and not in the front line of combat.

The greater presence of women in the Army had a variety of effects on the daily concerns of the Army Nurse Corps. In many cases, more females in the Army meant better overall treatment for women in general and for the women in the Army Nurse Corps in particular. Moreover, with many more women service members as patients, it also added a new dimension to health care that often transcended gender and affected the nature of the health service support provided by Army Nurse Corps officers.¹³

Although old-school traditionalists decried the greater inclusion of women into

the Army organization, they simultaneously applauded the adoption of a new philosophy, the Army of Excellence. The Army as an institution became committed to turn the so-called Army of Excellence into a reality to confront “a powerful and dangerous Soviet adversary, a global defense mission, an ongoing major cycle of weapon modernization, and an inflexibly capped Army end strength too small for the force needed.”¹⁴ Meanwhile, defense funding was increased to modernize the force with the Abrams tank, the Patriot Missile system, the Bradley fighting vehicle, the Apache helicopter, and the Multiple Launch Rocket System—the “Big Five.” The Army also invested significant money and energy into enhancing quality of life by promoting equality of opportunity, preventing substance abuse, and bolstering a number of morale and welfare projects. These efforts restored “confidence, self-esteem, and a strong sense of professionalism within the Army that did much to erase the Army’s tarnished image of a decade earlier.”¹⁵ The crescendo of modernization climaxed with the fall of the Berlin Wall in 1989 and the subsequent dissolution of the Soviet Union.¹⁶

In synchrony with the organizational, doctrinal, and equipment transformations ongoing within the Army, the AMEDD also was undergoing a sizeable evolution. During this period of fast-paced change and technological innovation, one of the greatest dilemmas facing the military health care system was the need to provide the best possible health care for troops at a time of rising health care costs, stringent fiscal controls, and limited financial resources. To address the predicament, the Department of Defense launched and the Army surgeon general supported cost-reduction projects that relied on information management systems such as the Defense Enrollment Eligibility Reporting System, Tri-Service Medical Information System, and Composite Health Care System, automated patient health data systems that helped to reduce personnel costs and overhead.¹⁷ The Army surgeon general also gave closer scrutiny to the burgeoning Civilian Health and Medical Program of the Uniformed Services expenditures in an effort to hold down patient costs.¹⁸ The AMEDD contracted for services from outside sources to augment health care delivery, a move believed to be cost effective. In the summer of 1985, the first Primary Medical Care for the Uniformed Services Clinic opened in Fairfax County, Virginia, with civilian vendors in charge. Private contractors offered primary health care along with limited laboratory and pharmacy services to military patients.¹⁹ By 1989, many more Primary Medical Care for the Uniformed Services Clinics were operational.²⁰ Although these initiatives contributed to alleviating the difficult situation, the chiefs who led the Army Nurse Corps during the 1980s also were instrumental in solving enormous problems. During their four-year terms, they faced hectic times and demanding issues.

On 1 September 1983, Colonel Connie L. Slewitzke was promoted to brigadier general and became the 17th chief of the Army Nurse Corps. Her most recent assignments had been as assistant chief of the Army Nurse Corps, chief nurse of 18th Medical Command in Korea, and chief, Department of Nursing, at Letterman Army Medical Center in San Francisco, California.

Slewitzke’s tenure coincided with a very challenging time for the AMEDD and



Pictured is Brigadier General Connie L. Slewitzke, who served as the 17th Chief of the Army Nurse Corps from 1983 to 1987.

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

the Army Nurse Corps. She capably dealt with issues of readiness, nursing shortages, retention problems, promotion delays, the physical fitness standards, and backlash against growing numbers of women in the Army. Slewitzke advocated for greater educational opportunities, more nurse autonomy, and increased input from Army Nurse Corps officers into the business of the AMEDD. She promoted the AMEDD Officer Structure Study, the publication of a history of the Army Nurse Corps, the introduction of information systems, the refinement of the standards of nursing practice, and quality improvement incentives. Additionally, she successfully lobbied for a general officer position for an Army nurse in the Army Reserve/Army National Guard, strengthening those components' stature, inclusion, and effectiveness. She created and sponsored the Army Nurse Corps fellowship in the Chief of the Corps Office, the preceptorship for newly graduated second lieutenant Army nurses, and the Workload Management System for Nurses. She began the program to collect oral histories of former chiefs of the Corps. She worked for across-the-board exposure to field nursing for all Army nurses, improved the Professional Officer Filler System and Mobilization Designee programs, expanded the Individual Mobilization Augmentee matrix, oversaw the widespread introduction of Army Nurse Corps officers into Forces Command roles, and assigned officers to key positions in the Army Reserve and Army National Guard. She actively monitored the activities and conditions experienced by Army nurses assigned to temporary duty in Central America and presided over Army Nurse Corps participation in Operation Urgent Fury. Slewitzke and her assistant chief, Colonel Eily P. Gorman, managed all of these pressing concerns while simultaneously interfacing with the whole of the Army, the other uniformed services, the civilian nursing community, and the retired Army nurse population and while attending to the routine, everyday leadership requirements inherent in managing a corps of thousands of Army nurses—Active, Reserve, and National Guard. Slewitzke retired after the completion of her four-year tenure in 1987. Following her retirement, she actively supported the efforts to build the Women in Military Service for America Memorial at the gateway to Arlington Cemetery.

On 1 September 1987 Brigadier General Clara Adams-Ender became the 18th chief of the Army Nurse Corps. She had been the chief, Department of Nursing, at Walter Reed Army Medical Center and, before that, chief of the Army Nurse Corps Division of the U.S. Army Recruiting Command. Throughout her career, Adams-Ender consistently broke new ground. She was the first female soldier to earn the Expert Field Medical Badge and to graduate with a master of military art and science degree from the Command and General Staff College. Additionally, she was the first chief of the Corps to choose a male Army Nurse Corps officer, Colonel John M. Hudock, to be the assistant chief of the Corps. Adams-Ender became the first chief to wear two hats, serving concurrently as chief of personnel for the AMEDD and the Chief of the Army Nurse Corps. She remained on active duty after her four-year term as chief of the Corps to assume command of a major Army installation, Fort Belvoir, Virginia, and become the deputy commanding general for the Military District of Washington.



Pictured is Brigadier General Clara L. Adams-Ender, who served as the 18th Chief of the Army Nurse Corps from 1987 to 1991.

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

Adams-Ender faced a serious and debilitating nursing shortage and embarked on many ventures to recruit and retain both civilian and military nurses, such as the Army Nurse Candidate Program, the Accession Bonus Program, incentive pay for certified registered nurse anesthetists, greater numbers and varieties of Reserve Officers' Training Corps scholarships, the AMEDD Enlisted Commissioning Program, and a selection of plans to bolster the U.S. Army Reserve and Army National Guard. Adams-Ender also encouraged the development of novel organizational configurations to enhance the efficiency of Army hospitals' nursing departments. Unwilling to degrade the Army Nurse Corps educational credentials, she maintained existing standards and gained input into legislation and policy formulation by beginning the practice of testifying annually before Congress with her Navy and Air Force counterparts and arranging for Army Nurse Corps officers to serve in congressional fellowships. Adams-Ender also led the Corps through the thorny challenges of Operation Just Cause and the massive demands of operations Desert Shield and Desert Storm while simultaneously responding to the substantial personnel requirements that these campaigns created.

To tackle the tremendous complexities of the 1980s, Army Nurse Corps leaders conceived and implemented imaginative strategies that paid unexpected dividends. They developed Army Nurse Corps officers, augmented the services they provided, and broadened their horizons beyond usual parochial limits. Two important programs were the introduction of Army Nurse Corps officers into the White House and the halls of Congress.

The Army Nurse Corps affiliation with the White House dated to 1970, when First Lady Patricia Nixon asked that women officers be allowed to serve as White House social aides. Formerly, only male officers served in this capacity. Major Susanne Philips Crowe was the first Army nurse to assume these extra duties while she was stationed concurrently at Walter Reed Army Medical Center.²¹ Subsequently, from 1973 to 1979, Major Janet Rexrode (Southby) represented the Army Nurse Corps as a senior White House social aide.²² Rexrode made her contributions in the limelight while simultaneously pursuing her doctorate at the Catholic University of America.²³

Strict criteria applied to selection as a White House aide. Applicants had to be single and between 24 and 37. Height requirements were at least 5'10" for male officers and 5'2" for female officers. The officer's military assignment had to be within 25 miles of the White House, and aides needed to have 18 months remaining on their tour of duty in the National Capital Region. Applicants also underwent an intensive scrutiny involving several detailed interviews, recommendations by a supervisor or commander, background checks, and a security appraisal. Only a few candidates survived the rigorous process.

One of Rexrode's classic duties was to attend formal state dinners where maintaining appropriate protocol and decorum were most important. She had to get "the right people to the right place at the right time." On a scheduled evening, Rexrode typically received her assignment and a briefing on the expected events and guests at about 6:00 P.M. She then greeted and escorted the visitors to the East



Before a White House state dinner in May 1979, Army Nurse Corps officer Major Janet Rexrode (Southby) conversed with President and Mrs. Jimmy Carter. Since she was marrying soon, Rexrode (Southby) also was concluding her tenure as a senior military social aide at that time.

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

Room in the White House, where they were formally announced to the president, given predinner drinks, and handed their dinner cards. She next shepherded the guests to the receiving line and later “toed the carpet,” lining up with the other aides along the grand hallway leading to the state dining room. Aides did not drink or dine with the guests but were “encouraged to mingle while retaining an air of separateness.” Rexrode compared these interactions to those between nurse and patient, “meeting guests while working is much like nursing—meeting and talking with someone doesn’t necessarily mean that you also see them socially.” As with nursing, Rexrode found the greatest returns were intrinsic ones. She had the opportunity to observe the shifting White House ambiance with three successive presidential administrations. The Nixon administration’s tone was very formal, while the Fords enjoyed dancing, and so the guests and aides went home late. At the other extreme, the Carters went to bed early, and so the guests departed

promptly as did the aides. Rexrode also participated in ceremonial presidential signings of agreements or bills into law, and she witnessed the signing of the Panama Canal Treaty in 1978.²⁴

In 1979, another group of Army Nurse Corps officers stepped through the White House portals to offer their professional skills as White House nurses. These officers staffed the White House Medical Clinic and occasionally traveled with the president to provide any health care needed during the journey.²⁵ Navy nurses were the first military nurses to serve in this role beginning in 1961. Eleven years later, in 1972, the Air Force assigned nurses to the White House Medical Clinic. By 1990 the staffing mix of military nurses changed so that at any one time, six military nurses, two from each service, worked together in this setting.²⁶

Three years later, an Army nurse assumed a different role in the White House, when Major Sharon Richie became the first Army Nurse Corps officer to be one of 14 White House fellows. The intent of the White House fellowship was to familiarize the participant with the nuts and bolts workings of the government on a national level and to encourage networking among fellows who came from such diverse venues as the military, the business world, the civil service, and so on.²⁷

Richie was the first nurse selected in the history of the 18-year program. However, instead of functioning in a nursing role, she served in the White House Office of Intergovernmental Affairs.²⁸ Her experience in the Old Executive Office Building involved contact with high-level public figures and observation of important decision making and was anything but a relaxed, tranquil duty. The hectic schedule involved conferences, document writing, and research, as Richie contributed to special projects that affected the nation's large and small municipalities. Travel and working groups with important government and business leaders also fostered Richie's professional development, as she "met so many people from different walks of life and learned so much from them."²⁹ Years later, Richie reflected on her year as a White House fellow as an incredible and unique educational experience.³⁰ Although these fellowships were associated with the White House, other Army nurses found comparable opportunities in the Congress.

The Congressional Fellowship Program for Army Nurse Corps officers began in 1988, but Adams-Ender unintentionally laid the groundwork for the opportunity several years earlier. During her assignment as chief nurse of Walter Reed Army Medical Center, she initiated an acquaintance with Senator Daniel Inouye while he was a patient on that facility's very important persons unit. Inouye was then the powerful chairman of the Senate Appropriations Committee and the two conferred on strategies to place an Army nurse in his office on Capitol Hill to furnish input on nursing and health care concerns. However, before that juncture and throughout her career, Adams-Ender

. . . observed many occasions in which we nurses lost many battles because others (mostly MSCs [Medical Service Corps officers] and MCs [Medical Corps officers]) were carrying our messages to the high places (e.g., DA [Department of Army] staff, DoD [Department of Defense] staff and to the Congress). Many times, when that message was carried and received, it was NOT the one that the nurses had originally sent, so we were often told that we lost an issue, when in effect, THE BOYS decided against us because we were not there to make our own case.



On 1 September 1982, President Reagan welcomed the White House Fellows Class of 1982–1983 with a certificate in recognition of their selection for this honor at a ceremony in the White House Rose Garden. On Major Richie’s right is her classmate Daniel T. Oliver (Admiral, USN, retired and later President of the Naval Postgraduate School).

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

When she later became chief of the Corps, Adams-Ender encouraged participation by Army nurses in the political process on every echelon, starting with their place of work.³¹

At about this same time, Majors Susan Connor and Patricia Wise were attending graduate school at the University of Maryland and seeking practicums for their health policy courses. Connor secured an internship in Senator John Glenn’s office early in January 1989. Wise simultaneously interviewed with Inouye and began her fellowship in his office. Wise impressed the senator so much with her

outstanding performance that he resolved subsequently to request participation by Air Force and Navy nurses as well.

Immediately thereafter in 1989, the Congressional Liaison Office approached the Army Nurse Corps for another Army nurse to work with the House Armed Services Committee. In response, the Army Nurse Corps nominated two individuals to job share the requested full-time position, after obtaining the concurrence of their university programs. Both were doctoral students, one at Catholic University and the other at George Mason University. Lieutenant Colonel Loretta Forlaw and Major Christine Galante began their practicums in the House of Representatives in February 1989.³² Adams-Ender had Forlaw and Galante provide her with first-hand information about legislation, assess situations, and advise her about “when it was time . . . to weigh-in on an issue” about the Army Nurse Corps. In one key instance, Forlaw and Galante personally thwarted an attempt to dilute Army Nurse Corps quality. Adams-Ender recalled the details:

During a congressional mark-up of a defense bill, a political appointee in the Army was hell-bent on changing the requirements for active duty Army Nurses to have a baccalaureate degree. Chris Galante was tasked to write the language for the final bill. When it was published, this fellow was sure that he had changed the law so that it would be so. He called me over to his office to personally give me a copy of the language and to “rub it in” that he had won. Chris had already provided me with a copy of the bill and it was written so that the requirement [for the BSN (bachelor of science in nursing)] remained. When I arrived at the Pentagon, I pointed this fact out to my “political friend,” and he was livid. Afterward, he made an attempt to have all of the nurses removed from Congressional offices. However, by this time, we were firmly entrenched because of our work ethic, attention to detail and knowledge of the issues.³³

Adams-Ender summarized the far-reaching effects of this innovative approach:

The influence of those nurses in nursing and health policymaking was powerful and set the stage for a new era of nursing leadership in . . . military health care. We were able to get incentive pay for nurse anesthetists, which was a good start. Also, Senator Inouye decided that the nurse corps chiefs should testify before his committee, . . . in 1989. The MSCs [Medical Service Corps officers] who worked in legislative liaison [sic] on the Hill called it a “love-in.”³⁴

After negotiating the congressional ramparts for the first time, Army Nurse Corps involvement on the Hill subsequently expanded. In 1994, Lieutenant Colonel Patricia Saulsbery was selected for the highly competitive Army Congressional Fellowship. She served for one year as a congressional liaison staff officer for the assistant secretary of the Army for manpower and reserve affairs. That same year, Lieutenant Colonel Barbara Scherb participated in a nurse-specific fellowship, once again in Inouye’s office.³⁵ This program evolved into a tri-service rotation with military nurses from the Army, Navy, and Air Force serving sequential one- to two-year terms also in Inouye’s office.³⁶ When Lieutenant Colonel Nancy Gilmore-Lee was a congressional fellow in 1998, she worked on legislation that dealt with special incentive pay for military nurse practitioners and nurse anesthetists, funding for the Graduate School for Nursing at the Uniformed Services



Senator Daniel K. Inouye and Army Nurse Corps fellow, Lieutenant Colonel Barbara J. Scherb, pause for a moment in Inouye's office in the Senate's Hart Office Building.
Photo courtesy of Colonel Barbara J. Scherb, Franklin, NC.

University of the Health Sciences, appropriation of TriService Nursing Research monies, and the reimbursement of advanced practice nurses under the Medicare program.³⁷ The benefits of the congressional programs included the integration of a distinctive viewpoint of military nursing into the legislative process that became an advantage for the Army Nurse Corps and the AMEDD when dealing with legislation and appropriations.³⁸

No longer were Army nurses found exclusively on hospital wards. Their widening involvement in high-level policy formulation led to greater self-determination, branch immaterial positions, and command assignments for nurses in the not-too-distant future. More important, Army nurses gained greater influence in the legislative and political processes that actually controlled their unique destiny and evolution.

Another innovative element for dealing with the strategic issues of the day was the AMEDD Personnel Proponency Division (APPD). Several years earlier, most of the Army had decentralized this function, but within the AMEDD the responsibility for officers' proponency remained an exclusive tasking for the Corps chief of each branch.³⁹ However, in 1987, the AMEDD established its own decentralized officers' APPD.

Regulations tasked APPD with structuring AMEDD branches into viable organizations with supporting staff compatible with war and peace requirements. This had to be done within the parameters of Department of the Army allocated budgeted end strength and authorizations. APPD also was accountable for doctrine, regulations, force structure analysis, and life-cycle development issues.⁴⁰

Like the rest of the Army, the AMEDD located APPD at its "schoolhouse," initially at the Academy of Health Sciences and later at the AMEDD Center and School, to comply with requirements for each proponent to have an integrating center. The integrating center's role ensured homogeneity, unity of purpose, synergy of effort, reduction of needless duplication, and a means to resolve differences of opinion among the various AMEDD branch proponents.⁴¹

In 1988, the Army Nurse Corps first assigned an officer as its representative to APPD and later each representative became known as a Corps Specific Branch Proponency Officer.⁴² Lieutenant Colonel Theresa Washburn, the first Army nurse assigned to APPD, faced many challenges when she reported for duty in July 1988 following a stint in graduate school at George Mason University. Washburn's first-ever staff position was in a newly created billet with no precedents and no job description. She recalled that her "early days were exciting, frustrating, overwhelming," and fearsome as she learned and understood "totally foreign concepts like Force Structure, TDA [Table of Distribution and Allowances], TOE [Table of Organization and Equipment]," in the context of the total Army, the AMEDD and Army Nurse Corps Active Force, National Guard, and the Reserve. Washburn rose to the challenge and contributed to numerous projects such as the AMEDD Leader Development Study, an analysis of war and peacetime area of concentration requirements, a review of all senior Army Nurse Corps positions to gauge the necessity for War College preparation, and an intense scrutiny of the

organizational structure of departments of nursing worldwide.⁴³

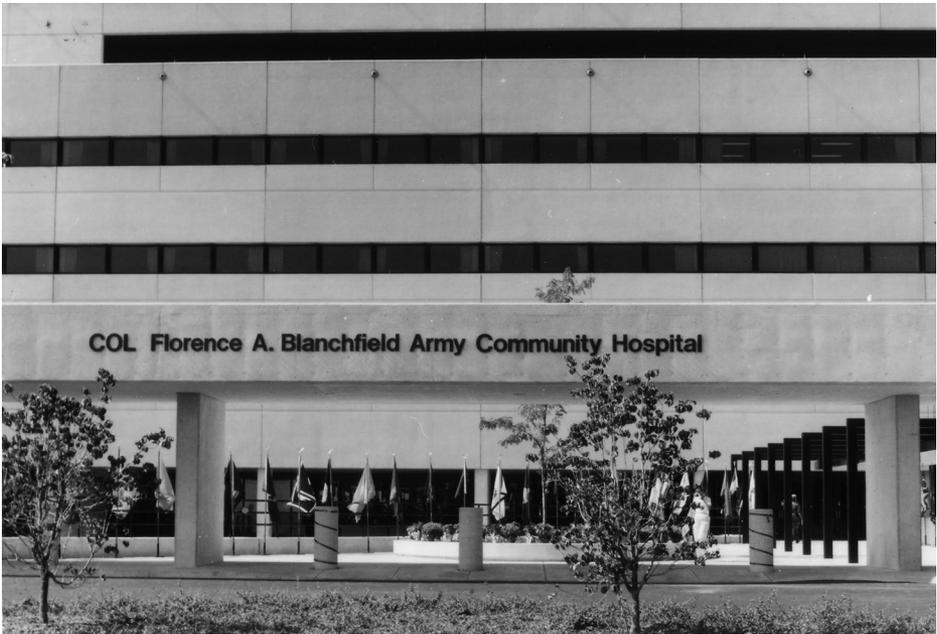
Other Corps Specific Branch Proponency Officers who followed Washburn worked closely with the chief of the Corps as well on issues such as developing plans to deal with critical care nurse shortages in all components, analyzing the force configuration, reviewing the Forward Surgical Team structure, planning the large personnel downsizing of the 1990s, eliminating the pediatric area of concentration, and establishing a distance learning system.⁴⁴ But innovation and enthusiastic service were not only the exclusive domain of those Army nurses actively serving, but also characteristic of the retired community.

In 1976, 38 retired Army nurses met informally in San Antonio, Texas, to form an organization whose objectives were to carry Army Nurse Corps comradeship into retirement and maintain communication among the Corps retirees. The following year the Retired Army Nurse Corps Association (RANCA) was incorporated.⁴⁵ The founding members chose—after considerable reflection—to devise two forms of membership. The first, according to Colonel Doris Cobb, RANCA's initial president, was regular status, and included retired Army nurses from the Active, Guard, or Reserve components. The second, or associate, membership consisted of Army nurses on active duty or those who had served previously and were honorably discharged but not retired from the service. Several charter members suggested inviting Navy and Air Force Nurse Corps officers into the organization, making it a "Military Nurse Association," but the group rejected this idea, fearing that it would promote competition with other wide-ranging military retiree organizations. Hesitancy about adding retirees from other services with differing backgrounds and priorities also contributed to the decision.

RANCA's original dues were \$5 annually, but several charter group members donated an additional \$1 or more each to pay mailing expenses to recruit new members and fund the costs associated with creating a nonprofit organization. In anticipation of incorporation in 1976, the group elected its first officers and directors, each one intended to represent one of five geographical regions across the United States.⁴⁶

It also organized the Army Nurse Corps Foundation to acquire donations for the construction of the U.S. Army Medical Museum at Fort Sam Houston, Texas.⁴⁷ Since its founding, RANCA has donated more than \$75,000 and countless volunteer hours to the establishment and daily operations of the museum. It also assisted in collecting and compiling selected Army Nurse Corps oral histories from various eras of service, sponsored the Army Nurse Corps Medal that was awarded to an exceptional Army nurse graduate of each Officer Advanced Course, and supported a medallion to bestow on an exemplary mid-level Army Nurse Corps officer annually as the RANCA Advanced Military Practice Award.⁴⁸

In 2000, RANCA metamorphosed into the Army Nurse Corps Association (ANCA). Although the name changed, the group's composition, activities, and purposes remained, and ANCA continued to offer membership to past or current commissioned officers in all three components, the Active, Guard, and Reserve, of the Army Nurse Corps. ANCA preserved the tradition of biennial conventions



Pictured is the Colonel Florence A. Blanchfield Army Community Hospital at Fort Campbell, Kentucky. Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

in various locations throughout the nation, and the organization's newsletter, *The Connection*, continued its quarterly publication. ANCA maintained RANCA's original goals as they had evolved, namely to furnish communication and social occasions for the membership, collaborate in the maintenance of Army Nurse Corps history, provide scholarships for students in collegiate nursing programs, and develop a means for regular interaction among Army nurses.⁴⁹ Many of these objectives converged into one major effort in 1978, as a movement to name the new hospital facility at Fort Campbell, Kentucky, after a revered Army nurse gained impetus.

Early in 1978, General Madelyn N. Parks resolved to honor Colonel Florence A. Blanchfield, the respected chief of the Army Nurse Corps during the challenging World War II era, in a meaningful way.⁵⁰ She asked for RANCA's support to commemorate Blanchfield's special contributions to the Army by naming the newly erected Fort Campbell, Kentucky, hospital in her memory. RANCA enthusiastically responded after Cobb initially contacted about 125 members, who in turn notified their friends and acquaintances. The letter-writing crusade snowballed and an avalanche of letters filled the mailboxes of the surgeon general (Lieutenant General Charles Pixley), the post commander (Major General John A. Wickham), and numerous congressmen and senators.⁵¹ Wickham, who would

make the final decision, did not ignore the tidal wave of requests. As he told the hospital commanding officer, he received so much mail from Army nurses who he would be terrified to call the institution anything but the Blanchfield Hospital.⁵² Wickham decided in March 1978 to name the institution as a permanent memorial to Blanchfield.⁵³ This was not the first instance of an Army hospital bearing the name of an Army nurse, but it was the only existing facility so named.⁵⁴ Army nurses, both active and retired, then pursued raising funds to subsidize a portrait and a bust of Blanchfield for the military treatment facility's lobby.⁵⁵ The surgeon general (Lieutenant General Bernhard T. Mittenmeyer) and a host of dignitaries and Blanchfield family and friends officially dedicated the Colonel Florence A. Blanchfield Army Community Hospital on 17 September 1982.⁵⁶ The state-of-the-art facility remains a testament to the contributions of Blanchfield and all Army Nurse Corps officers.

Collaboration, mutual support, and advancement were themes that emerged from the various innovations of the 1980s. This unity of purpose was but one of many factors that helped the Army Nurse Corps to meet its mission during the 1980s.

Notes

1. Paula L. Potts, "Women in the Military," *Military Lifestyle* 21 (October 1989): 38–42, 45, 50. Paula L. Potts, "Do Women Belong in the Military: A Debate," *Military Lifestyle* 21 (October 1989): 46–49.

2. William Joe Webb, *Department of the Army Historical Summary, Fiscal Year 1988* (Washington, DC: Center of Military History, United States Army, 1993), 33.

3. Mary L. Haynes, *Department of the Army Historical Summary, Fiscal Year 1987* (Washington, DC: Center of Military History, United States Army, 1995), 16.

4. Karl E. Cocke and others, *Department of the Army Historical Summary, Fiscal Year 1981* (Washington, DC: Center of Military History, United States Army, 1988), 98.

5. Vincent H. Demma, *Department of the Army Historical Summary, Fiscal Year 1989* (Washington, DC: Center of Military History, United States Army, 1998), 129–30.

6. Roxine C. Hart, *Women in Combat* (Patrick Air Force Base, FL: Research Division, Defense Equal Opportunity Management Institute, 1991), 14. Jeanne Holm, *Women in the Military, An Unfinished Revolution*, revised edition (Novato, CA: Presidio, 1992), 387–97. Les Aspin, "Manning the Military: The Female Factor," *Minerva, Quarterly Report on Women and the Military* 2 (Summer 1984): 133–51. "Utilization of Women Slows under Reagan," *Minerva, Quarterly Report on Women and the Military* 3 (Spring 1985): 18. Feminist scholars later refuted the notion that the inclusion of women "damaged military effectiveness" by citing the largely successful use of women in the 1980s Middle East peacekeeping efforts and in the combat support operations in Grenada and Panama. In these operations, they argued, "males and females all got the job done together." Lorry M. Fenner, "Moving Targets: Women's Roles in the U.S. Military in the 21st Century," in *Women in Combat, Civic Duty or Military Liability?* ed. Lorry M. Fenner and Marie E. deYoung (Washington, DC: Georgetown University Press, 2001), 41–42.

7. Karl E. Cocke and others, *Department of the Army Historical Summary, Fiscal Year 1981* (Washington, DC: Center of Military History, United States Army, 1988), 96–97. Rosemarie Skaine, *Women at War, Gender Issues of Americans in Combat* (Jefferson, NC: McFarland & Company, Inc., 1999), 62. Roxine C. Hart, *Women in Combat* (Patrick Air Force Base, FL: Research Division, Defense Equal Opportunity Management Institute, 1991), 13–15.

8. In 1982, the Army defined direct combat as "engaging any enemy with individual or crew-served weapons while being exposed to direct enemy fire, a high probability of

direct physical contact with the enemy's personnel, and a substantial risk of capture." It added that "direct combat takes place while closing with the enemy by fire, maneuver, or shock effect in order to destroy or capture him, or while repelling his assault by fire, close combat or counterattack." Rosemarie Skaine, *Women at War, Gender Issues of Americans in Combat* (Jefferson, NC: McFarland & Company, Inc., 1999), 29.

9. Mary Ellen Condon-Rall, *Department of the Army Historical Summary, Fiscal Year 1983* (Washington, DC: Center of Military History, United States Army, 1990), 60–62. Karl E. Cocke, *Department of the Army Historical Summary, Fiscal Year 1985* (Washington, DC: Center of Military History, United States Army, 1989), 22. Women's Research and Education Institute, "Facts about Women in the Military, 1980–1990," Fact Sheet, 2, n.d.; and "Women in the Army," Information Paper, 2 October 1989 (both in Army Nurse Corps Collection [ANCC], Office of Medical History [OMH]).

10. The backlash as a reaction to the feminist movement was not restricted to the military. There also was a "return to a more conservative political agenda" nationwide at this time. Thetis M. Group and Joan I. Roberts, *Nursing, Physician Control, and the Medical Monopoly* (Bloomington: Indiana University Press, 2001), 273.

11. "Direct Combat Probability Coding (DCPC) Policy," Information Paper, 16 July 1989; and Major Habitzreuther, "Women in the Army," Information Paper, 29 September 1989 (both in ANCC, OMH).

12. Women's Research and Education Institute, "Facts about Women in the Military, 1980–1990," Fact Sheet, 6–10, n.d.; and Soldier Policy Branch, Human Resources Division, Office of the Deputy Chief of Staff for Personnel, "Women in the Army," Briefing Slides, n.d. (both in ANCC, OMH). Title 10, U.S.C. 3012. Title 10, U.S.C. 6015. Title 10, U.S.C. 8549. The Coast Guard also was the most progressive in its approach to pregnancy and parenthood issues. Its "Care of Newborn Child Program" allowed any new parent, regardless of gender, to "leave the service for up to a year with the assurance that when they return, they will have the same rank and occupational specialty as when they left." Georgia Clark Sadler, "From Women's Services to Servicewomen," in Francine D'Amico and Laurie Weinstein, *Gender Camouflage: Women and the U.S. Military* (New York: New York University Press, 1999), 43–44.

13. Bette S. Mahoney, "1989 Department of Defense Women's Health Survey," Type-written Report, 28 October 1989, ANCC, OMH.

14. John L. Romjue, *The Army of Excellence: The Development of the 1980s Army* (Fort Monroe, VA: Office of the Command Historian, United States Army Training and Doctrine Command, 1997), xiii.

15. Vincent Demma, "The Army in the 1970s," Information Paper, 6–7, ANCC, OMH. Robert H. Scales, *Certain Victory* (Washington, DC: Office of the Chief of Staff, United States Army, 1993), 16–20. Frank N. Schubert and Theresa L. Kraus, eds., *The Whirlwind War, The United States Army in Operations Desert Shield and Desert Storm* (Washington, DC: Center of Military History, United States Army, 1993), 28–33.

16. John L. Romjue, *The Army of Excellence: The Development of the 1980s Army* (Fort Monroe, VA: Office of the Command Historian, United States Army Training and Doctrine Command, 1997), 1–2. *225 Years of the Army* (Tampa, FL: Faircount, LLC, 2000), 302.

17. "Army Medical Department ADP Master Plan, FY 71–78," n.d., Record Group 112, Entry 372, Box 2 of 4, National Archives. Gar Yip, "Composite Health Care System (CHCS)," Information Paper, 3 March 1988, ANCC, OMH.

18. Dwight Oland, *Department of the Army Historical Summary, Fiscal Year 1984* (Washington, DC: Center of Military History, United States Army, 1995), 195. William Joe Webb, *Department of the Army Historical Summary, Fiscal Year 1988* (Washington,

DC: Center of Military History, United States Army, 1993), 30. Vincent H. Demma, *Department of the Army Historical Summary, Fiscal Year 1989* (Washington, DC: Center of Military History, United States Army, 1998), 168. Frank F. Ledford, "Surgeon General Outlines Priorities for AMEDD Action," *HSC Mercury* 16 (March 1989): 2.

19. Terrence Gough, *Department of the Army Historical Summary, Fiscal Year 1986* (Washington, DC: Center of Military History, United States Army, 1989), 23, 94. Dennis Steele, "Patients First," *Soldiers* (January 1987): 28–33.

20. There were two PRIMUS Clinics each in Northern Virginia; Fort Stewart, Georgia; Fort Hood, Texas; and Fort Ord, California. One clinic was providing care in the Fort Benning, Georgia, and Fort Bragg, North Carolina, environs. Frank F. Ledford, "Army 'Innovative' in Use of Funds," *U.S. Medicine* 25 (January 1989): 41–42.

21. Janet R. Southby to Author, E-mail Correspondence, 28 June 2004; and Constance J. Moore to Major Fox Johnson, Typewritten Letter (TL), n.d. (both in ANCC, OMH).

22. Major Leslie Dempsey Brousseau followed Southby in this role after 1979. Janet R. Southby to Author, E-mail Correspondence, 28 June 2004, ANCC, OMH.

23. Carolyn M. Feller and Debora R. Cox, *Highlights in the History of the Army Nurse Corps* (Washington, DC: U.S. Army Center of Military History, 2000), 50.

24. Dorothy Dee, "White House Social Aides," Typewritten Manuscript, October 1978, ANCC, OMH.

25. Among those who served were Captain Vicky Sheldon, Major Dianne Capps, Captain Ann Treleven, Major Barbara Eller, Lieutenant Colonel Paula Trivett, Major Arthur Wallace, Major Leana Fox-Johnson, Captain Maureen Donohue, Captain Vinette Gordon, Captain Greta Krapohl, Major Brenda C. McDaniel, Major Rene Katial, and Captain Stacy Usher. Leana Fox-Johnson "History of Army Nurses Assigned to the White House," Memorandum, 3 December 1994, ANCC, OMH. Carolyn M. Feller and Debora R. Cox, *Highlights in the History of the Army Nurse Corps* (Washington, DC: U.S. Army Center of Military History, 2000), 86.

26. "The White House Nurse Directory," May 1995, ANCC, OMH. Major Arthur Wallace was the first male and the first emergency nurse to serve in the White House Medical Clinic.

27. Clara L. Adams-Ender to Author, Handwritten Note, 3 October 2003, ANCC, OMH. Former Secretary of State General Colin Powell was a White House fellow from 1972 to 1973. <http://www.whitehousefellows.gov/home.html> (accessed on 5 February 2004).

28. "Richie at White House," *HSC Mercury* 10 (November 1982): 4. Carolyn M. Feller and Debora R. Cox, *Highlights in the History of the Army Nurse Corps* (Washington, DC: U.S. Army Center of Military History, 2000), 54.

29. Pamela Noel, "White House Fellows," *Ebony* 38 (March 1983): 107, 108, 110, 112.

30. Jan Murphy, "US Seeks Movers, Shakers," *Sentinel* (18 September 1987): C1.

31. Clara L. Adams-Ender to Author, E-mail Correspondence, 4 July 2003, ANCC, OMH.

32. John M. Hudock, "Congressional Nursing Practicums," Information Paper, 12 October 1989; and John M. Hudock, Routing and Transmittal Slip to BG A-E, 12 October 1989 (both in ANCC, OMH).

33. Clara L. Adams-Ender to Author, E-mail Correspondence, 4 July 2003, ANCC, OMH.

34. *Ibid.*

35. A Navy nurse, Nancy Lescavage, preceded Scherb, who in turn was followed by an Air Force nurse. Terris Kennedy to Author, E-mail Correspondence, n.d., ANCC, OMH.

36. Michelle Kohl, Untitled Typewritten Document (TD), 12 November 1996; Daniel K. Inouye to Robert P. McAleer, TL, 20 May 1994; Nicolai Timenes to Daniel K. Inouye, TL, 20 June 1994; Nancy R. Adams to Daniel K. Inouye, TL, n.d.; and Daniel K. Inouye to

Nancy R. Adams, TL, 29 July 1993 (all in ANCC, OMH).

37. Nancy Gilmore-Lee, "A Year on Capitol Hill," *Army Nursing Newsletter* 99 (January 1999): 7, ANCC, OMH.

38. Untitled TD addressed to COL Mc[Call], n.d., ANCC, OMH.

39. Kathleen Srsic-Stoehr to Author, 24 May 2003; Clara L. Adams-Ender to Author, 11 July 2003 (both E-mail Correspondence, ANCC, OMH). Connie L. Slewitzke, Interview by Beverly Greenlee, 210, 457–62, n.d., USAWC/USAMHI Senior Officer Oral History Program, Project No. 88-8, ANCC, OMH. Headquarters, Department of the Army, Army Regulation 5-22, "The Army Proponent System," 3 October 1986.

40. Thomas Pozniak, Information Paper, 22 September 1992, Attachment to E-mail from Kathleen Srsic-Stoehr to Author, May 2003, ANCC, OMH. Tracy E. Strevey and Quinn H. Becker, "Army Medical Department Personnel Proponent System," Memorandum of Understanding between the Surgeon General, Department of the Army and the Commander, U.S. Army Health Services Command, 23 October 1987, ANCC, OMH. The eight life-cycle functions were structure, acquisition, distribution, sustainment, professional development, individual training and education, unit deployment, and separation. Kathleen Srsic-Stoehr, "AN Consultants Conference-'The Winds of Change: Nursing Opportunity for Leadership,' 13–17 July 1992: AN Management Study Workgroup," Memorandum for Record, 5 August 1992, ANCC, OMH.

41. Timothy Jackman, "Management of Proponency in the AMEDD," Draft Concept Proposal, 23 February 1993, ANCC, OMH.

42. The first Army Nurse Corps representative to the APPD was Lieutenant Colonel Theresa Washburn. Lieutenant colonels Lee Perry, Kathleen Srsic-Stoehr, Carol Reineck, Dena Norton, Stephanie Marshall, and Deborah Gustke followed. Kathleen Srsic-Stoehr to Author, 24 May 2003; John Hudock to Author, 11 July 2003; Stephanie Marshall, Interview by Mary T. Sarnecky, Transcript, 19–22, July 2003, Army Nurse Corps Oral History Collection; Carol Reineck, "To Provide Information on Role Development for Corps Specific Branch Proponent Officer (CSBPO), Army Nurse Corps," Information Briefing, 29 May 1996 (all in ANCC, OMH).

43. Theresa Washburn to Author, E-mail Correspondence, 30 September 2003, ANCC, OMH.

44. Kathleen Srsic-Stoehr, "Input for Legion of Merit Award," TD, April 1994; and Carol Reineck, Interview by Mary T. Sarnecky, Transcript, 36–38, May 2003, Army Nurse Corps Oral History Collection (both in ANCC, OMH).

45. <http://e-anca.org/ANCAHist.htm> (accessed 14 July 2003). "Retired Army Nurse Corps Association, Background Information," TD, November 1997. Demonstrating significant growth from its embryonic numbers, the organization had more than 500 members by November 1977. Doris M. Cobb to Dorothy Zalabak, TL, 28 November 1977, ANCC, OMH. By early 1978, RANCA claimed a total of 1,450 members. Lois Haase, "Shot in the Ego for Army Nurses," *San Antonio Express* (14 April 1978), 1-C.

46. The first officers were Doris M. Cobb, president; Sally H. Rawlins, vice president and treasurer; and Marian A. Tierney, secretary. Other charter board members were Alma B. Anderson, Marion K. Kennedy, Ann B. Cost, Edith B. Whitelaw, and Augusta L. Short. Doris M. Cobb to Retired Army Nurse Corps Officers, Former ANC Officers, TL, October 1977; and Mary Messerschmidt to Author, E-mail Correspondence, 5 August 2003 (both in ANCC, OMH).

47. Doris M. Cobb to Retired Army Nurse Corps Officers, Former ANC Officers, TL, October 1977, ANCC, OMH.

48. "Retired Army Nurse Corps Association, Background Information," TD, November

1997, ANCC, OMH. "The R.A.N.C.A. Advanced Military Practice Award," Standard Operating Procedure, 1 November 1998, ANCC, OMH.

49. "The Army Nurse Corps Association History Page," <http://e-anca.org/ANCAHist.htm> (accessed 14 July 2003).

50. Madelyn N. Parks, "Information for All ANC Officers," 3, 27 March 1978, ANCC, OMH.

51. Doris M. Cobb, "RANCA Newsletter," 1, April 1978, ANCC, OMH.

52. Lillian Dunlap, *33 Years of Army Nursing, An Interview with Brigadier General Lillian Dunlap* (Washington, DC: United States Army Nurse Corps, 2001), 316.

53. Madelyn N. Parks, "Information for All ANC Officers," Typewritten Newsletter, 1, 27 March 1978; and Doris M. Cobb, "RANCA Newsletter," 1, April 1978 (both in ANCC, OMH).

54. In World War II, Gardiner General Hospital in Chicago, Illinois, memorialized the contributions of Second Lieutenant Ruth M. Gardiner, an Army nurse who perished in a plane crash in Alaska. Mary T. Sarnecky, *A History of the U.S. Army Nurse Corps* (Philadelphia: University of Pennsylvania Press, 1999), 262. Knute A. Tofte-Nielsen to Raymond H. Bishop, TL, 6 October 1982, ANCC, OMH.

55. Patricia Silvestre, "US Colonel Florence A. Blanchfield Army Hospital Memorialization Committee," TL, 12 October 1978, Inclosure 1, in Madelyn N. Parks, "Information for All ANC Officers," 18 October 1978; and Rose V. Straley, "Colonel Florence A. Blanchfield Memorial Fund," TL, 19 August 1980, Inclosure 7, in Hazel W. Johnson, "Information for All ANC Officers," 12 September 1980 (both in ANCC, OMH). "Surgeon General Set as Dedication Speaker," *Fort Campbell Courier* (16 September 1982): 1A.

56. "Colonel Florence A. Blanchfield Army Community Hospital," Dedication Program, 17 September 1982, Blanchfield Collection, Army Medical Department Museum. "New Hospital Takes Nurse's Name," *HSC Mercury* 9 (October 1982): 1. Charles F. Bombard, Wynona M. Bice-Stephens, and Karen L. Ferguson, "The Soldiers' Nurse: Colonel Florence A. Blanchfield," *Minerva, Quarterly Report on Women and the Military* 6 (Winter 1988): 43–49.

