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**Medical Memoirs**

**Maj. Gen. Nancy Adams**

**U.S. Army**

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Office of Medical History  
Office of The Surgeon General  
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## Foreword

In 1998, Lt. Gen. Ronald R. Blanck, Surgeon General of the Army, reestablished an official historical program under a new Office of Medical History. Oral History forms a central element in the new program which will conduct regular interviews with key Office of the Surgeon General and Medical Command, active and retired personnel, publish selected interviews in a "Medical Memoir" series, and provide coverage of current operations and issues with participants and decision makers.

Maj. Gen. Nancy Adam's oral history is a part of the history of the United States Army during and after the Vietnam War, and was conducted on 9 January 2001 at Tripler Army Medical Center, Hawaii by Col. Mary I. Sarnecky, U. S. Army retired.

General Adams oral history reflects a lifetime of successes as an Army nurse, in education, as a staff officer, and as a commander.

Her early years include tours as a medical surgical nurse at Brooke Army Medical Center and a tour in Korea with the 121<sup>st</sup> Evacuation Hospital. She returned to the States where she was assigned as a night supervisor at the USAH, Fort Jackson, SC before attending Catholic University where she received an MS in Medical Surgical Nursing

Her next assignment was to Fitzsimons Army Medical Center as Director Of the Intensive Care Nurse Course where she also revised the POI for the first time in four years. Adams had a tour on the IG team, a difficult assignment accomplished with remarkable skill.

General Adams was appointed a student at the Army War College, Carlisle, Pennsylvania where she served with many future generals to include the future Surgeon General of the Army, Ronald R. Blanck.

Adams then filled a number of supervisory and command positions before retiring. She was assistant Chief, then Chief, Department of Nursing, Frankfurt Army Regional Medical Center, USAREUR. She then had a two year tour as Nursing Consultant in the Chief's Office before being appointed Chief, Army Nurse Corps for four years.

Additional command positions followed. Department of Army appointed her CG, Southwestern Regional Center, Fort Bliss, TX, then in 1997, CG, William Beaumont Regional Medical Center, Fort Bliss, TX. Her last assignment before retiring, was as CG, Tripler Army Medical Center and Pacific Regional Medical Command, Fort Shafter, Hawaii.

Major General Nancy Adams' oral history provides a valuable source of medical history for the inquiring researcher.

## The Interviewer

Dr. Mary T. Sarnecky earned a Bachelor of Science in nursing from St. Louis University; a Masters in Community Health nursing from the University of South Carolina; and a Doctorate in Nursing, a Family Nurse Practitioner certificate, and a School Nurse credential from the University of San Diego.

Before retiring from the military in 1996, Dr. Sarnecky served in the United States Army Nurse Corps for almost 23 years in a variety of locations both at home and abroad. She has held every grade from second lieutenant to colonel. A few of her roles as an Army officer were in community health nursing, critical care nursing, nursing administration, nursing education, infection control, and nursing research. She also has held positions in the civilian world as a general duty nurse; as a school nurse in the Department of Defense School System in Nuremberg, Germany; and as a nurse practitioner and school nurse with the San Diego Unified School District.

Dr. Sarnecky has lectured around the globe. She has published extensively in a diversity of peer-reviewed journals such as *Advances in Nursing Science*; *Nurse Educator*; *Image, Journal of Nursing Scholarship*; *Nursing History Review*; *Sigma Theta Tau Reflections on Nursing Leadership*; *American Journal of Nursing*; *Military Medicine*; and *Army Magazine*.

Along the way, Dr. Sarnecky has garnered numerous honors. While in the Army, she was the recipient of eleven medals. She was elected to the Order of Military Medical Merit as well. For her research work in the history of nursing, she has been recognized with an array of awards, distinctions, and competitive research grants.

Most recently, her volume entitled *A History of the United States Army Nurse Corps* has been cited as the American Journal of Nursing Book of the year 2000 in Public Interest Category. Moreover, the American Association for the History of Nursing also bestowed their prestigious Lavinia L. Dock award for Exemplary Historical Research and Writing on this book.



## Acknowledgments

Dr. Barry W. Fowle, Senior Historian, Office of Medical History, was responsible for publishing this manuscript. Dr. John Greenwood, Chief of Medical History and Annita Ferencz provided editorial and technical support.

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## **Nancy R. Adams**

The career of Nancy Adams reflects the diversity of duties that an Army nurse may encounter: floor nurse, surgical nurse, supervisory nurse, general staff officer, and senior commander.

Major General Nancy R. Adams' career as an Army officer began in 1967 when she signed on to the Army Student Nurse program while at Cornell University, Ithaca, New York.

Her first assignment was in 1968 as a Medical Surgical Nurse, Brooke Army Medical Center, Fort Sam Houston, Texas, before attending the Army Medical Officer Basic Course, United States Army Field Service School, Brooke Army Medical Center.

Upon completion of the course, Adams returned to her position as Medical Surgical Nurse, Brooke Army Medical Center, Fort Sam Houston, Texas. She left Brooke in June 1969 when she was assigned as a General Duty Nurse, 121<sup>st</sup> Evacuation Hospital, United States Army Pacific-Korea. Adams became interested in Intensive Care Unit nursing in Korea and essentially developed that interest during her next assignment at the United States Army Hospital, Fort Jackson, South Carolina. The chief nurse at Fort Jackson, Col. Thelma Freese spoke to Adams in terms of career development and what she wanted to do, and talked her into it.

Adams finished the course in two years and went to William Beaumont Army Medical Center. There Col Kitty Betz had a concept in terms of using the clinical nurse specialist role to provide assistance to patients and to the staff members. That was a unique outlook in that no one else in the Army was using it.

General Adams went to the Advanced Course in July 1977 and finished in December. She made a lot of friends there that stood her in good stead later on. They had a good group of dentists there and most of the students were MSC. They were not sending MDs there at that time. Gen Adams became aware for the first time that there was more to the Army than just clinical care of patients.

Adams' then went to Fitzsimons Army Medical Center, Denver, Colorado as Director, Intensive Care Nurse Course. The only preparation she had for the position was two weeks at the Faculty Development Unit, at the Academy of Health Sciences. It taught the student in terms of presentation of the material.

A big problem arose in the ER between the head nurse and a subordinate and Adams was sent down to be a head nurse and straighten it out. Another problem arose in trying to get articles published. There was a block in the chain of approval for sending out articles so Adams called personnel to see about getting out of the job and she was nominated for the

Inspector General team in June 1980.

Her preparation was a one week course at Fort Leavenworth by the DAIG. There was a new IG, LTG Trephey whose approach was not just “are they doing it” but “If not, why not” then trace the problem to the ground. Because Adams was so dogged in tracing problems, she seemed to have made enemies and was talked to by senior nurses. Even so, Nancy insisted on doing her work as she saw it and she was supported by her boss.

From the IG Adams went to Health Affairs for two years where she did quality assurance for them, basically trouble shooting, writing policy, and changing how business was done in the military medical services.

Her next assignment was The War College, Carlisle, Pennsylvania. Here she found out that there were other people who were bright in areas of their own expertise, and that war essentially was a failure on the part of diplomacy. General, Blanck was the senior officer and so he was class president. Adams decided she wanted to do the oral history part of The War College and she was given Colonel Clark to do, Corps Chief in the early sixties. They developed a friendship that lasted until her death.

From Carlisle Adams went to Frankfurt as the assistant Chief Nurse and then Chief Nurse. The commanders at the time were Col. Mel. Butler and Col. Ron Blanck, both classmates at The War College. A major problem encountered was that of the Nurse anesthetists and the anesthesiologists. It seemed the nurses were taking all of the calls on weekends and at night and home life was pretty miserable for them. When it was brought to the attention of Butler and Blanck, they got the two sides together.

General Adams was assigned back to The Surgeon Generals, as a nurse consultant to the Surgeon General’s position, working first for Jim James then for Colonel Jim Peake. My job was to advise the Chief on practical or personnel issues about what the Corps should be doing. It was not a decision making position, but one in which she advised the Surgeon General on nursing matters and the Chief made the decisions.

After two years in this position, General Adams was made Chief, Army Nurse Corps. One of the big jobs at this time was the drawdown in the Gulf War. Bosnia and Haiti were other problem areas beginning to arise.

General Adams served four years as Chief, Army Nurse Corps, and in 1995 she was appointed as CG Southwestern Medical Command, Fort Bliss, Texas, and eventually the commander of William Beaumont. That was a challenge to me for it was the first time I got to command a hospital as such. Another area that was new was that of UCMJ portion of the job. Adams had never been exposed to it before.

General Adams came out on the two star list and was assigned as CG, Pacific Regional Medical Command and Tripler Army Medical Center on 17 March 1998. She retired from that position on 17 June 2002.



## Personal Data



**Married:** Not married.

**Children:** No children

### Schools Attended

#### Civilian:

Cornell University, BS Degree in Nursing

The Catholic University of America, MS Degree, Medical Surgical Nursing

#### Military Schools:

United States Army Medical Officer Basic and Advanced Courses

United States Army Command and General Staff College

United States Army War College

## Career Summary

### 1967-1968

Army Student Nurse program, Cornell University, Ithaca, New York

Second Lieutenant, 5 December 1967

### 1968-1969

Medical Surgical Nurse, Brooke Army Medical Center, Fort Sam Houston, Texas

First Lieutenant, 5 December 1968

### 1969-1969

Army Medical Officer Basic Course, United States Army Field Service School,  
Brooke Army Medical Center

### 1969-1969

Medical Surgical Nurse, Brooke Army Medical Center, Fort Sam Houston, Texas.

**1969-1970**

General Duty Nurse, 121<sup>st</sup> Evacuation Hospital, United States Army Pacific-Korea  
Captain, 5 December 1969

**1970-1972**

Evening and Night Relief Supervisor, Department of Nursing, later assistant Head Nurse, Military Dispensary, United States Army Hospital, Fort Jackson, South Carolina Student

**1972-1974**

Student School of Nursing, The Catholic University of America, Washington, DC

**1974 1977**

Master Nurse Clinician, Intensive Care, William Beaumont Army Center, El Paso, Texas  
Major, 6 June 1977

**1977-1977**

Army Medical Center Advanced Course, Academy of Health Sciences, Fort Sam Houston, Texas

**1977-1978**

Special Assistant to the Assistant Chief, Department of Nursing, Fitzsimons Army Medical Center, Fitzsimons Army Medical Center, Denver, Colorado

**1978-1980**

Director, Intensive Care Nursing Course, Fitzsimons Army Medical- Center, Denver, Colorado

**1980-1983**

Assistant Inspector General, Health Services Command, Fort Sam Houston, Texas  
Lieutenant Colonel, 1 August 1983

**1983-1985**

Senior Staff Associate, Office of the Assistant Secretary of Defense (Health Affairs), Washington, DC

**1985-1986**

Student, United States Army War College, Carlisle, Pennsylvania

**1986-1989**

Assistant Chief, later Chief, Department of Nursing, Frankfurt Army Regional Medical Center, United States Army, Europe

**1989-1991**

Nursing Consultant, United States Army Health Professional Support Agency, 5109 Leesburg Pike, Falls Church, Virginia

**1991-1995**

Chief, Army Nurse Corps, Office of the Surgeon General, Falls Church, Virginia  
Brigadier General, 1 Dec 1991

**1995-1998**

CG, Southwestern Regional Medical Command, Fort Bliss, Texas

**1998-2002**

CG, William Beaumont Army Medical Center, Fort Bliss, Texas

**199??-2002**

CG Tripler Army Medical Center and Pacific Regional Medical Command, Fort Shafter, HI

**United States Decorations and Badges**

Defense Superior Service Medal

Legion of Merit

Meritorious Service Medal (with two Oak Leaf Clusters)

Army Commendation Medal

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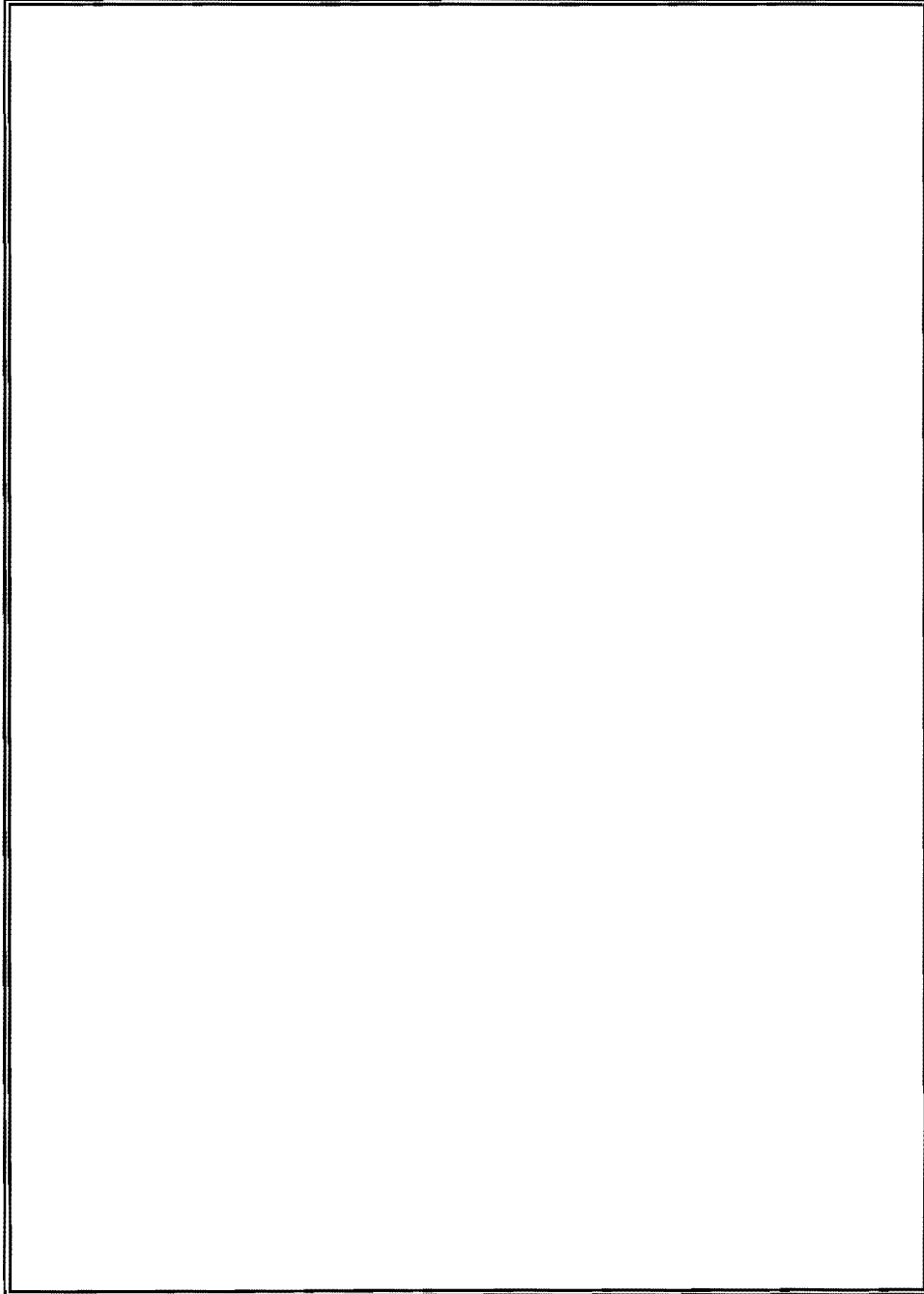
**Medical Memoirs**

**Major General Nancy Adams**

**U. S. Army**

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Nancy Adams

**Maj. Gen. Nancy Adams<sup>1</sup>**

**Early Years**

Q: General Adams, thanks very much for being with me today and giving us the opportunity to do this interview. So without further adieu, why don't we begin.

[REDACTED]

[REDACTED]

Q: And what were your parents' names?

A: My mother doesn't use her first name. Her first name is [REDACTED] but she always went [REDACTED]. At the time my parents met, it was during World War II and my mother was an Army Nurse Corps officer, and my father was a lieutenant in the Army Air Corps, and they were both assigned in Clovis, New Mexico, at the army air base in Clovis, New Mexico.

My father was injured in an automobile accident, I think. He had a head injury and was admitted to the hospital. So she met him when he was a patient, and they were married in July 1944. This all happened in a space of weeks. And they married, and I came along very soon — or rather she knew she was pregnant. So indeed she ended up getting out of the Army. I think her total time in the ANC was about 18 months. Women who were pregnant were discharged. Of course, many years later we were changing that, but during the war and the 1940s that was what the policy was.

Q: [REDACTED]

[REDACTED]

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This is a career oral history interview with former chief of the Army Nurse Corps and presently Commander of the U. S. Army Medical Center, Maj. Gen. Nancy Adams. The oral history interview was conducted at the U. S. Army Tripler Medical Center by Col. Mary I. Sarnecky (USA Ret.), a contract historian, Office of Medical History, Office of the Surgeon General, beginning on 9 January 2001. This document has been edited by Dr. John T. Greenwood, Chief, Office of Medical History, and by Dr. Barry W. Fowle, Senior Historian. The original tapes are located in the files of the Medical Oral History Program, Skyline, Alexandria, Virginia.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

**Q:** Describe your parents' influence in your decision to become a nurse and then join the Army.

**A:** When my father retired from business, my mother and father moved to Atlanta, Georgia. That was my father's home when he had come into the military, but because my mother was an only child, he decided to move to Rochester, so that's where her parents, my grandparents were in Rochester. So the family was raised in Rochester, New York.

I think my parents are very important, and in retrospect, you know, I can remember when I decided what to do, and it was a two part decision. Initially I was in a nursing program that took five years, so it was two years of undergraduate work.

Then I transferred to Cornell University for three years of nursing. Then after three years of the five-year nursing program, and as the oldest of six and with my sister, Barbara, two years behind me, and then my brother was about another two years behind her, I felt the need to be able to pay my own way. My father essentially paid for my college education. A college education was for him a must do thing. And, in fact, when I decided I wanted to be a nurse, he said, "Fine, but you're going to college." And, of course, back in 1965 when I graduated from high school, baccalaureate programs in nursing were still a relative rarity. The percentage of nurses who had a college education was, I think, around 5-6 percent back in those days. So when he insisted that, okay, you want to be a nurse, but you're going to go to college, that was his priority and indeed, he was prepared to pay for me to go to college.

My nursing school was in New York City, and living in New York, wanting to have a little bit more money, not just the money for food and such, I looked at the military. There was a student nurse scholarship program. For two years of participation you had to join for three years, and for one year's assistance it was a two year payback. To hedge my bets, then if I didn't like it I knew I could leave at the end of two years and I could make that.

Initially, when I told my father what I was going to do, he did not want me to join the Army, and we had some heated discussions. Of course, he was the father of five daughters back in the mid-sixties. There were still some stereo-types of women in the military. And yes, he had met my mother during the war and they had married, and everything was fine. But, you know, that was kind of different. He said, "Well, you know, I met your mother, got married, and she didn't stay in the Army."

Q: He saved her.

A: Yes. Well, you know, he never articulated that but it was kind of like well, I took her away from that. And, oh, by the way, there was a war. And this was 1965, you know, Vietnam was beginning but I don't think most people thought of Vietnam as a war. When I got in the Army it was 1967, because I was commissioned in September '67 -- no, I wasn't commissioned. I was commissioned in December '67, entered in September '67. There were discussions about Vietnam, and it was in the newspapers and on TV, but I don't think many people were paying attention to it. And for sure it never really got the status of a war, I think, until after it was over, you know. People still thought of it as a conflict or something that we shouldn't have been doing, that we were kind of messing around with in our spare time.

So he did not see the need in terms of the war, and his preference was that his daughter did not go in the army. So we had some discussions about it, but I was in

my young twenties and I really believed in it, and my mother supported it, of course, because she thought, "why not?" And I think gradually, you know, there's a difference between verbal opposition and standing in somebody's way. So initially my father tried to talk me out of it, but he really never stood in my way, and it never became a source of disagreement or disharmony after maybe those one or two initial discussions when I said well, this is what I'm thinking and what I want to do.

Q: Let's backtrack a little bit and describe, if you will, your growing up years.

A: Well, probably what I remember most about growing up is always taking care of my brother and sisters. As the oldest of six, you know, that kind of comes naturally, and I always enjoyed my siblings as babies. When you look retrospectively, I've never married -- do I miss being a mother? No, because I took care of them when they were younger, and quite frankly, I think I always liked them better as babies than I did in terms of the middle years. So maybe I got what I needed back then. Taking care of them in the early years and babysitting for other people in order to make money was enough. I got my first job when I was 16.

Q: And what was that job?

A: I sold -- I worked in a department store selling scarves, gloves, and hosiery. I got that job very soon after I was 16, working in a local mall in a department store, and stayed working there through my first two years of college part-time because I went to school in Rochester, New York. And I was always an avid reader. I read all the time.

Q: What kinds of things did you read?

A: Well, the nursing books, Cherry Ames and I can't remember -- there was one Barton. It wasn't Clara Barton.

Q: Sue Barton?

A: Sue Barton, and Sherry Ames, Nancy Drew, the mysteries, so I read those, and I read the Hardy Boys, too. I mean, those were available, and I tried not to discriminate, but I always enjoyed reading.

I was never any good at sports, did not play on teams in school or do that in terms of recreational activities. In fact, you know, back then we didn't call ourselves couch potatoes. We didn't have the TV as an excuse early on, but I was probably more of a couch potato than being active.

So my time was spent either helping around the house, trying to help my mother, and

with books. Girl Scouts was probably the primary activity in terms of socialization and doing things. When I was old enough, I got a paying job.

Q: Did your family move much?

A: No. We only moved twice that I can recall. Right after the war my parents bought a house in Rochester. In fact, a double house, I guess, or a duplex you call it now. We owned the whole house, but they rented one part of it, and we lived in the other.

Then when I was in fourth grade, we moved to the suburbs. That was the house that they sold when they moved to Atlanta. I was stable compared to what I've done now, in terms of the number of moves.

### **Nazareth College of Rochester New York**

Q: Did you do well in school? Where did you attend school, grammar school?

A: Grammar school, I went to Catholic grammar schools. Of course, I went to one school and then changed when we moved. When my mother and father married, my mother was Catholic and my father was a non-Catholic. The rules back then required him to be a Catholic in order to marry my mother. So he indeed became a Catholic and raised us as Catholics, and we all went to Catholic grammar schools. But then when it came to high school, we had a very good public high school that was within walking distance of where we lived. The Catholic high schools all required busing, plus they charged tuition. So when you're looking at a family of five or six, he did not think it was worth the money, plus the public high school right in our neighborhood had an outstanding Regents program in New York State. When it came time to go to college, I went to Nazareth College of Rochester. Initially, when I had planned to go to Nazareth, they had a school of nursing. My father had a working relationship with the school. My dad's professional background was as a certified public accountant, even though he worked in business.

But when he was doing CPA work, one of his clients was the Nazareth College of Rochester. So he had made arrangements for me to go to Nazareth and that was fine, and they had a school of nursing. I think the year I started they were closing their school of nursing, so it was obvious that I was going to have to change schools — if I still wanted to be a nurse. I started looking at the University of Rochester right in Rochester, which had an outstanding reputation, but even 35 years ago it was prohibitively expensive -- several thousand dollars a year.

On the other hand, Cornell University, which is one of the ivy league schools, had a nursing school which was very affordable -- a couple of hundred dollars a semester.

And I was able to get a New York State Regents Scholarship. Cost was a determinant of where I went to school.

Q: Were you a good student?

A: I always had to study. I never could take it for granted. And I did best in history and English, but was not a very solid math student. Algebra was fine, geometry was difficult, and I had to work with foreign languages. That didn't come easy, but I worked at it. And the sciences were okay except for physics -- I flunked high school physics, but it was a year when everybody flunked it, so then when the State adjusted the passing grade, I passed. I always did well in like the human sciences -- biology, physiology, pathophysiology. But with the more esoteric ones, even when studying, I didn't do well.

I did a lot of my school work at school before coming home because in a house where you have five or six kids, there's always a lot of noise and things going on. So I used the study hall at school and then I wouldn't have to be bothered with it at home.

### **Influence in becoming a Nurse**

Q: Who had the most impact in your decision to become a nurse?

A: There was a school nurse, a lady, and I corresponded with her for years, even to the point when I was in the Army. I think her name was, I want to say Phillips, Miss Phillips. And she was the nurse in school. So obviously, I was attracted to her, I think, because of who she was as opposed to visiting the school nurse all the time.

I think, in terms of her identity as a role model, she was very important. It's funny, I can remember my mother only working as a nurse twice during all that time. She went back to work once right after we moved into the new house out in the suburbs because when you have a new house, you want to buy things. And so she went back for a short time. But every time she went back to work, she worked nights, and she worked in OB or the nursery, and every time she did that, she ended up getting pregnant subsequently, and then that took care of the work. So I think my father finally decided that wasn't beneficial for the short term or the long run. But I don't remember her working that much as a nurse. So, you know, I think the nurse identity was more intellectual than actually substantive.

Q: Did anyone else influence your career choice?

A: My next door neighbor when we moved out to the suburbs also played a part. Her

mother lived with her, a lady by the name of Mrs. Clare. She had a stroke very early on. I used to go over and stay with Mrs. Clare, and essentially her daughter taught me how to help her. I remember learning how to get her out of bed, which side to assist her on, how to put clothes on, some of the same things that I learned when I went to nursing school -- walking her to the bathroom and being on affected side to support her and assist her in everything. So I think being comfortable around sick people, and thinking, I want to do this, and then working in the hospital as the flower girl, and seeing that environment, which I thought "it was exciting."

All of those experiences determined who and what I was to become. Also, in the sixties, realistically when women were thinking about careers, it was teaching, nursing, or secretarial work. Secretarial work, you know, equals paper work. I said no, I don't want to do that. And teaching students, that didn't appeal to me, so I guess by default that left nursing.

Q: You sort of fell into it.

A: Yeah, right, and then it worked.

Q: You talked a little bit about how you decided to go for your baccalaureate degree rather than the diploma program.

A: Well, the two years at Nazareth I think was a very good education. The sisters of St. Joseph were the teachers, and it was a total education. The nuns were involved in everything, so indeed I think paying attention to the maturation of young women was important. There was some affiliation with the boys college that was down the street, and I remember the Spanish courses were co-ed. There were a few classes when the boys went to the classroom with girls.

If you tell people that today, they look at you like what are you talking about. It was new back then. I liked Nazareth, and it was interesting. The nuns really were not happy when I decided to go to nursing school, and they talked to my father about it. They thought I should stay at Nazareth, complete the four years at Nazareth, and then if I really wanted to become a nurse, then do it then.

But that wasn't affordable -- well, it probably was affordable from a dollar perspective. I wasn't willing to invest two more years just doing college work, and not be doing something I wanted to do. But indeed they were very concerned that I was going to head off to New York City. In fact, I remember one sister saying that I would love my religion.



### Cornell University School of Nursing

Q: At Cornell, did you have any earth-shaking experiences there?

A: The city life at Cornell, life in the nursing school I think was new. I don't know if it's a function of my Catholic background or what. I don't remember my mother or my father sitting down telling me the difference between boys and girls. But I can remember having that realization as well as the knowledge imparted to me during my basic anatomy class when we had a male cadaver, and we started talking about it in specifics. So I guess I'd consider that kind of earth-shattering.

There was not a lot of excitement in terms of the educational experience. Being in New York, in a way, to be a student in New York City was exciting.

Q: How so?

A: Well, one of the ways I earned money, the only way I earned money prior to joining the Army, was babysitting. The nursing school ran a babysitting service where the student nurses took the phone calls in and scheduled babysitting services. I earned a dollar an hour initially in nursing school by babysitting. And, of course, it was people who lived on the upper east side in New York City, along the East River, in the sixties, seventies, and eighties, so I had the opportunity to go into people's homes. They were very nice. So it was a good experience.

And I guess the second part of my educational experience that was a little bit unique and also related to after-hours employment. After the first semester, the hospital, Cornell -- New York Hospital would hire the student nurses to work in the hospital on weekends or nights. You could schedule it for evenings or weekends. I was doing nursing assistant's work. My routine position was the chaperone for grand rounds. I chaperoned for all these senior physicians, surgeons, a nursing student with senior physicians.

It was very educational, too, and it was an education of a dimension that was beyond what I was getting in the classroom, in terms of Nursing 101 and Medical-Surgical Nursing.

I didn't have much dialogue with them as a student. They got to know me, and I got to know them, so it was kind of neat when I go on the wards then in my student nurse uniform, which was a blue plaid, versus on Saturdays when we worked we wore a white nurse's uniform. But when I put on the blue plaid, I still had an identity with some of those physicians, both staff physicians as well as the residents.

So that was something I really liked. It was an easy job, you know, for about two and a half hours on Saturday morning, then once I finished, I would go down to the supervisor who would assign me to a unit for the rest of the shift.

I liked surgery because this was surgical nursing. Then I would go down and report to the surgical nursing supervisor, and then they would assign me within the hospital where they would use me wherever they were short. That was kind of a downer in that I never got the experience of establishing rapport in some of the other units because they were used to getting the same people all the time. I always wanted to be independent, I guess, or pay my own way. So my parents gave me \$40 every other week, and that was to cover food, you know, if you ate in the hospital facility. That essentially paid for food, but any other expenses like clothing or entertainment were extra. I saved money from when I was working in the department store, and that was a benefit. I could buy clothes and get a discount and such like that.

I always had money to buy what I needed. Now, that said, I never was out buying more than what I needed, so I guess I was always kind of in balance in terms of what I needed versus what I had money to spend.

Q: How did you develop such wise spending habits?

A: Well, I guess part of that is due to my father, a CPA. He always focused in terms of "how much money do you have? What do you want to buy? How do you plan to get the money you need?"

I find that has worked well for me, especially in my current job as the commander, you know. I ask, "What do you want to do? Okay, where are you going to get the money?" Because being a commander is almost like being a parent. They come to you saying, "We want the money." I respond, "Well, you've already got all the money I had, so now what are you going to do?"

Q: Did you live in a dormitory at Cornell?

A: Well, I lived at 1320 York Avenue, the nurses residence, and it was the typical brick, nine-ten story building with a residence for staff nurses in the hospital. I think about the first four floors were the student nurses and then the rest were staff nurse rooms. The doctor and medical students lived across the street. They had another residence. And it was the first time that I ever had a single room because at home with four sisters, I always shared with either one sister or two sisters, depending upon the arrangement. As I was getting older, I shared with my two youngest sisters because then I was in charge, so it was my room. The nursing residence had a sink, a closet, and then a bathroom down the hall.

Q: Do you still remain in touch with any of your former classmates?

A: Oh, yes. Sadly, Cornell closed its nursing school back in the mid-seventies when the federal government changed the reimbursement for nursing education. They put out like a quarterly nursing letter that reflects the alumni. We have a secretary for the class. In fact, now we're on e-mail, so they send you messages about where people are and get-togethers.

So there's about five personal contacts that I maintain in the group. There was one faculty member, and now I can't remember her name, but she was very -- she was the lady who taught fundamentals. I did remember some of their names, but not now. One I do remember now, Doris Schwartz, who has got a pretty broad reputation. She was in the Army back in World War II. She always was very — I think she wrote poetry. Yes, she was very scholarly back then.

Q: Did you at any time during your nursing education have second thoughts about your career choice?

A: I remember anxiety during my nursing career. Because of the responsibility of taking care of patients, I guess I always was comfortable with what I was doing, and that was always important to me. In some areas of the hospital I felt more comfortable than others. The medical-surgical experience was my favorite.

So I never worried that I didn't like people, or I didn't like the knowledge or doing the work. I always liked the work. I never minded making the beds, you know, things like that. There was a kind of a satisfaction in making it look so perfect in terms of the square corners.

### **Joining the Army**

Q: When did you attend Officer Basic?

A: I had joined the Army a year before, so the expectation was that I would come on Active Duty after my State Boards. I stayed at Cornell to work that summer because they would allow us to work there pending the receipt of our State Board results. This was after the Tet offensive in Vietnam and the Army was caring for lots of patients. The Army had been working hard during that year, 1968, because of the casualties from Tet.

So I was in a group of about 10-20, I can't remember how many exactly, nurses. We were all baccalaureate degree nurses. They brought us on Active Duty to Fort Sam Houston, and with the intent of going to work at Brooke. They told us they were

going to give us a week to get us all oriented and get us to work, and we all went to work at Brooke. And the idea was that because we were coming in October, and we were at work by November, that this group would then be available for all the holidays of Thanksgiving, Christmas, New Years, because the staff had been working hard since Tet, which I think was February of 1968.

Q: Was it a good experience?

A: You had this group of nurses who thought we already knew it all, you know. We had been working for three and a half months at Brooke. So I must say we probably did some things that we shouldn't have done like skip classes. Why do we have to go to nursing documentation class? We've been doing this for two months.

Colonel Brook Serpe was in my basic class. She is the only one that I can remember by name, and somebody who also stayed on Active Duty for a career.

But I think at a point we were called in as a group and basically told, you know, "You guys need to go to class. You need to pay attention. If you think you don't need it, then come and ask permission and we will consider whether or not you can leave."

They were very accommodating. I know that we were being difficult. We thought we knew what we were doing, so to speak.

Q: Let's backtrack just a little bit. What made you decide to join the Army, not the Navy or the Air Force?

A: I think I went to the Army first of all because my mother had been an Army nurse. So I thought well, my mother did it, and maybe I can do it. One of my good friends at Cornell, she and another friend, they went to the Navy, and we were kind of checking them out at the same time.

And the Air Force, I don't know. I've always worn glasses since I was 13, and it was the prevailing thought that the Air Force wouldn't take anybody who wore glasses and, you know, it's funny when you think about it. You had to fit the image, and you couldn't wear glasses, or it was physically disqualifying because of the aviation message, or they weren't recruiting to the same extent that the Army and the Navy were.

So my two friends were checking out the Navy, I was checking out the Army, and of course, we compared notes. And I probably stayed with the Army because of the recruiter, and my recruiter was Major Mims Gately, who now lives in Florida, and we have stayed in contact my whole career. But she was Major Fately back then. She

was very personal in terms of her approach with me, very professional, very accommodating. She answered all questions, she made things happen. She had a vested interest, and I think it was the relationship or the interest that she showed me the basic wonder woman. I mean, she really just had it all -- she projected a very good image. She was well spoken and a lady. Everything else was basically equal in terms of the benefits package and all that other stuff.

Q: So you arrived at Fort Sam Houston and were immediately put to work you said in October of 1968?

A: Probably by then it would have been the first of November, because I got there about 20 or 21 September 1968.

Q: How many weeks in duration was Officer Basic?

A: Four weeks. Actual dates were 13 January - 14 February 1969. Since we are already working at Brooke, we did not know whether they were going to allow us to go back to Brooke or whether we would go on to another assignment. And the majority did stay at Brooke.

But that said, I was not back to Brooke more than a month when I knew I had orders to go to Korea. So we did basic at the Medical Field Service School, right there in the quadrangle at For Sam.

Q: So you attended basic at MFSS when it was in the original quadrangle. Did you go out to Camp Bullis?

A: And the only thing I remember about going out to Bullis was sitting in some open bleachers having some didactic lecture, and the gas chamber. I think we did a gas chamber experience out there.

Q: Is there any part of the curriculum or the POI that stands out in your mind about basic?

A: A movie on nuclear weapons. The only other memorable part was the nursing documentation only because it was such a new way of documenting. I liked the Kardex system. I can do better with the Kardex today than with all these new forms, you know. At least then you could see the chronologic order. So the Kardex and nuclear warfare were kind of the two things that stuck out most in my mind in terms of the basic experience.

Q: So overall it was a good experience?

A: Yes. Because we had been working, I think it was more or less a fun time because there was very little homework, and socialization with the people that were in the course was a big part of it, and hanging out together, and the regular hours.

Q: Monday through Friday?

A: Yes. You know, back in those days, I mean, you were lucky if you had one weekend in every six off. I worked on a ward that had only three military nurses, and the rest were civilians.

Q: Were you impressed with the caliber of people you encountered?

A: I think I was impressed by them, and I guess at the same time enjoyed them as individuals, It was a good feeling that we were all there together. There wasn't the distinction that you would think. You know, ordinarily in an educational experience you have the students and you have the faculty. But I remember more of a sharing time together because of places like the Pit, and there was lots of activity in the Pit during the week as well as on the weekends.

Q: Even as a student, you felt like you were part of an organization?

A: A lot of what I think basic was intended to communicate back then was already done by the work experience.

### **Korea, 1969**

Q: Did you intend to make a career of the Army from the beginning?

A: I expected to come in to pay back the two years because of the Army Student Nurse Program and to leave. I went from Brooke to Korea and was in Korea for 13 months, and in 1970 I decided to get out.

The war was going on in Vietnam, and Korea was kind of a second choice. It was great for physicians. We were short nurses, but not physicians because we had the draft going on for doctors. But there were not enough nurses and corpsmen.

The chief nurse in Korea and I did not get along at all. The nursing supervisor and I did not get along in Korea either. I was satisfied personally, I guess, in terms of taking care of patients. Some of my dissatisfaction was professional. For example, the one nursing supervisor I didn't get along with was more interested in appearances than patient care. Sitting down holding your skirt out was not a priority of mine, but it was a priority of hers. She did not like wrinkles. You know, sometimes things got

spilled on me, too, and those always were the important things to her.

That was what she focused on. Now, the chief nurse's big idea when she came in in the morning was to look at the Kardex. If you had not changed the numbers and dates through to the end of the form so that when you went to write it was in sequence, she said something. Nurses' roles were not important, but the numbers were. You had to go all the way to the end of the form. So I kind of decided, if this is what the Army's priorities of life are, this is not where I'm going in terms of nursing.

So I had decided when I left Korea that I was going to get out, and my next assignment coming back from Korea was Fort Jackson, South Carolina. At the hospital there, I had a totally different experience with nursing leadership. Our chief nurse was a lady named Thelma Freese. She was interested in me as a person. She assigned me to be the evening and night relief supervisor, which was the greatest job in the world. I was a captain, and I was in charge of the hospital when I was on duty. It was great. I roamed the whole place, knew what was going on. If they needed a nurse in ICU, I worked there. If they needed nurse in the ER, I worked there, and that early on caused a little consternation because they were so used to the supervisors pulling people to go from one place to the next, and I was a young nurse and wanted to work. My showing up cut down on the requests for help, by the way, because oh, you're the help?

But she trusted me to do that with increased responsibility, and I know that made the total difference, because I processed for separation at Jackson. The discharge physical examination, everything was done when I went in to say good-bye to Colonel Freese. She said to me, "Is there anything I can do to get you to stay?" And I said, "No, it's too late." She said, "You just tell me you want to stay." I said, "Well, I want to stay."

Q: While in Korea, did you have a mid-tour leave?

A: No. And that, I think, was probably a morale factor. They were trying to send the doctors away all the time, either continuing medical education, or they would take air evacs and take patients back. Rarely would they allow a nurse to go because they were short of nurses, vice the number of doctors we had. So we weren't even encouraged to take leave during that time, and quite frankly, you know, in Korea I thought, "Well, where do I want to go?"

I was always concerned if I left, I might not want to come back. So I thought it was best just to stick it out.

Q: While in Korea, how did you keep in contact with your family?

A: I can remember calling them from the airport at McCord Air Force Base,

Washington, at 1:00 in the morning. Because I had left from San Antonio to go up there, and then to Washington State, they were concerned. Back then I can't remember what the phone calls were, but in Korea it was like \$4.00 a minute or something. So for a year I did not call. I wrote many letters. They wrote frequently and all, but with the exception of letters, you know, it was a long 13 months away from home.

**Q:** Did you get any casualties from Vietnam in Korea?

**A:** No. No, no casualties from Vietnam. Back in those days, though, there were little border skirmishes that we were having with the North Koreans every now and then. They crashed a helicopter when I was over there, and the crew was held prisoner in North Korea for a while, and then returned to us. They weren't seriously injured or anything, and there were a couple of small fire fights where people would get hurt but, quite frankly, I think part of it was naive. If I knew then what I know today about Korea, I probably wouldn't have slept nights. But I didn't know about it. It was like, okay, we fought the Korean War, we drew a line, this is my side, that's their side, never the twain shall meet. We're okay. I just didn't think -- in fact, I often made a joke. I said, I'd rather be bored to death than scared to death, realizing that Vietnam was a hot combat zone. And most of the patients I took care of were either drug overdoses because there was a big drug problem among the GIs, and manipulative behaviors just like attempted suicides and things like that. There was somewhat of a retired population over there, and every now and then a retired sergeant would die from GI bleeding, liver disease, and such like that.

So it was interesting nursing, kind of different in a way. And, of course, I worked medical ICU, which was not my choice, but once I started it, I kind of liked it. I said hey, this is okay.

### **Graduate Degree Program**

**Q:** How did you fit in as a baccalaureate graduate with a preponderance of diploma graduate Army nurses at that time?

**A:** You know what, that has never been an obvious discriminator in my mind in terms of nursing. It took me a while to know nurses had different educational levels, and maybe you only know what you know, because I came into the Army from a baccalaureate program, and the group that I went to work with was all baccalaureate degree nurses. I never stopped to think about what the rest of the people were. It was only when I made the decision to make the Army a career and the Army sent me to graduate school that I realized well, I'm ahead of the pack because I have my baccalaureate degree. Then I had my Master's degree back in the early seventies, and



after I got my Master's degree I even realized what an advantage it was, you know, in terms of where it positioned me in the profession, as well as in the Army Nurse Corps.

### **Differences Between Registered Nurses and Corpsmen**

I think the bigger issue was always in terms of what is the difference between our registered nurses and our corpsmen, because our corpsmen were so good. I don't know when we formalized that, but I just remember my corpsmen in Korea were very skilled. Anything I could teach them to do, they could do, and that was kind of the attitude. And many of them were draftees who wanted to get out of the Army, wanted to go to medical school, so they obviously had an interest as well as the potential.

So I think early on I was not threatened but in awe of some of the enlisted personnel that I worked with. I remember early on making a commitment to myself saying I was always going to know what they knew in addition to what I knew.

So when I went to the ER I made sure to say you teach me how to do an ECG and suture to do those things that our corpsmen who were not registered nurses typically did. I never really, until I had a very good friend who had to get out of the Army because she did not have a baccalaureate degree, I never thought of that in terms of the differences among the nurses. It was more the professionalism in terms of our enlisted soldiers and what their capabilities were, and what do I as a professional nurse bring to patient care that is better and different than what my corpsmen bring to patient care.

Q: So you saw the discrimination -- discriminator, I guess I should say, between the nurses and the corpsmen?

A: Right. And, of course, when it comes to how you co-exist in the work environment, the obvious discriminator there was rank and the nurses' status. There was no tension in terms of who was doing what. It was more of the different levels by virtue of their enlisted status versus our officer status. But among the officers I never noticed any discrimination.

Q: Where did you live in Korea?

A: In Quonset huts. There must have been about five of us in a Quonset hut, in separate rooms with a common bath, a bathtub, shower, and toilet, and a separate kitchen area.

### **Physician in Charge Program**

Q: Do you have any recollections of the Physician in Charge program?

A: I only have recollections of the discussion that surrounded Colonel Frazier at the time.

Q: Colonel Doris Frazier?

A: Yes. And I think that happened back in the early seventies, and it was the time right after graduate school. So I went to graduate school at Catholic University of America from 1972-74, and I remember some of the discussions at night, and from an intellectual perspective and the fact that the Nurse Corps somehow got into cross purposes with the leadership of the ANA and the Army Surgeon General.

The physician, I guess, you know, was going to be in charge of nursing and nurses. We were very accustomed to taking physician orders. They were now going to be in charge of us in terms of evaluating our performance, and the time off and everything. Instead of having nursing in charge at the unit level, the doctor is going to be in charge. So there was going to be no organizational representation for nursing.

You know, I don't think that we heard the dialogue at all. I never thought much about it at that time.

So we were talking about Korea. Did you work long hours, because, of course, we were in a nursing shortage then, or did you just work eight hour shifts?

A: We worked -- we were scheduled to work eight hours, but I think the reality of it, we often worked six days a week, and that's how we made up the difference. I had a boyfriend in Seoul, so what I did was volunteer to work nights. The advantage of working nights was when you were at the end of your \_\_\_\_\_, I guess it was eight on and four off. The staff at the 121 was a very nice group of people, you know, and that's important in the small assignments.

There's a personality of the group, and I remember when I first arrived, the group personality was rather wild. It was what I would have called acting out back then in terms of behavior, and then that group rotated. Some were not happy to be in the Army or to be in Korea, and some of them adjusted better than others.

### **Intensive Care Unit, Korea**

Q: When did your interest and experience in ICU begin?

A: As I said, when I went to Korea, I worked in the medical ICU. Initially, I did not want to be there. I wanted to work surgical because that had been my experience.

My ICU interest developed when I worked as evening and night supervisor at Jackson. More often than not the ICUs or the ERs where they needed nursing help, and I would go down and work there, and liked it. After I made the decision to stay in the Army, they changed my job to being the assistant head nurse of the emergency room. I did ICU seven years before I went into nursing administration.

I guess I was never smart enough to put it in context of a career. It was basically this is what I'd like to do in terms of patients. I wanted a dynamic environment where I thought nurses could make a difference in both taking care of patients as well as working closely with the physicians.

### **United States Army Hospital, Fort Jackson, South Carolina**

Q: Okay, we talked about your intensive care interest starting really in Korea and in 1970 when you were at Fort Jackson?

A: Right.

Q: And — How did your assignment to Fort Jackson come about?

A: The Army sent me to Fort Jackson. I was in South Carolina, which was closer to New York than where I had been. Also my family — and my father's family is from Atlanta, Georgia, so I figured well, that's not bad. I'd never been to South Carolina. I have never said I don't want to go — you know, never said I have to go here, I must do that.

When we were filling out the so-called dream sheets, there were places I thought I wanted to go because they sounded good. West Point was always on my dream sheet, Fort Carson, Colorado, was always on the dream sheet. But the destinations were never a priority for me. So I never bothered to ask to come to Hawaii, you know. Just figured they wouldn't do it.

Q: So I guess when you arrived at Fort Jackson, it was USAH Fort Jackson?

A: We were in the midst of constructing the new hospital, and in fact, we moved into Moncrief Army Hospital. The hospital was old ramp construction covering two or three blocks, you know, a lot of walking.

Q: Did you have any input into how the new hospital was built?

- A: Yes, as far as the emergency room went because I was the assistant head nurse in the emergency room, and I do remember discussion about where bathrooms were to be located, where the sleep rooms were, things like that. It seemed to me it needed a lot of fine tuning in order to make it efficient. It wasn't very functionally organized.
- Q: Did you consult with the group that came around and planned the hospital construction?
- A: What I remember was periodically we would have to schedule time to go over there, do the walk-through, and talk, okay, what's going to be there, what's going to be there. The people were there and I don't know if they were the local engineers or they came from someplace else. There was no bathroom for staff or for patients. That was something as I recall that couldn't be changed because of where they were in the construction process.
- Q: You changed roles frequently at Jackson. Did that affect your career and subsequent assignments?
- A: Lo and behold I applied and was accepted for graduate school. I realize now, I went to graduate school before I went to the Advanced Course, you know. So from a Corps chief's perspective, I never would have allowed that. Here's someone who has had two assignments in the Army, barely four years on active duty, figuring I came in in '68 and I started graduate school in '72, so I was selected after having three years in the Army. I had not been to the career course, so they were making a giant leap of faith. I have to thank Colonel Freese for that because I know that was not the impression my chief nurse in Korea had. I think she thought I was a thorn in her side.

### **Officer Efficiency Reports**

- Q: At that time, did you get copies of your OERs?
- A: You know, when they went to microfiche, they gave them all back to us.
- Q: So you saw what the Korea chief nurse had to say about you.
- A: Yes. I was never what I would call a wallflower, I guess. I always had something to say about something, and so yes, they felt free to criticize me and I felt free to criticize them. Which, you know, nowadays, when I meet a lieutenant or a captain who may be inappropriate and they're talking to me, and I remember what I was like.
- Q: So your experiences in Korea seasoned you?

A: I survived that, and it had a beneficial effect because rightly or wrongly, since I was a lieutenant, the commander knew me. I started at Brooke and the gentleman who was in charge was a colonel. He made general when I was there, but he and I knew each other personally. Now, how many 2d lieutenants know the general? But for whatever reason, my whole career, I have known and been known by the general of the hospital.

### **Off Post Housing**

Q: Did you live on post or off post at Columbia, South Carolina?

A: I lived off post.

Q: In an apartment?

A: In an apartment, initially by myself and then met another Nurse Corps officer at Fort Jackson and we shared an apartment.

Q: Did you enjoy living in Dixie?

A: I don't know what your experience was, but I felt like a Yankee. So if you didn't talk southern and you were in the military, they didn't really particularly care for you. And that experience -- I had that experience in church off post, going shopping off post. I felt very much drawn to the military community because the civilian community was not a positive or nurturing experience. It was kind of like we were second class citizens.

I figured out we were essential to their economy, but they were not very inclusive. I never really stopped to think about military community relationships until I went to El Paso, this time as a commander. When I was in Washington, D.C., for graduate school in the mid-seventies, that was in the peak of the anti-war demonstrations. We were told not to wear our uniforms to school. In fact, in Washington, D.C., I don't think they were wearing uniforms in transit to work because of the demonstrations. The seventies were kind of a tough time, I guess, for civilian military relationships.

Q: How were your transitions moving from job to job handled?

A: I think nursing in the Army has always been well organized. My attitude was well, if I don't like this, then something better will come along and, you know, I'll put up with it.

### **Military Staff Returning from Vietnam**

Q: What were your observations about the military staff who returned from Vietnam to assignments at Fort Jackson?

A: I do remember that among the corpsmen there was frustration. You had to watch that our physicians would not inappropriately delegate to the corpsmen. The surgeons did not want to come in, so there was a lot of that in terms of laboratory tests and X-rays were done before they were called to come to the ER.

Q: What was your contact with Reservists then?

A: In fact, I don't remember Reservists or National Guard per se becoming — even having an identity with me until I was at William Beaumont during the summer with Reserve units coming in and training, and maybe extra help.

Q: Were there staff shortages?

A: We worked hard, but I didn't think we were abused, in terms of the hours, the days, and days off. It was tough because there was a nursing shortage at the time. I didn't mind working when there was work to be done. But I don't think there's nothing worse than making people work and calling it training.

### **Masters Program, Catholic University**

Q: Now we're going to move on to your Master's program. What motivated you to apply to go to school?

A: The chief nurse at Fort Jackson basically talked to me in terms of career development and what I wanted to do. Of course, I knew the Nurse Corps was involved in education because I was part of the student nurse program while an undergraduate. But I did not really have any awareness of graduate level preparation until she talked to me about it.

Q: And were there many people going for their Master's degree? As I recall, there were a lot of them going for their baccalaureate.

A: I had two other military -- two other Army nurses with me in the class, and there were one or two Navy nurses. So there were, I think, at least five of us there. And that was also at the same time LTC Rosemary McCarthy was getting her Ph.D., and there was another Army nurse, Dee Kucha, who was also getting her Ph.D. I didn't have any visibility of people at other schools. But I thought that was a pretty significant

contribution at the time.

Q: It really was. So Colonel Thelma Freese encouraged you to go, and what universities did you think about asking to go to other than Catholic?

A: Well, you know, at that time I recalled the NLN put out a brochure that basically listed the program titles and requirements. And I was never a fan of nursing research, and did not have any vested interest in a particular topic, and really wanted to be -- was looking at acute care nursing in MEDSURG. I wanted a generalist type role. And I remember from reading the NLN brochure that Catholic U. had the MEDSURG focus, as well as a non-thesis requirement. And Washington was a good place to go to school, and so that was the only school I applied to. I applied and was accepted, and it met my needs, so that was fine. I wasn't looking geographically to go further away, and their program just seemed to be a fit.

Q: Did you get picked up for schooling the first time you applied?

A: Yes. As I recall, I was getting ready to leave the Army in October of '70, and so the following year I applied in '71, and then I moved in July of '72. So it happened as it was supposed to, I guess.

### **Job Hunting**

Q: Now, you talked about how you were going to probably get out of the Army at that point.

A: Right. I already had gone out, looked for a job, had a job, was planning to go to Tennessee and work at Vanderbilt University. I went there and interviewed for the job at Vanderbilt. It's a great university, and a great hospital. Why I didn't follow through was because of what I perceived as limitations in nursing practice in the civilian community vice what we were allowed to do in the Army. This includes such things as being able to draw venous bloods, being able to put in an NG tube, being expected to do, even back then, physical assessment in terms of your patients, listening to breath sounds, and bowel sounds, and such.

That was not the expectation of nurses in the civilian hospitals. In fact, and because they had medical students and residents at Vanderbilt, it was made very clear that that was the doctor's role.

Now, I had worked with residents down at Brooke and I knew that even in those settings, that the Army nurses were still starting IV's and irrigating NG tubes, and doing things like that. We didn't call the physician for everything.

So in terms of the practice environment, I was not convinced that that was what I wanted to do, and in terms of a nursing job, it didn't seem to be any better of a job than what I was already doing at Fort Jackson. And at that time, as I said, I was evening night supervisor, but yet in terms of the nursing responsibilities, I felt I could do more in the Army than what I could do as a civilian.

Q: Do you think that holds true today? Do nurses in the Army do more?

A: I don't think I have a good basis of comparison, though I think from what I hear and what I read in terms of the non-licensed personnel that we may be doing more for patients under the auspices of nursing and its fragmented care in the civilian community. I'm not satisfied with care here at Tripler, and in some ways I think it still is too fragmented. But I see us trying to bring it together, more than what I hear is going on in the civilian community.

And now when I read about expanded roles of nursing to educate a nurse to replace a resident in ICU, I think there is now the tendency in the civilian community to use nurses to do more for patients, but not necessarily under the auspices of nursing, to replace somebody else who is more expensive in the system.

### **Quality of Education at Catholic U.**

Q: Back to Catholic U., how would you characterize the quality of the educational experience you received there?

A: I thought it was outstanding. In terms of the didactic, it was great. I think the one limitation of Catholic University is the competition in the national capital region for clinical facilities. So essentially, it was up to the student to find the clinical experience you needed to support what your academic course-load was. And, of course, the university and the nursing faculty could recommend where you could go. I was an Army nurse so of course they said well, you need to go to Walter Reed.

Well, I didn't want to go to Walter Reed. I wanted to see how other people did work. So that's how I ended up going down to George Washington University and working in their intensive care unit as part of my practice in one semester.

I also went over to Washington Hospital Center. It added an extra degree of difficulty to the educational experience when you have to go seek out your practice setting, because there was nobody then who has fostered the relationship there in the environment between the student and the facility. So I don't think it's as efficient as when you have your own university hospital where they know the faculty, and then you have a stable experience.



Well, the tendency at Catholic U. was each semester, depending upon what the focus of your curriculum was, finding a different practice site to support your objectives.

Q: So if you knew a lot of people, you were in good shape probably, and maybe got a quality experience.

A: And, of course, you networked a lot among your other classmates and there was a cardiovascular nursing program at Catholic U., and those individuals were doing more ICU than maybe even I was doing in terms of the program because the cardiovascular was so specialized within ICU. I wanted a more generic experience, so those individuals helped me.

But I think overall, because I had the luxury of going to school full time and not having to earn a living because the Army was paying, I could really maximize the educational experience. In fact, I was able to take an education minor as well as the minor in clinical nurse specialization.

So I did the curriculum development and related experiences, in addition to doing the clinical nurse specialist role, because I had the time. And, of course, they allowed us to go to summer school so I could take some extra courses in patho-physiology. And, in fact, I remember I had taken the one course in the nursing program and wanted to take the advanced physiology course. But nurses weren't ordinarily allowed to take the course. So I had to ask if I could do it, and indeed did it and enjoyed the course, passed it.

Q: It gave you a good background.

A: Yes, right, but that was where my interests were in terms of learning more of the science and how the body works and such. So the education was good and the faculty was good also. I especially appreciated the content on the nursing process. Mary Walsh, who was on the faculty at Catholic U., later wrote Nursing Needs and the Nursing Process (Helen Yurg and Mary B. Walsh).

Subsequently, I had the opportunity to contribute a chapter to their book. After I left the university and was back in clinical practice, I stayed in contact with Ms. Walsh. But I haven't heard from her in years. But that was obviously a very quality faculty there at the time.

Ms. Janet Fitzwater, who taught patho-physiology, and was a very good Public Health Service officer, was on the faculty there — the first indication I ever had that there were nurses in the Public Health Service. And things I know today and I take for granted, I was so naive about 30 years ago.

- Q: Well, that's how we learn and grow.
- A: You know, how could I not know there was a public health service and there were nurses in it? There was a time that I didn't.
- Q: Do you feel that the knowledge you gained there in that civilian sector was readily transferrable to the military?
- A: It was readily transferrable. I think the big challenge I had was going from the educational setting at the Master's level, back into a traditional hospital setting, and then for me to be able to quantify in tangible terms the difference that that educational experience made in terms of my practice as a nurse. And I think when you have your education, you want to prove it, so to speak, to look at how better you are able to do the job.

Initially that was kind of a challenge, and I know I challenged some of my peers who are still friends with me today because they were the head nurses on the SICU, the MICU, the CCU, coronary care unit. They had the day to day responsibility for taking care of those patients, and I was, as a clinical nurse specialist, not accountable per se for caring for those patients, but wanted to tell them what to do, literally. And indeed on occasion I was there as an extra pair of hands, and could deal with the complicated cases, did a lot of work with families, supporting families in times of crisis early on, but then I started to gradually find a niche in terms of the health care delivery role.

Once I got over the intellectual hurdle of recognizing if you can't do the minimum essential nursing care, which is implementing the doctor's orders, there is no role for advanced practice. You've got to be able to do what has already been established, and then once that's taken care of, then you start looking at advanced practice nursing in terms of having a comprehensive, integrated plan to meet the patient's needs.

So I came on a little too strong there initially at William Beaumont for my peers, who all subsequently went on to get their Master's. So at the time I was just a little bit ahead, but they all caught up in the long run. Jo Ellen Vanetta, she was one; Patty McCormick and then Val Johnson, all great nurses who were good head nurses. Working in partnership with them, I was able to develop the role of the clinical nurse specialist in ICU, which, of course, you know, we hadn't had before, and it was new. They didn't know what to expect, I didn't know what to expect, but I knew I wanted to do something because I had had this great educational experience and thought I had something to offer.

- Q: Do you feel that they were sympathetic with you on campus at Catholic U., with your special needs as an Army student; for instance, knowing that you had a set amount

of time to get through?

A: Actually, I don't think that was an issue at all because essentially I had four semesters to do the program, which for the Master's program is more than adequate. I had extra time, so I really did not need to -- I didn't need any dispensation or anything. I was just making the best use of the time that was available. I thought that was my responsibility, so that if I had free time, since I didn't have to go get a job, because I was paid a salary by the Army to invest myself in the educational effort versus doing anything else.

So I think it was obvious, and I say that because we had a couple of study groups, that the faculty liked the military students because the military students were committed to the educational experience. Because our tuition was paid, they knew we were going to stick with it. Many of our classmates were either mothers who were going to school part time, or nurses who had to work full time and try to go to school full time, and I have a couple of friends who did that. I marveled at having the physical stamina to be able to do that. While graduate school does not involve being in the classroom eight hours a day, you need the time to think, to write papers and such. So I think the military students were appreciated because we were able to become full time students, and they knew that because of the military requirements, we were probably going to be successful. We weren't going to drop out.

### **Assignment to The Office of the Surgeon General**

Q: How were your personnel needs met? Were you assigned to the student attachment at the Academy of Health Sciences, do you recall?

A: I think we were assigned to The Office of the Surgeon General, and I only say that because I remember a couple of contacts with The Surgeon General's office, you know below the level of the assistant Corps chief, but I don't remember anything coming out of Fort Sam Houston. And, in fact, our personnel -- I remember in-processing over at Fort Myer, and I was trying to think where we turned in dental and health records. I don't think I accessed either during the two years that I was there, so it wasn't an issue.

Q: It probably wasn't a problem at all.

A: No. Pay was never an issue. But I thought we were assigned to the Military District of Washington, MDW, because I seem to remember getting a crest to wear on my uniform with a sword and whatever, to say we belonged to MDW. And the Army had little to no contact with anybody in school. As I said, a couple of times we called the office of the chief for something. Probably when it got time for assignments to say

who do we need to talk to, and that became an issue.

### **Prejudice in the District of Columbia Area**

Q: Was there any prejudice against the military? Here we're talking early seventies, again, before Vietnam was over.

A: No. You know, we were in Washington and we were given written guidance about not wearing the uniform. But the people who knew we were in the military didn't seem to have any problem with us. And that was '72-74. In fact, it was during that time the Vietnam War ended because I remember the prisoners of war coming home and staying up to watch it on television as they landed, and that was when I was in grad school. That's why I remember staying up until 1:00 in the morning, because I had the freedom to do that.

But no, there wasn't any prejudice -- not at Catholic U. There was no anti-war activity.

### **William Beaumont**

Q: Now your next assignment was to William Beaumont. Were you allowed any input into that assignment?

A: I think I was allowed input in it. They told me about this great job, and it sounded so wonderful, I said yes, I want it. That was a function, I found out later, of Kitty Betz, who was the Chief Nurse at William Beaumont. Colonel Betz got her graduate degree from Duke University, I found out later on. She had a concept in terms of using the clinical nurse specialist role to provide assistance to patients and to the staff members.

So subsequently, when I got to Beaumont, we had a clinical nurse specialist in psychiatry, in pediatrics, in ICU, in infection control, which was a relatively new role then, and in respiratory care. So that was part of her concept, and I was lucky enough to be asked if I wanted to do the ICU and I thought gosh, that sounds wonderful.

Q: Did you know Colonel Katherine Betz before?

A: No.

Q: Do you think that was a unique outlook that she had there at Beaumont?

A: Yes.

Q: Because it wasn't going on at other places?

A: Yes. And, I guess, looking at it historically and seeing where we've come or not progressed with the role of clinical nurse specialist, I think she was a visionary, because somewhere along the line she communicated to me my job was to help the nurses in terms of how they're taking care of patients. And yet when I look historically at how the role of the clinical nurse specialist has evolved, I've seen the clinical nurse specialists be in their own orbit, so to speak, and you can't count on them to take care of patients, or to take care of the staff.

Q: So they're doing other things like research or teaching?

A: Right, and they're doing nice to do things. And then you get back to okay, what is the core business, what are the minimum essential tasks? And if somebody tells me that I've got a lot of young lieutenants who don't know how to take care of patients, my first response is where are my Master's prepared nurses? Well, where are they? They're wearing not hospital whites, they're wearing Class B uniforms sitting in offices.

So I think even back then she was on the cusp in terms of saying where this role needed to evolve, and I think she planted a seed in me. I'm still searching to make that the norm in terms of the Army Nurse Corps, because I don't see it happening. And, in fact, someone said, and it's not original to me, we've managed to master ourselves away from the bedside. And I think there's a lot of truth to that. And part of it's because people are escaping from what the traditional bedside nursing has been.

Well, the patients don't need us to escape, so to me the approach would be well, how do I change that environment? You don't change it by separating yourself from it. You've got to immerse yourself in it and be a change agent. So yeah, I think Colonel Betz was very much ahead of it in terms of best utilizing all the resources that she had.

Q: So you, then, had a number of peers there who were doing the same thing already, and that was probably a help.

A: Yes, that was a lot of help because, you know, first of all, there were a lot of people who did not think we were gainfully employed. The nurses that you worked with directly, like the head nurses in ICU, knew we were working hard. There were some differences in terms of what we could do to make the best use of our time, and that was a learning curve. When you'd see the physicians and because I was a hands-on person, they knew what I did. I knew how the Swan-Ganz catheter worked, and I

knew how arterial lines would work, and I was always making myself available to them when they were putting in lines, and zeroing the equipment and all.

Of course, the doctors wanted me to work for them. They said, "Well, good, you can come work for me now." But I felt, "I'm working where I need to work." So there was a lot of confusion.

Another source of consternation was within the nursing leadership, with the nursing supervisors, because we worked directly with the bedside staff. My rater was the assistant chief nurse, and my senior rater was the chief nurse, and for me, that made sense because I was working between medical and surgical ICUs. So we had, you know, the medical wards -- the medical belonged to the medicine supervisor and surgical belonged to the surgical. So they could not have shared me as an asset. And they were very unhappy that I did not work for either one of them, because, of course, if they had a nursing shortage, the first thing they wanted to do was for me to be the staff. And Colonel Betz was very adamant in that. And, in fact, I was willing to be staff prn because I thought it would help to solidify my position with the staff nurses in terms of my skills and knowledge, and I liked taking care of patients.

But she said, "No, you know, if you start down that route, then you're not going to be able to do these other things." And I admired her for doing that, because that might have been the easier way to go, for me, to get acceptance early on.

Q: And keep everybody happy.

A: Right. But she said no, you're not here to be the part time staff. I've got other ideas in mind for you.

### **My Management Style**

Q: Describe your management style at that time. I guess you really didn't have a management style.

A: No, I didn't have a management style, but it's interesting because one of the limitations that I thought I had was not having any line authority over assets. Changes had to be implemented by consensus rather than just by saying you need to do this. And such things as taking an orientation class, and getting the right people to come to class, I couldn't tell those nurses and I couldn't tell the head nurse how to do the schedule or anything like that.

My management style tends to be more authoritarian, deciding what we need to do, and then assigning people. That job forced me to work in a staff relationship with them, and it had to be their idea when we did things. And so, you know, maybe in the

long run it compromised efficiency, but we got it done. And, in fact, subsequent to that experience, I've always thought that the clinical nurse specialist, or the advanced practice nurse role in this type of an environment needs to have some line responsibility. I've tried to do that here at Tripler using a product line concept, realizing the balance between administration and management is going to change, depending upon how large your area is.

So if you've got the medical product line or the surgical product line, that lieutenant colonel who works with the medical director or the surgeon is going to be essentially 100 percent management. I mean, they don't have the capacity left over for anything clinical. But I think as you go down, then, you need to look to see how you organize within your product line so you can have a blend of management and clinical expertise, with the clinical being what dominates.

You need to focus on the clinical responsibilities instead of what we've tended to do historically, i.e., magnify the management responsibilities to justify the ranks. So you've got to supervise more people, and you have to manage more dollars, and you have to cover more area to justify the rank.

The main question is, what are the clinical needs? Then focus on that, and give the person the management to meet the clinical, instead of just to justify the rank or the position. So, you know, I think you have to have accountability. That's the bottom line, and how you structure that depends on your environment.

Q: So at that point in time you were trying to be more persuasive.

A: Right. And I was a captain, you know. And the interesting thing about my career, I have never been a head nurse or a supervisor. I escaped those roles. I was the assistant head nurse at Fort Jackson for the ER. Then the clinical nurse specialist, so that was not a traditional role, and I became the director of the ICU course, so that was a leadership role, but not-- not within the traditional hospital structure.

Q: Not on a par with the head nurse, either.

A: No, so it's kind of out in your own realm. And then I was out of the hospital for several years, and when I came back in, I came back as the assistant chief nurse at Frankfurt, and that was for a year, and then I became the chief nurse.

So I've never done the traditional mid-management roles, I guess, is what you would call it. Though I would consider the head nurse role to be the pivotal role. That's where the nursing makes the difference in whether you're talking about an outpatient unit, or an inpatient unit, or a specialty care unit in terms of a concentration of

nursing assets. I think that's where you have the ability to have the accountability as well as the responsibility for the outcomes in the management of the resources.

Then when it comes to those other roles, I think that's where it becomes difficult to get the best return on the investment for the education and experience, because those are usually your individuals with your advanced education.

### **Other Roles**

**Q:** The other roles -- what other roles are you talking about?

**A:** Well, the nurse practitioner roles, advanced practice nurse roles. I tend not to talk about nurse practitioners in the same sense because I do think that nurse practitioners do not do the nursing role per se. They do not augment nursing in the clinical environment. They augment the physician in the clinical environment. Now, they're doing nursing within that context, but I see them more as the physician extender rather than the nurse extender, or the advanced practice nurse role, clinical nurse specialist role, I think gets more from the overall investment in nursing as opposed to taking over patient care responsibilities from the physician.

### **Changes in the Critical Care Environment**

**Q:** Tell me how the environment -- the critical care environment was changing at that point in time.

**A:** I think this was in the mid-seventies, so I think we were getting more pro-active in taking care of patients, and more aggressive in terms of resuscitation, such as the use of the ventilators, pacemakers, the pharmacology, thinking in terms of giving a pressor agent on one side and something that would increase your output on the other side, which might lower blood pressure because it dilates.

So there was a lot of -- experimentation is not a good word, but there was a lot of aggressive medical practice that was coming into the ICU. When I graduated from nursing school in 1968, student nurses were not allowed in the ICU. In fact, I can remember looking in from the window. That's all we were allowed to do. We weren't even allowed to cross the threshold. So that was in 1968, and here this was 1974, so it's not even a decade later, and I saw nurses being very much involved in delivering those therapies as ordered by the physicians.

**Q:** With a lot more knowledge for the critical care nurse.

**A:** Right. A lot of education, and that was one of the roles I took on early in terms of my



role. That was also when the Critical Care RN certification program began and ICU nursing started. One of my proudest accomplishments at Beaumont was to teach, of course, to prepare people for certification. I passed, as well as several other of the individuals who took the course. I think we were within the first year or two of that exam, the critical care registered nurse, the CCRN.

Q: So the American Association of Critical Care Nurses administered that credential.

A: Yes, right. And that was back in the early seventies when that started.

Q: So did you have any other contact with critical care students at that time?

A: No, it was within the context of the staff nurses that I had the most contact. Because with the exception of a few graduates who had come from the Army program, Captain Vanatta, the head nurse of the ICU, and Captain McCormick were among the few who had both attended and graduated from the Army's ICU course up at Fitzsimons. Most other people who worked in ICU did not have any specialty education. They were all OJT, people who expressed an interest in working there, and then learned what they needed to know.

Initially, ICU started with the coronary care nurses who were expert at arrhythmias, but in the mid-seventies you had to know a lot more than arrhythmias, the fluid, the electrolyte balance, different pharmacologies in terms of the effects of the drugs and such. So it was starting to mushroom, I think.

In terms of what you needed to know for SICU was not the same as what you needed to know for medical ICU. Wound management in the SICU was a big issue. And there were some things that crossed over the units and that we tried to reach consensus on like decubitus ulcers, something we're still dealing with today; complications of immobility; and some of those things that were kind of core curricula that you share among the different units.

Q: Is that the time when the critical care courses were being started in the Army?

A: No, we must have been at least three or four years into it. I'm trying to think because Captain McCormick came from on the Fitzsimons ICU course. I think Millie Fritz had been the course director, and I think she started it at Fitz. So that must have been within the first two or three years. And when I took over as course director at Fitz, Nan Borg was still down at Brooke, and I think Nan started the course at Brooke. I'm not sure on that, but I know Nan was very early on in terms of the ICU nursing course.

I remember working with Nan as a director, and as I said, I remember one of the first things I was told I had to do was to update the POI. So that suggested to me we had a POI that had been put into place, and so we were at the point of improving it. So it seems to me that it must have been going on for a couple of years, or four to five years of experience when I started to get involved in the teaching of the ICU course.

### **Katherine (Kitty) Betz**

**Q:** At this time, in the mid-seventies, post-Vietnam era, how do you feel that the Army Nurse Corps was fairing? Were there major threats to it?

**A:** Well, I think, you know, because I was a captain, I was relatively isolated from the Corps business. My environment was my hospital and my chief nurse. And I think I lucked out. Kitty Betz was fantastic, and she was my role model for a chief nurse because she was the chief nurse for anybody who worked at William Beaumont. She knew every doctor by name, she knew all the staff. So she wasn't just the chief nurse for the nurses. She was the hospital's chief nurse, and that's how she implemented the role.

In fact, my only cognizance of the Corps came when they chose the Corps chief, and I can remember because you knew intellectually what the Corps chief was -- the number one person in charge. And I thought my chief nurse should be the Corps chief. And when Madeline Parks got it, I did not know General Parks or Colonel Parks at all. I mean, I didn't know her personally, or as a figurehead or anything. And I can remember I and another nurse went and told Colonel Betz that we're going to get out of the Army, because she wasn't going to be Corps chief. And because I think it was about the time that announcement was made, Colonel Betz also then let us know that she was going to retire. I don't think it was cause and effect, but I know you reach a certain point when you've done what you wanted to do and there's nothing else to do, and so if she wasn't chosen to be Corps chief, it made sense that she elected to get out.

But I remember I and my good friend who was the clinical nurse specialist for pediatrics said, "Well, we're going leave -- if you're going to retire and leave, we're leaving, too." And she said, "No, no." She sat us down and did some counseling in terms of our career development. And, of course, this was before I had even gone to the career course. So I was still relatively new in Army nursing. I came in in 1968, this was about 1976, I guess. So I was still relatively new in terms of Army nursing.

### **Pregnancy**

So from a Corps perspective, I don't remember anything going on. I do remember a

couple of IG visits where senior officers would ask us, "How do you like the Army, and what don't you like?"

A lot of focus at that time was about the issue of pregnancy. Of course, because of the large number of women in the Army Nurse Corps, that was an issue for us because, quite frankly, if you weren't married and you weren't pregnant, it seemed to me that the rest of us were working harder because of the losses, you know, the six weeks to three months or longer of convalescent leave if people had difficulty.

So the pregnancy issue seemed to be the one problem that I remember coming back and people asking and talking to us about. Shortages of staff were another issue. Part of that was because I worked in ICU and it exerted great demands on us. We worked very hard back then, and in fact, I try not to think about the good old days when I'd go upstairs and see a nine bed unit and there are four nurses on duty. Well, we had 15 bed units, and if we had two nurses, we were lucky.

Was that good? No. But we did it, and I think we gave quality care. So I know we worked hard. I typically came into work before 6 in the morning and left after 6 at night, so nothing much has changed for me in 30 years! Many of the nurses worked that hard, and we didn't seem to mind it. Today people mind it and won't do it, so there is a change.

Q: Or they do it and gripe about it.

A: Well, yes, and they won't stay. That would be a reason for them to leave. So taking care of patients was never a reason for me to think about leaving. And as I said, the time at Beaumont, that was from a clinical perspective -- those three years were the best nursing experience that I had in terms of being able to make a difference in taking care of patients.

Q: So that is probably the one thing that stands out in your mind about this assignment, your great relationship with Colonel Betz and the things that you were able to accomplish.

A: And good peer relationships in terms of the nurses that were there, both from the staff nurse perspective as well as those that worked in the clinical nurse specialist positions. And my best friends today are from that period of time.

And the other neat thing, when I went back to Beaumont as the commander, was the civilian nurses who still work there who remembered me, for better or worse, you know. Some of them came out of retirement to come back to see me just to say, "I can't believe it!" But the fact that there are those relationships, and good

relationships with the physicians, too, I remember that, especially on the medical side of the house, in terms of my interpersonal relationships, working with the physicians.

### **Sexual Harassment**

**Q:** Is there one thing that you'd most like to forget about that assignment?

**A:** I don't know if I would actively want to forget it, but it has come full circle. It's become relevant in today's environment and that's the issue of sexual harassment. I was young, I was 30 or so, and not married, and I will tell you, because of being in a different role per se, my working relationships involved the fact that 99 percent of the physicians were male back then.

I can remember one female physician and she was a neat lady. I was friends with her because for female physicians, there weren't that many other colleagues around. But it was a tough environment for women. We could do the job, and we were providing the care to patients. But really, in terms of the tensions that were created by male-female relationships, it was not nice, and a couple of situations evolved where I just had to assert myself.

The good news is I knew how to handle myself and I could do it. But in today's environment where we have a system in place to deal with that, I often think back to those days when there was no way to handle it, except if you handled it on a one-to-one basis. And then, of course, you, the individual paid the price in terms of doing that.

I know what my experience was. I don't remember ever talking about it with anybody else. I think it existed in your personal space, so to speak. You thought it was something that you, as a woman, caused so you dealt with it as a woman, and you really didn't -- you didn't share that with other people. You put it out of your way, you put it out of mind and moved on.

But it was a part of the environment, and it had to be dealt with. And today, I guess I don't get as worried because I think people are sensitized to it, and we have the systems in place. So yes, while we still have problems, if people will bring the problems to the attention of their leadership, there is a way to address it formally, and indeed we do it, in fact. I have a physician who is in his third or fourth year of training who has been dropped from his training program because of two incidents, one where he was given the benefit of the doubt. We said okay, whether you think you did this to the magnitude or the reality of it, there are these things that were wrong in the situation. Be advised and don't do it again. Well, he did it again and he's out of his training program.

systems in place. So yes, while we still have problems, if people will bring the problems to the attention of their leadership, there is a way to address it formally, and indeed we do it, in fact. I have a physician who is in his third or fourth year of training who has been dropped from his training program because of two incidents, one where he was given the benefit of the doubt. We said okay, whether you think you did this to the magnitude or the reality of it, there are these things that were wrong in the situation. Be advised and don't do it again. Well, he did it again and he's out of his training program.

If we had done that back in the seventies, we might not have had any people around. But indeed, there was no way to deal with it back then, and you had to, as an individual, take on the ownership. And whether it was with physicians in training or some of the staff guys, you had to be willing to stand up for yourself.

Q: And take the consequences.

A: Yes, which were usually personal in nature. It wasn't that the Army punished you, or the leadership did anything, because it was on a one to one level. So the Army as an institution was not guilty of these problems. It was the individuals that were working within the Army structure.

Q: Anything else you want to say about your experience at Beaumont?

A: No, I think we've covered it.

### **The Advanced Course in Residence, July to December, 1977**

Q: Okay. Next, I believe you went to the Advanced Course in residence.

A: Yes. That was a fun time.

Q: Was this a predominantly good experience?

A: Yes. We had a very good time. Six months. Went in July and finished in December, and I was lucky that two of my best friends from Beaumont, the head nurse of the MICU, Captain Patty McCormick, and then the clinical nurse specialist in pediatrics, Chris Addison, the three of us went. So we had our own little cohort group, and we had a very good time. It was good education, and it was a good time.

Q: You made a lot of good relationships working there that have stood you in good stead, would you say?

Q: Veterinarians?

A: Yes, but no MDs.

Q: What was the most useful block of instruction there?

A: I think when they started talking, that's when I first remember us starting to talk about doctrine, and the Army as an organization. So starting to give you the bigger picture of how the medical department interacts with the rest of the Army, talking about the logistics tails and things like that. Previous to the career course, I think everything was basically the clinical focus -- how do you take care of patients, how does an Army hospital run, and in the beginning of talking about what the Army looks like when they're in the field, the TO&E aspect, because I didn't have any visibility of that prior to going to the career course. And I think it was the sensitivity toward how you fit into the larger organization that goes beyond the Army Medical Department was the biggest help.

Then there were some basic management -- hospital management type courses where they started talking to us, and we had some of the instructors from the Baylor program who talked to us in terms of statistics and management expertise, because in grad school I had stayed away from hospital management per se. Clinical was my focus. That's all I wanted to do was the clinical. And I didn't take any hospital management courses per se, but I remember that being a key component of the career course.

Q: So I think before this time there were STRAC units and nurses were assigned to them, but really didn't get much field experience. Did you?

A: No. In fact, I was trying to think in terms of BDU uniforms. I think until we got to the career course and needed them for Camp Bullis and stuff, I don't even remember owning BDUs.

It's interesting, I know they were part of the clothing issue when I went to Korea, but the chief nurse in Korea insisted that we wear hospital whites. She said those other uniforms were not feminine. So we literally were cold in Korea because she would not allow us to wear the fatigue type uniform, the pants. I had worn fatigues at Officer Basic Course. I know we wore them a couple of times because I remember going to the goat lab, and that's the uniform we had on, and I remember them telling us to take off our shirts, and I hadn't worn a tee shirt because I always thought it was stupid. Why would women wear tee shirts. That was a problem.

So I know I had those uniforms. But the Advanced Course, I think, was the first time

I wore them for more than just occasional wear.

Q: Now, was this course still over at the quadrangle at MFSS or were you in the Academy of Health Sciences?

A: No, we were in the new academy, in the Academy of Health Sciences.

Q: And you felt that the faculty and students there were pretty good --

A: Yes, I can remember the Military Science (MILSCI) faculty. I also remember the Baylor faculty, which included the statistician, Art Badgett, who is now part of the Lead Agent staff up at Fort Carson, Colorado. So Art is still around, and I can remember some of the personalities. The Military Science and the Baylor guys are the two groups, I think, that we spent the most time with.

### **Physical Training Tests**

Q: Were there PT tests running at that time?

A: We did some, and we had formations three days a week. And even though I was physically challenged because I was never physically adept, you know, the testing part of it didn't seem to be emphasized as much as just doing the group physical activity. So it included going out at 6:00 in the morning and doing the exercises, and then finishing it off with a run. But I don't think we were testing at that point. We were just doing the physical fitness.

Q: It wasn't until the late seventies that that came in?

A: Yes.

Q: And why do you suppose that came in? Why did they begin to do that?

A: Well, I think because they realized that just saying that you're going to train without having an outcome measure wasn't having the return on the investment. And in fact, yes, it must have been, because it was when I was at Fitz as a course director that we started having to give PT tests, and I remember as a course director, that's the first time I remember taking a PT test, per se. I remember running the fence, running around the parking lot and doing things like that.

### **Director, Intensive Care Unit (ICU) Nurse Course**

Q: General Adams, when you had finished the Advanced Course, you received an

assignment as director of the intensive care nurse course?

A: Right, the ICU course at the . . . .

Q: Right. Were you pleased to get that assignment?

A: Yes, because of the fact that I thoroughly enjoyed working in the ICU as a clinical nurse specialist at William Beaumont, and this was an opportunity to stay focused on ICU nursing. So other than being a head nurse at that time in ICU, I think there were relatively limited jobs in terms of clinical focus for somebody who was a major and wanted to work in ICU.

Q: What preparation did you receive for the role?

A: I think the only preparation was attendance at the notorious FDU, Faculty Development Unit. I think it was at least a two-week course that was taught at the Academy of Health Sciences that basically taught you in terms of presentation, whether it's 5 minutes, 15 minutes, or 60 minutes, and how to write objectives, and how to talk to the objectives.

Q: And was that worthwhile, do you think?

A: It was, but I think it was — you know, it's one of those generic courses that they use to prepare anyone from a sergeant who is going to teach 91 Charlies up to doctors who are supposed to be teaching graduate medical education. It was probably a little bit too much time for too little content, because in my Master's program, part of my preparation had been curriculum development and such. So I had spent some time when I was doing my Master's looking at educational preparation essentially in terms of how to teach.

I had some of that, so probably two or three days would have accomplished their objectives, but I think we had two weeks of it.

Q: How much autonomy were you given in administering the course when you were at Fitzsimons?

A: Actually, I'd say total autonomy. I worked for the chief of nursing education and training, and I believe for the assistant chief nurse. I can't remember how the ratings game went, but essentially when it came to how the course was administered, and what decisions we made in terms of what we did with students, it was all — those decisions were made by the director of the ICU nursing course and by the assistant.



When I went to Fitz, I got there in January 1978, and the current course director at that time was still there. It was Major Donna Wright, and Donna, in fact, was staying through the course that had started about January. So I had talked to her, and her assistant was Captain Bonnie Jennings, and both of those two individuals were doing an outstanding job of running the course.

I did not want to be a third wheel, so essentially I went over and worked in the hospital, I think for five months. Part of that was sitting down with Major Wright and finding out some of the Corps curriculum requirements, and there were some that I did not have any experience with — for example, Neonatal Intensive Care. That was part of the POI, the Program of Instruction, but I had not worked in that area, so I went and worked in the NICU.

But all those decisions were essentially between me and Major Wright in terms of just how I was integrated into the program early on, and then after I took over from Major Wright, essentially it was my program to run.

Q: So it was probably beneficial for you to get there early and to have that overlap so that you could establish relationships, bring up your skills.

A: Most definitely, because part of the time I worked in the NICU, the SICU, so I rotated through the adult Intensive Care Units, and then the time that was left over, it was my intent to work in the Neonatal ICU for the rest of that time, which would have been, I think, about three months altogether. But I believe after I had been up there about either six or eight weeks, the chief nurse polled me because she had an immediate problem in the emergency room.

It involved the head nurse down there — or it involved a supervisor down there and one of the subordinates who I believe was the head nurse. I believe the head nurse was pulled out of the ER, and they needed a head nurse, so they put me in for a month or six weeks because “I was extra,” because I went to the ER. By definition it should have been ICU, but the reality of it is at Fitzsimons, the ER saw very, very little emergencies, and it just wasn’t positioned in the community, and we saw hardly anything that you would have classified as an emergency in the six weeks or so I worked there.

Q: Were the conditions such that you had a lot of work to do, or was it a personality clash and everything was working well otherwise?

A: No, it was a combination. There was definitely a personality clash between the head nurse and the supervisor, but there was also some indication of potential misutilization of drugs by the head nurse in the emergency room. So there was also an

ongoing investigation that had to do with that. And then there was also then, because of the personality then, a polarization of the staff in terms of those who supported the head nurses versus those that supported the administration, which was the supervisor and the chief nurse? So it was kind of dysfunctional, I guess, is what I would say.

Q: And how did you resolve that?

A: Well, in six weeks you can't resolve too much. I mean, basically what you can do is get people back into a reality footing and say okay, we're here to take care of patients, and what do we need to do to be more efficient and effective as we support patient care in re-establishing, I guess, a sense of trust between the emergency room staff and the rest of the hospital, because there was this conflict that had been set up.

Of course, it happened about the May-June time frame, just before the summer rotations are starting, and I moved out of there, I believe, in June because I believe students came in in July. But the tough part, I think, was that immediate part where they relieved the head nurse, and we got over that. And we got over that, and there was a new head nurse coming in. So it was up to that individual, basically, to take charge and make it okay for the long run.

Q: Backtracking, who did you work with in that NICU when you there?

A: Well, the two people I remember most strongly, Barb Turner, and Barb Turner was essentially the clinical nurse specialist in the area up there. And then I remember Warren Todd, who was one of my predecessors here at Tripler, General Todd was one of the pediatricians. That's where I first met General Todd — Warren Todd — Colonel Todd. At that time he was up there, and there was another neonatologist by the name of Weinstein or something like that who worked up there.

The strongest relationship was with Barb Turner because of her expertise, and I'm trying to think — I don't know whether Barb at that time was a clinical nurse specialist. Yes, I think she was the clinical nurse specialist because I remember a major who was the head nurse, and I don't remember the major's name, but the major was kind of what I remember — she was the old school. The Palmer graduate initially got her B.S. but really did not believe in any of the specialty preparation for nurses. And then I can remember Barb Turner being — Barb was smarter than the average physician who was in Neonatal ICU because of the way — her specialization in terms of taking care of the neonat.

So I really worked and learned a lot from Barbara Turner in terms of — and Barb had an excellent rapport with the nursing staff as well as with the physician staff in

the Neonatal ICU.

Q: A special lady, no doubt about it.

A: And she was then a key instructor in terms of the ICU course, coming over to teach the students, too, as well as being available when they rotated up there.

Q: Did you have people coming in from the hospital — physicians, nurses, what have you, to teach?

A: That's how the course was set up when I took over, and I was there — the first course I had, Bonnie Jennings continued to be my assistant. But then Bonnie left after one rotation. She was there for six months with me, and then Bonnie left, and Rosemary Robinson came in. Rosemary and I — it was the first time I got to know . . . hard to take people in the context in which you know them today and think about them when they were young.

But Rosemary and I kind of sat down, and we used a lot of physician instruction in the ICU course. And my personal bias was it was too much physician instruction, and I wanted to use more nurse instructors, both myself as well as — I guess she was Captain Robinson then. Rosemary was very sharp in clinical nursing, pathophysiology and such, and that was also one of my strengths.

So we gradually kind of, I think, changed the course so that we took on — I think she and I together probably did 20 to 30 percent of the initial teaching on the fluid electrolyte balances, and some of the things that we were asking the physicians from the hospital to do initially, like the nephrologist to come over and talk about fluid and electrolytes, and somebody from the lab to come out and to talk about blood and composition of blood. So she and I took on some of the basic science type courses and left the clinical instruction from the physician perspective to the complex medical and surgical problems that ICU nurses were expected to be taking care of. And they had the cardiovascular surgeons come over and talk about the open heart scene, how you take care of a patient with a valve replacement and such like that. So trying to use the physician expertise for those things that were specifically physician topics, and then use the nursing experts for other topics, whether they were the clinical preparation, the clinical sciences that you need to know to understand the physicians, and for some of the nursing problems, starting to look for talking about the nursing issues like care of the patient with immobility and things like that, and then using some of our clinical nursing experts who were developing, using our nurse practitioner, Fran — I can't think of Fran's last name — one of our first nurse practitioners, one of the early ones that I remember.

Q: I remember her, but I can't remember her name either. She was over in the internal medicine clinic.

A: I'll go look at my health record because I think I even saw her clinically.

Q: So you had no trouble finding nurses who had the resources to teach for you.

A: And I found with the nurses if you thought they had the expertise and they hadn't really done something like that earlier, that if given enough warning, they were willing to put the preparation into it, to come over to do a two hour block of instruction and such. And quite frankly, my motivation for doing that was twofold. One, I was spending too much of my time tracking down doctors to give lectures, and the doctors more often than not would change the schedule. So it was a nightmare trying to — so I figured if Rosemary and I could do some of the courses, you know, if we had to change the schedule, then we could adjust the block of instruction. We could then move one of our blocks in and substitute it for a physician. And the nurses, when they were asked, also were more reliable than the physicians in terms of scheduling time to come over and teach.

So it was both from, I think, a parochial perspective in that I believe that nurses needed to teach nurses as well as from a time management perspective. I thought it was a better use of my time having the nursing input into the program rather than just supervising the physicians and getting them over to the class.

Q: Was there a lot of intent critical care nursing or intensive care nursing learning taking place in the civilian community at that time as well as in the military?

A: No, and I say no in that I was unaware of any other courses that were available in the Denver community, and then I would go yearly to the Critical Care Nursing Association meeting, and did not really have — with the exception of the national meetings, which was a learning forum, did not run across any other course directors per se in the civilian community.

Now, I thought there would be more because when I was in graduate school at Catholic U, I went down to George Washington University for my ICU experience, and they did run a very extensive critical care nursing program. They taught their ICU nurses, and they had a huge — they had a combined medical/surgical/coronary care unit, fifty-some beds. So they had an ongoing class all the time, which was great in terms of a learning experience. When I went down there to do clinical, I was also participant in some other classes. But I never encountered — and even that, though, was only about, I think, a four week course. I never encountered any other courses that had the depth of experience or didactic that we were providing in terms of the

Army nursing program.

### **Chain of Command at Fitzsimons**

Q: In your chain of command at Fitzsimons, did you come under the chief of nursing education?

A: The chief of nursing education and training, which was — Jim Swinson was there for the duration of the time I was there, and then I believe the senior rater was the assistant chief nurse.

Q: Was Colonel Swinson helpful and supportive to you?

A: He was — two questions. He wasn't too helpful, but he was very supportive, and part of that was Colonel Swinson's style. He had an anesthesia program. George Hague ran that. And he had a pediatric nurse practitioner program — Marian Walls initially and then Marilyn Dejerole. And then we had a 91-C program that was next door. So they were in addition to the continuing education requires, and the CPR and stuff like that.

So he kind of had a hands-off attitude. If you need me, come to me. Otherwise, I trust you to do what you need to do. He was very supportive if we went to him, but we were very independent in terms of how we ran the program.

Q: That's good. What was the quality of your students when they were coming in, and did you see a big change in them as they were going through?

A: There were some super stars. In fact, a couple of them are still in the Army today. Judy Powers is one that I remember very well. And each class had the range from the super star, who I would have identified as the nurse who, given the time, could have reached the level of expertise in ICU without coming to a formal course. And then at the bottom were those individuals who had worked ICU, most of them at a MEDDAC level, so not in a MEDCEN level, but a MEDDAC level, who came to the course to get away from whatever assignment they were coming from, and who expected just to vegetate during the course.

Some of those people learned that they couldn't vegetate because there were requirements and expectations, and if they didn't meet them, then we would ask them to leave. But there were a lot of people who, I think, just came to validate what they already knew versus coming to learning something that would have long-lasting benefit where they could indeed use that as a preparation for doing something more in terms of nursing.

So I don't think it was a function of our criteria for selecting them or anything like that, or overall quality. It got down to the personal motivation of the students and what their expectation was in coming to the ICU course. So if their expectation was to get out of Fort Leonard Wood, well, once that expectation was met, then it became a struggle to get something more from it.

If it was like Judy Powers, who I can remember was hey, she wanted to really maximize the learning experience, and she did.

Q: What did you do with these other folks that weren't performing up to par?

A: Well, a couple of them were asked to leave, one in particular I can remember who just — a couple of students failed the curriculum because it was a tough curriculum, and we did have a couple that could not meet academic requirements, and they were let go from the course. And one I think that was really an attitude problem in terms that she just didn't really want to put the time and effort into the program.

The rest of them, you basically kept at them to make them successful, I guess would be the way to say it. And that's probably why I thought this would be my ideal job, and there were some things that were ideal. The independence was ideal. The fact that I could concentrate on intensive care nursing, immerse myself in not only the literature, but also the practical experience, and have the freedom to essentially go from medical ICU, to surgical, to neonatal, whatever I wanted to do.

All that was very positive, but after about a year and a half in the job, I told Branch that I would go anywhere to do anything, and I can still tell him — I told him I never again wanted a job in education. And it was because I felt like I was a full time babysitter, and I got tired of doing that. So if the students were expected to be on a unit working, that's where I expected them to be. Now, I couldn't be on every unit, and a lot of times I had to be back over in Building 221 where we worked doing the things I needed to do to get ready for class and such, and then I would get a call that either somebody wasn't on the unit, or I would go over there unannounced to see what the students were doing and couldn't find the students.

So after going through about a year and a half of that, I said, you know, it wasn't worth it. That wasn't what I wanted to do. The part that I could do in terms of my own professional development was quite satisfying. The return on my time and efforts in terms of the students was not nearly as satisfying. And as I said, you'd have one or two super-stars in each class, and on the others, you were just trying to pull along. So indeed, that's how I called — I think that was when Pat Miller was up in Branch, and I said, "Hey, I'll go anywhere, do anything, but this isn't for me," and she took me up on it.

Q: Were there any patient care disasters that involved your students that you recall?

A: No. You know, the students were all registered nurses with experience, so indeed they were safe — more than safe practitioners in the fact that they were extra help in the units essentially, because they were working with the assigned staff. I don't remember any disasters where the presence of the student was a factor.

I do remember, because I remember the lady real well, and you probably remember the head nurse of the SICU — there were things I was teaching my students in class in terms of what is the standard of care, that I could not get the head nurse of the SICU to follow, to go along with. For example, not adding drugs to a blood line, you know, you shouldn't do that because it sensitizes a patient. The staff would do it all the time, and the head nurse would allow it.

The other thing I did was open up the classes that we had for the ICU students to anybody on the hospital staff. So my idea was education is for everybody. It wasn't just limited to the students. So we tried to share the good news, the information. But for the SICU it didn't work.

Q: Did many take you up on that?

A: Periodically, one or two would come over. But the reality, if you're working evenings, it's kind of hard to come to class during the day and such like that. But every now and then, and depending on the topic and who the lecturer was, you would have one or two that were auditing it sitting in the back of the room.

### **Most Significant Accomplishments During that Time**

Q: What were some of the most significant accomplishments that you made in that time?

A: Well, probably two. One was the revision of the POI, and by then I think the ICU course had been going on for about five years. I know Milly Fritz, I believe, was the first director at Fitzsimons, and then Donna Wright came in and followed her, and then I followed Donna. So I would have been about the third director. So I think among the three of us, we probably had about five to six years.

Down at Brooke, Nan Borg was still down there, and I don't know if Nan started the course down there, but I know Nan was quite prominent in ICU nursing from the outset for the Army Nurse Corps. So I wouldn't have been surprised if she had been there like five years. But one of the things we did was to revise the POI. I think that was the time where we tried to segregate out the neonatal and have two tracks,

because it really didn't make sense to have the neonatal nurse be doing — 80 percent of the course was adult, and only that small portion was neonatal, and that's what they wanted to go back to, so I think that was part of it.

I think we also tried to incorporate some emergency room nursing in as a separate track, because that really hadn't been identified per se as ICU nursing, but the reality of it is when you start looking at the acuteness of the conditions, and the therapies and such, that was relevant. So I'd say the POI revision, from an institutional perspective, was probably the best achievement.

From a personal perspective, that's the time I started to get involved in doing some more publishing. I wrote a chapter for a nursing textbook on food and electrolyte balance, and edited a critical care quarterly, put together an issue of the journal on hemodynamic monitoring, so I was able to do a couple of those professional activities which, of course, were done in my own time, but were still within the mainstream of what I was doing in terms of my full time job. So I enjoyed having the educational environment to support those ideas.

### **Ideas for the Course**

**Q:** Is there anything that you regret not accomplishing when you were director of the intensive care course?

**A:** No. I'm trying to think — I know we had at least one course director's meeting where we went to Washington, DC, and met with Colonel Miller, and Ann Hiers was there. I know she was a chief nursing consultant at that time, and talked to them in terms of our ideas for the course. I can't think of any — what I would consider outstanding issues. Assignments weren't an issue in terms of students or anything like that.

**Q:** So when they came out of the course, they were always put into --

**A:** ICU. Yes, there was never a problem in terms of that, in getting them to a good — usually in a medical center, too. Very few went to small places. I think that was one of the reasons I was so — after two years it was kind of like okay, I've published, I've done what I needed to do, now I'm ready to move on and let somebody else have this experience.

**Q:** Did somebody help you to publish, to get your foot in the door?

**A:** Actually, no. My first publishing experience came when I was at William Beaumont, and I read an article on heart and lung, having to do with Swan-Ganz catheters, and



the article said something that I disagreed with based upon my experience, and I wrote a letter to the editor. As a result of my letter to the editor — the magazine used to be Nursing, whatever the year was, Nursing '78 — they contacted me and wanted to know if I would do a photo essay on the care of Swan-Ganz catheters. So they approached me essentially, and I did that.

In terms of helping with the publication, I would go to physicians who I worked with, so when I did the article on Swans-Ganz, the Department of Cardiology at William Beaumont, two of the cardiologists there, the chief, Mel Spicer, and his assistant, Dr. Price — I don't remember his first name — they were very helpful to me in terms of reading for accuracy. And, of course, they had published in their own realm, so they were very supportive.

Interestingly, when I went to Fitzsimons, nobody really gave me any help, and in fact, I can tell you that was at the time that in order to get a manuscript published, we had very strict protocol to follow in terms of the approval. Besides education and training and the chief nurse, it had to go through the deputy commander level, I guess, to get it approved. And the deputy commander at Fitzsimons was a surgeon, and he would not approve — in fact, that was the editing I did for the Critical Care Quarterly.

I was the editor, and I had to go out and get eight to ten people to write articles, which I did. It was half nursing and half medicine, so I had physician authors as well as nurse authors, and I was the editor. But because of the requirement, I had to work that manuscript through the hierarchy at Fitzsimons. But he wouldn't approve it — just would not sign it. And, of course, I had to get it out of there.

So I went over and asked to see him, and I said, "I need this. Is it not good, whatever," and he said — he hadn't even bothered to read it essentially, and the bottom line of the conversation, and I remember, is he said there is no reason for nurses to publish. I was a young major then, to say the least, and of course, I had put a lot of work into this, and I said something to him — "I guess there's no need for nurses to read and write either." And he was a colonel and I was a major, so that conversation did not go well, and I just essentially left his office.

In fact, I left his office and went right over to personnel to ask how I could get out of the Army. Well, the bad news was I still owed the Army for graduate school and the career course, so that was not an issue. They were not going to — I had like two years and six months before they would let me out, so quitting the Army was not an option.

So then I went over, and the chief of cardiology at Fitz had been one of the authors

of this for me, so his manuscript was part of this. So I went to him and said, "What am I going to do?" He said, "You do what I do. You just send it in without the approval." I said, "What do you mean?" Of course, publishing for nursing was relatively new back then, and it was totally new to me, so I had internalized the deputy commander's angst as being directed against nurses, and indeed the way he said it, "Well, nurses don't need to publish," that's the way I internalized it. But indeed, when I went to talk to the chief of cardiology, he assured me that the DCCS was not treating me any worse than what he treated the ordinary physician around there, except then he would approve the manuscripts, but it was a real gauntlet, and there was a lot of pettiness and everything. So the chief of cardiology just said, "Hey, what are they going to do to you?"

Q: And so you did?

A: So I did.

Q: No repercussions?

A: I never heard a word from anybody or anything about it. But it was discouraging. And then after that, I think I even stopped asking permission, at least while I was at Fitzsimons I never asked permission anymore, and actually, that was the last time. All my publication efforts, the two chapters for nursing textbooks and the journal articles, all that was done while I was at Fitz because when I left Fitzsimons, I left the clinical nursing practice, and I didn't feel I had the credibility to continue to do that if I wasn't working in the area.

Q: Have you ever been involved in research studies?

A: Only if people ask me to do something. I will always fill out a questionnaire or do my part. Nursing research per se, I guess I'm too short-term oriented. I want it now.

Q: You want results.

A: Yes. So I will support anybody else's research, and if they ask for help will give them what they need, but from my perspective to do it, it's never been an interest. Matter of fact, that's why I never thought about doctoral training, because I knew --

Q: You would be forced to do it.

A: Yes, I would be forced to do it. And I selected a master's program that had a non-thesis option, though in the long run I'm not sure that saved me anything because we did everything short of doing the actual data collection. We had to write the

proposals and stuff, so I think there was all the angst without the return on the investment.

### **The Inspector General Team, June, 1980**

Q: After you left Fitzsimons, you went to the Inspector General Team. What year was that?

A: Let's see, June of 1980.

Q: How did that assignment come about?

A: Because I told Pat Miller I would do anything, anywhere, to get out of the education job. So I still remember her calling and said, "Well, we've nominated for the IG team," and I can remember saying to her, "Well, I can spell it, but I have absolutely no idea what it means." And she said, "Well, not to worry. They'll teach you what it means." And indeed, before reporting to Fort Sam Houston, I reported to Fort Leavenworth where we had a one week IG course that was taught at Leavenworth by the DAIG team in terms of what are the requirements of the job.

Now I think it's a three week or a six week course in Washington, DC, so the demands on the IG have increased. But that was the job that they picked me for, and I said fine. I told them I would go anywhere and do anything. The interesting thing, my motivation was to get out of education. When I get to the IG job, the first thing they did was say — the cliché, "We're here to help," well, a new IG came in, Lieutenant General Trephey, and he was the one who started the systemic approach to inspections. No longer just compliance, where you look to see if they're doing it, yes or no, but if they're not doing it, then ask why not, and then you trace the problems to ground. So it became an educational focus. So I said, "Well, I can't get away from education."

Q: Did anything in your past assignments prepare you for IG?

A: Nothing. I mean, because I — to that point I had been totally clinical. I had never been head nurse, so I had not even taken on administration in that role. So indeed, this was about my twelfth year of Active Duty, and everything had been all clinical nursing. And so this was the first headquarters job in an area which I knew nothing about.

Q: How much time were you on the road?

A: On the average, 50 percent of the time. But then things could come up where I would be gone six weeks at a time. We had two nurses on the team. Initially, Sandy Hampfer was the other nurse on the team with me. Sandy and I were on the team maybe less than a year together, and then Mary Kay O'Neal came next. And there were no physicians assigned permanently to the team. We, as the expression goes, picked up a physician each time we traveled, so it was always a new physician who traveled with us, usually no more than once or twice during the time I was on the team, and the idea was it was an educational experience for the physician, so let them see how the IG worked, and also the thought was you could not afford to have a physician, or two, assigned full time to the team.

Interestingly enough, we had a dentist who was assigned full time to the team, so the Dental Corps said it was important enough, and that one dentist covered two teams, so he had to work extra hard. But the physician was always part time.

Q: Did they know as well what they were doing?

A: No. The physicians, essentially, the way of dealing with them was the rest of the IG team either told them what to do, or the non-physicians would look at areas. For example, the nurses were expected to look at credentials. So I would look at the credentials, and then if I had findings in terms of a physician's credentials, then I would write the findings, go to the physician, and then the physician would validate the finding and say yes, absolutely. We need to write this. So it was a lot of teaching of the physician on the team.

But because the nurse that was the only full time clinical asset on the team, there would be times when we had special investigations where you would finish doing the inspections in a place, and then you would have to go off and do a special investigation. So you might not come home between them. Ordinarily, we were gone for two weeks at a time, and during those two weeks we would do two community hospitals, one week each, and then rotate during the weekend, or we would do one medical center, and that would go over a two week period. But there were times when I did inspections for two weeks, and then just go off and do the special inspection, or inquiry, or investigation before I would get home.

Q: So you had regularly scheduled trips, and then if a crisis came up, you went out and --

A: Right, did something else. So once I was assigned to go with the DAIG team to inspect our health clinic in Japan, so that was extra travel. I went to Alaska a couple of times because we had some significant quality assurance issues up in Alaska. That was a case in the *Army Times* where we had a lady who died in the hospital, and she

was put in a bed in an unoccupied ward with a bicycle horn.

Q: I don't remember that.

A: That was notorious at the time.

Q: Did it really happen?

A: Oh, yes, unfortunately, it did. And that experience probably taught me when you have tragedies with patient care, it's usually not one thing that goes wrong, it's a litany of things that go wrong, and it's the cumulative effect that takes its toll rather than one person doing one thing that results in a tragic outcome.

So it was very informative, I guess, in terms of doing — now we call it root cause analysis. I don't know if I was sophisticated to be doing root cause analysis back then, but we would go in, do a formal investigation, take evidence, and then reach conclusions based upon why an adverse outcome happened.

Q: And do a report?

A: And do a report. And then sometimes we would go in and we would be there to investigate individuals because of reports of misconduct, maybe not directly related to patient care, but in terms of their officership or something like that, or leadership responsibility. So it really was a very eye-opening experience in terms of the job.

### **Emphasis From Looking at a Problem to the Systemic**

Q: Could you talk a little bit more about this emphasis shifted from looking at a problem to the systemic cause effect kind of thing?

A: Yes, the IG would go in and we would have — we had some checklists, and you would go in and you would look to see whether you're doing something or not doing it. I'll talk about one area that I have to laugh, it's my favorite, because it's followed me forever, and it got me into lots of trouble. That was AR 40-407, the Nurses' Documentation regulation, and that was relatively new back in the early '80s.

We had just, I think, made a significant revision in our documentation requirements, and in our forms and such. And in the compliance way of inspecting, we would go out and look at what 40-407 was telling us to do, and just validate are they doing it or not doing it. In the systemic format, if they were not doing something, we would ask the question, "Why not?" If it was because there was lack of support from a higher echelon in headquarters, we would write the finding, not against the facility

that wasn't doing it, but against the higher headquarters.

Where I got into trouble, or where I caused notoriety, is probably — brought attention to myself I guess is the nicest way to put it — in 40-407, it said that every patient admitted to the hospital had to have a nursing assessment done within 24 hours. It was absolutely fine.

When we had hospitals that had minimum care units, places like Fort Benning, and I remember Fort Benning because Susie Sherrod was the chief nurse down there, and a very sharp chief nurse. When I did my inspection at Fort Benning, Colonel Sherrod brought to my attention on their minimum care ward, or I brought it to her attention, that they weren't doing the 24 hour assessments.

Well, she had just been visited by the Manpower Team, and part of their justification in the manpower team for a nurse on the minimum care ward was to do the nursing assessment. That was turned down. And I guess it was Colonel Sherrod who brought it to my attention, so she said to me, "How can you tell me that I'm not doing my job," and yet the manpower team says we're not going to give you a nurse to do this. This does not make sense. And then to me, in my mind, it didn't make sense because how could I require them to have a nurse to do a particular function, even — and her request was from one nurse five days a week. It was not 24 hour recovery, so we were trying to build structure, and to me that seemed like a pretty reasonable requirement, to achieve the objectives in terms of taking care of the patients, and especially the documentation.

So I wrote a finding against the higher headquarters, which if you look at regulations of proponents to AR 40-407 is the chief of the Army Nurse Corps. So that's the example of saying okay, it's not the fact that the nurse's bedside didn't comply. The fact is that the guidance is not relevant to the situation because we're not giving them the resources. So where does that decision go? It goes up to the higher headquarters. So it either went to the Health Services Command, where we had a chief nurse, or it went up to the chief of the Army Nurse Corps.

So there were a couple of issues in nursing at that time that, as I said, instead of doing compliance — another one had to do with the availability of the nursing white uniform. I was finding that nurses were not — and there was a time when we standardized the nursing white uniform. It was the wash and wear one with the belts and everything. Well, it suddenly became non-available. Well, it's because somewhere along the line the system had decided that we could wear cook's whites instead of nursing whites.

Well, that was not — if you've ever seen cook's whites, they look like cook's

whites, and they didn't have pockets in them or something like that. So that's not the chief nurse's fault that her people are not wearing the standardized uniform because most chief nurses then would go out and have their supply people buy locally. And then we started getting a variety of uniforms into the system.

So there are issues like that that rather than just holding the local leadership accountable, tried to race it to where the resolution for the problem was, you know, where did it start.

Q: And what was the reaction in the Office of the Chief, Army Nurse Corps?

A: It wasn't very positive, I have to say.

Q: And this was General Johnson at the time?

A: That was General Johnson. And it was Ellen Gan and Charles Reddy down at the Medical Command, at the Health Services Command, as we called it then. And, of course, you know, when you're in the IG tem, this was the first time I was outside the nursing realm per se. I'm working for the IG, who is a Medical Service Corps officer. We had a team chief who was Medical Service Corps, and then we had the IG, and he was also Medical Service Corps. So it was being rated and senior rated by the Medical Service Corps.

It did not have a formal linkage per se with any nurse because of the way the job was structured. And I thought I was doing a good job because my boss said I was doing a good job, and the IG team had a good reputation in the headquarters down at Health Services Command. We worked for General Bishop and General Baker, I think, were the two generals I had down there.

We had a good team. Especially, we went from compliance to the systems approach at about the same time we changed IGs from a Colonel Coke — he used to be Joe Coke, who was a pharmacist to Colonel Tom Jackson. Colonel Jackson was health care administrator, Baylor graduate and such. So we had a change in the leadership, and then we had a change in the inspection framework, and under Colonel Jackson, we had a really good reputation with the DAIG as well as within our own headquarters, the DAIG at the MEDCOM. We would brief them, and everything was going real well.

### **Running into a Stumbling Block**

So I was very surprised when one day, I guess I was called down to the chief nurse's office for Health Services Command, and in that office there were four or five key

Nurse Corps leaders that I remember — Colonel Gan, Colonel Reddy, and I think Darlene McLeod was there, and I don't remember who else, but it was kind of like a room full. And I was, I believe, either — probably major promotable, because I didn't get promoted to lieutenant colonel until just before I left the IG team. And basically, they were there to tell me to shape up, that they did not like the way I was doing the inspection, and that I needed to — I don't want to get them in trouble in terms of — how was this put?

One of them essentially said to me, "I don't" — they didn't care the way I told the chief nurse how to do his or her job. I could tell a chief nurse whenever I wanted to tell a chief nurse, and they would support me. But I was not to tell the chief of the Corps, or the Health Services Command chief nurse how to do their job. So it was obvious they were telling me where the buck stopped, and the buck stopped at the chief nurse.

I remember having this dialogue saying, "Okay, so if I go to 10 hospitals and all 10 hospitals have the same problem, and I tell this chief nurse that he or she didn't do something right, yet they don't have the resources to do it, I'm not supposed to follow that problem to ground," and they basically said, "That's right. Tell the chief nurse it's her problem or it's his problem. It doesn't go any further than the chief nurse."

Well, they told me that, and, of course, then I went upstairs and pondered that from two perspectives. One is I didn't agree with it because it didn't make sense to me, and the second was well, this is not the way that I'm supposed to be functioning in accordance with the guidance or the direction we're getting.

So I ended up going to see my boss, Colonel Jackson, about it, and also there was some implication that I wasn't really doing a good job, and they were disappointed in me. And that kind of — okay, I'm not doing a good job. So I went to talk to Colonel Jackson about it, and, of course, he was — I don't want to say the typical male reaction, but he wanted to go down and tell Colonel Gan and Colonel Reddy and all those guys what bad people they were and whatever. He didn't do that, though.

But that was kind of the beginning of what I would call a tumultuous period because I really got the affirmation from Colonel Jackson that I was doing the job the way it needed to be done, and that he would support me doing that, and he did not expect any change, and if I did change, that that would be looked upon negatively as opposed to if I continued to do the work the way I had been doing it, which he thought was with integrity and with the right purpose in mind.



Q: Okay, so how did you resolve that sort of dissidence between what they were telling you and what you didn't think was right?

A: I didn't resolve it in terms of the Corps leadership, I guess. But there was one person that basically let me know that he thought I was okay, and that was Colonel Reddy. I wouldn't say he was disloyal, but he let me know both in a personal and a professional way that what I was doing, he was okay with the way I was doing business. And I believe when Ellen Gan retired, Colonel Reddy took over as the chief nurse in the MEDCOM. So that change in leadership basically kind of made me feel better in terms of how I was doing my job.

### **The Corps Chief**

Unfortunately, I think, with the Corps Chief, at least during her tenure as Corps Chief, I never got on good footing with her. She really thought I was a maverick, I think, and was not trying to do the Corps any good. And indeed, I think the day she retired from Corps Chief, she called to tell me how disappointed she was in me, and at that time is when I had ended up with being recommended for a job in Health Affairs, and she really did not want me to take that job, and she basically told me that, and basically said, "If you do, you'll regret it."

My attitude then was I didn't have anything — I didn't think it was recoverable, quite frankly. She was leaving Active Duty, and my die had been cast, and now I had other people supporting me to go to the Health Affairs job. So if I pulled back from that, then I was going to disappoint people who were not in the Army Nurse Corps, who had tried to help me in terms of getting a good job, I thought. But I remember General Hazel Johnson-Brown calling me on her last day as Corps Chief to say that.

Q: That must have hurt.

A: Yes, because by then I was like 15 years, I think. So I wasn't ready to quit, and I thought I had done a tough job and done it well, and indeed there was no — I didn't have what I thought were any hidden agendas. I wasn't try to — I was trying to make Army nursing better. That was my only agenda. And by highlighting the problems, I thought, at a level where a resolution was possible.

So it wasn't an ego trip. In fact, I didn't even have visibility that the Corps Chief, per se, would be held accountable or would take any ownership of these type of issues. You know, when you run organizations, the leadership manages the issues. But I didn't put anything personal to it at the time, in my mind. Obviously, it became personal over a period of time because I didn't change what I was doing, and it continued to come to her attention.

Q: So after you did the 24 hour assessment, and that uniform situation, and when you continued to see these things happening, did you continue to refer them to the Office of the Chief?

A: Yes, because that was the way the finding form was set up, you know, to identify where it would go for resolution. So if it had its basis in regulation, you went to the proponent of the regulation. The proponent was at The Office of the Surgeon General ordinarily. Then it goes to the chief of the Corps as the representative.

### **Scope of Responsibility for Physician Assistants**

Q: Were there any other major issues that surfaced all the time?

A: Probably the biggest had to do with scope of responsibility for physicians assistants, nurse practitioners. In the Army, we have a tendency in emergencies to tend to utilize people's skills and talents to the utmost, whatever they feel they can do to help a patient care situation, and some of that spills over into routine health care. And as we got into periods of, you know, the quality assurance concerns, we had to start looking very closely at who was doing what type of activities in patient care. So whether it was nurse practitioners exceeding their practice guidelines, or the PAs not having the requisite educations and training to support their credentials, or the corpsmen — there used to be a time when corpsmen sutured routinely. That was the way it was when I worked in the ER in 1972-73.

Then it came to a point where you had to be able to document their training, and so we started looking at that. And so the scope of care issue, the scope of services issues, I think, was the dominant thing that kept coming up.

Q: Were there at that time problems between the anesthesiologists and the nurse anesthetists as well?

A: You know, I don't remember — I want to say no. I got involved in the anesthesiologist CRNA issue when I became the nursing consultant in 1989. But from an IG or a practice perspective — and I'm thinking back on the chief nurse at Frankfurt, there was not — the disconnect was the nurse anesthetists were doing most of the work, and the physicians were providing the supervision. And I use the word "supervision" in quotes because the supervision wasn't there. They were at home, or they were down the hall in another room. They were not doing supervision as I would define it, which is being the eyes and ears in the room with somebody as they're doing the task. To me that's supervision, not being remote to them and saying call me if you need me.

So from an IG perspective, I don't remember any practice issues back then. The only finding I can remember writing was I think there was a JCAHO requirement that if you had a facility that did not have an assigned anesthesiologist, you had to have a physician anesthesia consultant as part of your hospital staff, and he or she had to make periodic visits to the facility to oversee the standard of care.

So it was that type of a finding in terms of how was that hospital meeting that requirement, to bring in that supervisor, usually from the civilian community to overlook it, and how do you provide emergency backup if you needed it. So that was the issue as opposed to any internal dynamics between the two factions.

### **Standout Chief Nurses of the Medical Treatment Facilities (MTF)**

Q: Who among the various MTF chief nurses that you visited stands out in your memory and why?

A: I think the one — Edith Walsh, and I met Edith Walsh when she was the chief nurse at West Point. She was a very good chief nurse, and she was either a lieutenant colonel or promotable. She was fairly senior in rank, but she had a new baby. And so at the time, we had gone through — when I came in you couldn't have children under the age of 18 or whatever. So here was a chief nurse, doing a good job, who had a baby, and I remember that because I think she had to leave to go home to feed the baby. She was breast-feeding or something like that.

And West Point, yes, is a small hospital, but she seemed to be doing it all very well in terms of how she did her job as chief nurse, as well as having that other dimension to her life.

Another person who did real well — I can't remember her name.

Q: I think we talked about her before, so we can pull that name out, but tell us why.

A: She was chief nurse of the hospital out at Letterman — I can see her face. Maria Gately. And she had a very well run hospital, Letterman, and very good rapport with all types of her staff, and in some ways she reminded me of Kitty Betz, who I talked about earlier. I guess the way I'd describe her, she's everybody's chief nurse. She was the chief nurse to the doctors as well as the chief nurse to the nurses and the Medical Service Corps officer. There are some places where the chief nurse only has an identity within the nursing leadership chain of command, but Colonel Gately had an identity that pervaded the entire medical center, the Medical Service Corps officers as well as the physicians. And, you know, that type of a leadership not only in terms of effectiveness, but also in terms of respect that they showed the nursing

leader.

I always said there were three people I could think of in terms of being great as chief nurses, and I can't think of who the third one was. But I remember Walsh and Gately.

### **Changes in the IG Team Today**

**Q:** Okay, could you just now, to tie up this IG thing, tell us how it's changed from when you were on the team to where it is now?

**A:** Well, one thing is I don't think we have the visibility of the IG anymore. We used to go out every two years, so every facility was visited every two years. And now they come yearly, and the agenda is determined yearly. So while we do see them yearly, it's not with the same authority and scope of influence that we had back in the early '80s. And it's called command assistance visits now, so it's the IG team, but they're coming out under command assistance.

Now, that may be marketing against the IG function, but it's much more deluded than it used to be. And the agenda when we were out — when I was on the IG team was not only the commander's special topics, so you go to the Medical Command, or HSC commander and ask for his specific guidance in terms of what he wanted feedback on, but you also did the total JACO agenda. They don't do that anymore. So essentially, we're on our own for JACO, I guess is a nice way to put it. But in a way I thought that was a good reinforcement that we were keeping up our level of effort in terms of JACO because JACO is every three years, IG is every two years. And some of these changes I think are because of all the regulatory inspections that we now have everywhere from nuclear assurity, and the lab that comes out and such. I think the IG pulled back because the impression was we were spending all of our time getting ready for inspections.

### **The IG: A Tool for the Commander**

The IG is a tool for a commander. You don't want them to come in and tear you apart, but you also want to make sure that you're addressing all those things that could potentially get you in trouble. I'd rather have an IG tell me what can potentially get me into trouble than to wait for a situation to deteriorate when there is an adverse outcome.

So I think the lack of visibility, the constriction in terms of their agenda, that they are not as global as they used to be.

Q: So they pick the specific topics when they come each year.

A: Right. So this year I think they looked at X as to care and something else. Some of those things, quite frankly, are part of the TRICARE metrics, so they're being monitored in another venue. So the IG didn't really tell me anything better or different when he came in. He just basically told me what I had already known from some of the other reports that we do.

### **Finding Another Job**

Q: After you left the IG team, were there any career-wise repercussions that were leveled on you as a result of this conflict?

A: I think the only repercussion was relatively short-term, and that was just all the controversy in terms of what my next assignment would be. The IG job was my first non-clinical job. I still liked clinical nursing. The only request I had for an assignment after IG was I want to get back into a hospital. I didn't care where it was or what I did. I just wanted to get back to a hospital basis. And the Corps came up with the 7<sup>th</sup> MEDCOM nurse methods analyst job. And no matter what I did, and I tried for three to four months to get out of it. I mean, the hole just kept getting deeper, and they were just adamant that that was it.

I even went back to them. I said, you know, you guys say you shouldn't do back to back staff jobs. This is a back to back staff job. Well, no, we want you to do this. You're the only one available.

I even went so far, and I can't remember who it was — I found somebody else who really wanted the job, and they wouldn't give it to her for whatever reason. And the Surgeon General, General Mittermeyer, because I had had some interface with him because of the IG business, and I had also met him when he was the commander at Walter Reed and I was on the IG team, and he kind of knew me and knew of me, and knew about my ICU background, and when he asked me what I was going to do after the IG, I said I wanted to get back into the hospital.

When I ran into trouble doing that, Colonel Jackson, who had more influence with General Mittermeyer, even mentioned to General Mittermeyer about the job and all, and General Mittermeyer even called me one day and said, "Nancy, I've been trying to help you, but I think I'm doing you more harm than good, so I'm going to back off." I said, "Fine, Sir."

## Going to the 7<sup>th</sup> MEDCOM

But it was just that you are going to the 7<sup>th</sup> MEDCOM, you will be the NMA and all that. And I even met with — was even asked to meet personally with General Johnson-Brown because I just didn't think this was a good use of my talents. I didn't go to Baylor. I didn't want to do admin, and nobody would back off.

I think that was kind of the line in the sand they drew. Okay, she's been doing her own thing for three years, now she's going to do our thing.

Q: No matter what.

A: Whether it made sense or not, whether it was good utilization, this is what she's going to do.

Q: You were really doing a great job at that point. I was sort of your contemporary, and I think you were, from my viewpoint. But it sounds like you were in a downward spiral, both personally and with your reputation with the Corps.

A: And I guess I thought it was all rather self-limited until — well, I went over to Health Affairs and did that job for two years, and then got picked up for the War College. I went to the War College, and I was coming out of the War College for the assignment then, and by then General Slewitzke was chief of the Corps, and I thought okay, we're all back to "normal" or something. Darlene McLeod was in Branch, and Colonel McLeod called me and told me about a utilization tour coming out of the War College, and being the assistant chief nurse at Frankfurt Army Regional Medical Center was a utilization tour that was at MEL-1, validated and all that stuff, and I said it sounds great. Assistant chief nurse — I was a lieutenant colonel then — lieutenant colonel, assistant chief over in Europe. It all sounded really good to me. And she said, "Okay, well, I need to run your assignment by your chief nurse." I said, "Who is that going to be?" They said, "Colonel Gail Croy." I said, "Oh, fantastic. Colonel Croy and I were together at William Beaumont." She was the infection control nurse as a major, and I was the clinical nurse specialist, and we were part of that advance practice group that Colonel Betz had kind of put together. So Gail and I were friends from that assignment, at least we had socialized at Beaumont, and then she had gone to the academy and was a TAC officer for part of my time in the career Corps.

So I had a good relationship with Gail. So I thought hey, not a problem. So I did get to go to Frankfurt and all. After Gail and I were there maybe a couple of months we were just talking and she said, "You know, I got a strange call from Darlene McLeod about you coming to Frankfurt." I said, "What was strange?" She said, "Well, she

let me know in no uncertain terms that it was up to me whether or not I took you.” Gail always confronts things head on, and Gail said, “Well, why wouldn’t I want to take her?” And Colonel McLeod said, “Well, you know, she really has some baggage with her, because of the IG time,” and Gail had been the chief nurse at Fort Polk when I was on the IG team, and of course, she had a great hospital, and she, too, ran a good shop. Maybe she was the third one I couldn’t think of before, because she’s a personal friend. I kind of left her out of the equation.

But Gail also had a presence, a persona that permeated the hospital, and, of course, Colonel Croy ran the hospital to standards. I mean, she was probably writing standards before they were implemented. And it was Gail who told me that. She said, “Well, Darlene told me I didn’t have to take you.”

Q: A bad penny.

A: Hey, I know, and not a problem. And so yes, there must have been some --

Q: The twitters were going around.

A: And I think, quite frankly, that was probably where the old history got lost, because I worked real well with Colonel Croy, and then General Slewitzke retired, and General Adams-Ender took over as Corps chief and made a couple of trips to Europe, both when I was assistant chief as well as chief at Frankfurt, and I think I was doing a good job.

And, of course, General Adams-Ender had been in IG, so I don’t think --

Q: She understood.

A: Yes. I don’t know what she knew of the previous — and actually, General Slewitzke, in all fairness — General Slewitzke had been assistant chief for General Hazel Johnson-Brown, and when I went to Health Affairs — in fact, General Slewitzke, within the first week of her becoming Corps chief, called me personally to ask if I was sure I wanted to go to Health Affairs. And again, she was trying to tell me this was not a smart or good thing to do. And by then I had already thought about hey, this is a no-win situation. I just need to go to Health Affairs and do the job, and hopefully ride things out.

But General Slewitzke ended the phone conversation by saying okay, when you get to Washington, you need to come over and sit down and talk to me. I said, “Fine, thank you,” and I did that. And General Slewitzke basically said, “Tell me how you got to where you are today.” I went through the whole litany — my IG experience,

and how I got the Health Affairs job just like we've talked about.

General Slewitzke said, and I'll never forget it because she listened to the whole story, and she basically said, "Well, I can see where you were in a very untenable situation." And then she said, "Let's start anew." And she then invited me to her monthly staff meetings that she was having, that the Corps chiefs have in terms of the OTSG staff.

So I had a very good rapport with General Slewitzke when she was Corps chief and I was in Health Affairs. And that was probably back to normal when I went to Frankfurt. I think it really came before that because while she had known of the dissonance that was going on at the time that I was in the IG, as the assistant Corps chief she really wasn't personally or directly involved, and she basically wiped the slate clean when she became Corps chief and said, "Okay, let's see what we can do now in a win-win," and that's the way she worked it.

Q: That was very fair.

A: Yes. She didn't say anything about what — didn't cast any dispersions on General Hazel Johnson-Brown or what she said or did, but just said okay, we're back to a level playing field, this is the way we're going to do it.

So I would say yes, things started to get back to normal with General Slewitzke.

### **Command and General Staff College by Correspondence**

Q: We'll just quit on this note: I wanted to ask you, did you do Command and General Staff in residence or by correspondence?

A: By correspondence.

Q: So that wasn't a big thing in your life then.

A: Well, it was bigger than — I kind of stumbled into doing CGSC. When I left Fitzsimons to go to the IG course that was being held at Leavenworth, and of course, Leavenworth is where CGSC is held, and one of my MSC colleagues, Ernie Morris, who was the pad guy while he was there, he was going to go over and sign up for CGSC and pick up the first set of books and whatever, because we were all PCS . . . So I said, "Well, if you're going to go, I'll do it."

So I went over with him, signed up for it, did all this stuff, and got the first set of books. The first set of books kind of sat. About the first year on the IG team maybe



I did one or two lessons and sent in a couple of exams, but was not really paying a lot of attention to it. Then a couple of people that I knew did not get promoted to lieutenant colonel the first time around, and then the talk was well, why not? Well, because they didn't have CGSC. Oh, I guess this is really important.

So then we started the study group among the IG office, and I think there were three of us that did it. So we started working together in a predictable study group, which became kind of a focus, I'd say for a year. And when we're in the office and between IG trips, we didn't have a lot of purposeful work to do. We had to finish the report when we were on the road, so that was already done. So there would be a very little paperwork that we had to keep up with. So it was basically reading the regulations and just staying current.

We didn't have a lot of other stuff to do, so we would use the office time to work on CGSC. And then if we had a big project to do like the offensive campaign, or defensive campaign or something, we would then schedule a Saturday session, and usually met at my house because I didn't have any kids or anything, so we could use the whole dining room and everything.

So after doing almost nothing for a whole year in CGSC, managed to finish it in probably seven months we got it all done. And the other funny thing is, you know, you work with a bunch of MSCs. They all think they know the answers, and they brow-beat you into whatever. Well, I was the only nurse in the group. Well, as it turned out, I graduated with honors. Well, I tell you, they almost — that was almost the end of friendships. I said, "Well, I listened to all your informed opinions," and of course, we did our own exams and stuff, but I was not vested in one person's opinion or another. I got this information, so you guys made me what I am, you know.

I can still remember, because we had a little awards ceremony in the office, and Colonel Jackson gave us our diplomas. And I thought it was funny because he didn't do it alphabetical — Adams, I always come at the front of the list, and he didn't start with Adams, he started with one of the other guys. I was like, why couldn't he start with me.

Well, it was because it was with honors, so he wanted it separate. For about half a day they were mad at me. I said, you know --

Q: Give me a break.

A: Yes. You made me who I am. What can I tell you?

**Quality Assurance Division, Office of the Assistant Secretary of Defense for Health Affairs**

Q: Now we are up to the point where you went to the quality assurance job at DOD Health Affairs.

A: Well, that was back at the time when military medicine was really being scrutinized because of some sensational cases that reflected poorly in terms of quality care. So there was a quality assurance division in the Office of the Assistant Secretary of Defense for Health Affairs.

At the time I joined the office, they had only an Air Force MSC. They had a civilian administrator who did not have a health care background. They had an Air Force Medical Service Corps officer, a colonel, and I was the first nurse, and at that time I was a lieutenant colonel when I arrived at the quality assurance office. They accompanied the IG team on one of our inspections at the time I was assigned to HSC IG. Of course, we were telling them — the Army Medical Department was telling Health Affairs, we don't need you guys to do quality assurance. We're doing quality assurance.

So the lady who was in charge, Diane Lawrence, I think, was her name, accompanied us to observe how we did it. She was with me during the inspection at Dwight David Eisenhower AMC. And so she shadowed everybody, but she stayed with me a lot, and she was impressed by the way I did business. We encountered a very unusual situation. It was back in those days when we had the AMOSIST program. They were supposed to be using the algorithms to diagnose and treat patients, and one of the common findings was that the AMOSIST would exceed the scope of practice, and the supervision wasn't there. Well, in the midst of inspection of the AMOSIST program, we found out there was an individual who indeed was exceeding his scope of his practice. We then followed it to ground in terms of why it was happening, and found out that the individual had graduated from medical school, but had elected not to take an internship. But the hospital was allowing him to function as a doctor.

Q: And this was at Dwight David Eisenhower AMC?

A: Yes. The commander didn't know anything about this. This was all happening down at the troop medical clinic level.

Q: Was this gentleman enlisted?

A: Yes, he was a specialist. And indeed, when I went to his supervisor, he was very proud of the fact that he graduated from medical school that he had elected not to

take an internship, and that he had come in the Army to be a medic, and that they were using him as essentially a GMO. This, of course, was not acceptable since he was not a physician.

So Diane Lawrence was very impressed by two things - one, the way we tracked the problem to ground, and second, the way the Army dealt with it, because indeed we stopped it right there. The commander was consulted, and the problem was resolved. So on the basis of that trip, she offered me a position in Health Affairs to be the first nurse in quality assurance. This, by then, was the summer of 1983 and I was up for reassignment. For over six months I had been dialoging with the Army Nurse Corps about not wanting to be the nurse methods analyst in Europe.

Their position had been when nurses got on these extra-curricular jobs like IG or manpower teams, they didn't want to leave them. The nurses wanted to stay in the staff jobs, yet there was a need to rotate people for maximum experience. And oh, by the way, they needed to get nurses back to nursing, so you shouldn't do back to back staff jobs.

So I said, "Hey, I agree. I don't want to go be an NMA. It's a back to back staff job." Well, that didn't work. Then I said, "Hey, I'm not an administrator. I didn't go to Baylor, I don't like administration, I want clinical, I want to go back into the hospital." And I just was not communicating. They would not listen to me.

Q: Who was in career activities at that point?

A: Colonel Baskfield. So it was between Colonel Margaret Baskfield and Marilyn Sylveiler. She's retired now in Tacoma, that got attacked in Washington, D.C., when she was at Branch. She was the assistant. They were calling me all over. My boss, Colonel Tom Jackson, had a very good relationship with the Army Surgeon General, who was General Mittemeyer, and I had inspected General Mittemeyer when he was hospital commander at Walter Reed, so he knew me. Even he tried to influence the Army Nurse Corps saying, "Nancy really wants to get back in the hospital; don't you think we can do this?"

The Corps chief, who was General Hazel Johnson-Brown and it just was not working out. So when I was offered the job in Health Affairs, I was at the end of my options. I thought okay, if I'm going to have to do a purely administrative job, at least this one has nursing in the title. It's Washington based. If I don't have any further career in the Army Nurse Corps, this will position me to get out because by then I was a lieutenant colonel, and it was 1983. Well, I had 15 years in the Army, so retirement wasn't around the corner. I had at least three years payback for lieutenant colonel, so I was looking three to five years.

So it was, to me, the best of the options that were available to me. So I told my boss, the Medical Service Corps Colonel Tom Jackson, that I wanted to take it. And so, of course, Colonel Jackson, in communicating to the surgeon general, who had to approve all health affairs assignments, basically said well, if that's what she wants, I know she's tried other avenues, I will support it. So he did.

But interestingly enough, the Chief of the Corps went to the deputy surgeon general, who then went over to Health Affairs to convince them why I was not the person they wanted. But their attempts to block my assignments didn't work.

It was obvious that I was not in sync with what was going on in Army Nurse Corps leadership. But because Health Affairs already knew me, or had experience with me, they thought, Well, they really don't want us to have her, so she really must be good. That was their read on it. And because I had been out in the field with them, they did not take any of the comments negatively.

### **Health Affairs for Two Years, 1983 to 1985**

So I went to Health Affairs for two years, did quality assurance for them, which was a matter of going out, and at that time basically trouble-shooting what the media was discovering in terms of adverse outcomes, and finding out the rest of the story. If there were things within military medicine that needed to be addressed, we wrote the policy. The supervision of non-physician health care providers, was one of the DOD directives that I wrote.

I wrote another one that had to do with Emergency Medical Services, and the standards for EMS, and I wrote another policy on off-duty employment because moonlighting was a big issue, the number of hours that people were involved. So it was about two years of finding out what the deficiencies were in terms of military medicine across the board, and then coming up with policy changes, such as the requirement for licensure of all health care personnel. Prior to the directive in DOD, only nurses required licenses. Everybody else, for whatever reason, did not. Nurses required a license since the mid-1930s, I think, back in the early days of the Army Nurse Corps. But physicians did not require a state license in order to practice in the military.

So it was those types of policy issues that we addressed that then changed how we were doing business in the military medical services.

### **The War College, Carlisle, Pennsylvania, 1985**

Q: So you were there two years.

A: Two years, yes. Just under two years, because I was picked up for the Army War College while I was there. So I left in the summer of 1985. I served there from the fall of 1983 to the summer of 1985.

Q: And what impact did the War College have on your career?

A: That was probably a turning point for me. And the turning point probably had begun a little bit earlier, and that's when I was on the IG team, because I didn't even know that the Army War College existed until I was doing CGSC. I knew what that school was at Fort Leavenworth, and I knew the level of education, but my boss on the IG team, Colonel Tom Jackson, was Medical Service Corps. He had come out of the War College to the IG team and, of course, told us as young officers who had potential, about the War College. I liked the sound of it, and that was at the time when you're thinking about schooling. It was either to think in terms of a doctorate in nursing or further military education. A doctorate in nursing did not appeal to me, so I thought well, the Army War College sounds interesting. I wanted to learn more about the Army.

So he turned me on about the idea. I also liked the role of the IG and my job in Health Affairs. It was a bigger picture in terms of military medicine and I liked that. So when I was selected to go to the War College, that was my opportunity to find out about how the Army really works.

I think the biggest benefit of that stemmed from being a member of the Army Medical Department. I think I was somewhat parochial during my career. I thought we had the best and the brightest of human beings doing Army medicine. And when I went to the War College, I found out there were people who were bright in areas that I had not even thought of before, in terms of their expertise. I found really outstanding managers, leaders, subject matter experts in war fighting, you know, whether you're talking about armor, or infantry, or some others. I never had given any cognizance to the depth of information that was represented there. But by virtue of the discussions, and by then realizing how you do the military part of our business, and linking it to the national strategy I got a very complete education in the role of not only the U.S. Army, but the U.S. military in our national agenda. What does the military do? It just doesn't fight wars.

### **Lt. Gen. Ronald Ray Blanck**

I mean, when we fight wars, that's a failure on many other fronts, and the war is the result. So the knowledge base, the speakers that we were introduced to, the networking, the people that are currently in key positions that I had the benefit of being their classmate. All helped me to develop. Our most recent surgeon general,

General Blanck -- General Blanck was the senior officer in the class. The physicians are often the senior officers because of their time in grade as colonels. General Blanck was the class president there, so that's when I really got to know General Blanck.

Q: For the first time?

A: I had encountered him previously. In fact, I encountered him when I was inspecting Eisenhower and he was in Medical Corps Branch. So I knew who he was, but never really had a relationship with him or got to know him. I did in that year in the War College.

### **Classmates Making General**

Then subsequently we both went to Europe and I became a Chief Nurse at Frankfurt, and then he went from Berlin to Frankfurt as commander. So then that working relationship started, and then he made general, I made general, and he became surgeon general and such. So even in my own army medical department, those relationships -- General Timboe was one of my classmates, now the commander of Walter Reed Army Medical Center — become important.

In the Army, the current commander of TRADOC, General John Abrams, was a classmate. He and I were lieutenant colonels together, and because of Adams and Abrams, we would often get positioned close to one another, and so I got to know John as a classmate.

All together in the class of 1986, there must be around 50 to 60 army generals who came out of that class, and we all started making general basically at the same time. The current DCSOPS of the Army, Larry Ellis, was part of that class.

So in terms of the working relationships, and when I became chief of the Army Nurse Corps, there was a comfort level because I knew people over in the Pentagon, in the Army positions, that I had been a student with. That whole environment up there in the Pentagon is echelon above reality.

So having some contact with people that you know who can at least point you in the right direction is very important. And then people that you developed a working relationship with, I think that, to me, was probably a key benefit to the War College in residence. Now we send a lot of people by correspondence. In some ways they do all the work, but I'm not sure they get the true benefit of the War College experience. The best, the brightest in the active Army are going to be in residence, not doing it by correspondence. The correspondence is going to be the special branches, it's

going to be a lot of the reserves.

So you'll need a few key people to attend in residence. The relationships as well as the knowledge base, I think, are very unique, even if you don't become a general, even if you're just in a key leadership position.

Q: Were you the only Army nurse to attend that iteration?

A: Yes.

Q: At that time the Army Nurse Corps was only sending one?

A: One, right. There were three MSCs, I think six physicians, one dentist, and one nurse.

Q: Up to this point you really hadn't had much contact with the reserves. Did that continue on until you became the consultant of the Army Nurse Corps?

A: Yes, I would have some contact with the reserves in Europe because of their participation in REFORGER, but REFORGER was a field exercise. I was back at the 97<sup>th</sup> General. So periodically in the summertime we would get some IMAs and individuals who came in for training. But it involved nothing in terms of the readiness issues that involve the reserves, or what do we need to do to work smarter or better with the reserves.

I didn't really get visibility of that information until I worked in the office of the chief and was the nursing consultant, and then had the opportunity then to start working with General Pocklington, who at that point was in her position as chief for mobilization. It was a readiness position. We didn't call her chief of the Army Nurse Corps. I think her position was the IMA to the chief for mobilization and reserve affairs.

So supporting her in her nursing role as the Reserve chief nurse, I think, was my first appreciation for the depth of what is involved in the reserve components.

### **Col. Mildred Irene Clark**

Q: It was while you were at the War College that you developed your relationship with Colonel Mildred Irene Clark. How did that happen, and can you share some memories of her?

A: When I was chosen to go to the War College, I had a conversation subsequently with

General Slewitzke, who was Corps Chief then. She emphasized to me the importance of the oral history program that was a part of the War College curriculum. She shared that the oral history was an option that many of my predecessors at the War College had done. They had completed oral histories on former Corps chiefs. She as the Corps chief really wanted to get that project continued as much as possible.

So she planted the idea. "My expectation is you would do this." I think I asked the Corps Chief's office, who is it that we need to complete an oral history on? They submitted Colonel Clark's name, the Corps chief back in the early sixties. So the project was funded by the War College.

The War College funded me to go out to Ann Arbor, Michigan, where she lived. I went out there to visit her, and it took all day Saturday and all day Sunday. Not only was she delightful to talk to, she had boxes of things organized, papers and stuff, so that when she talked something, she could go and lay her hands on the papers.

Q: I wonder what happened to all of them?

A: I don't know. But as part of my oral history, she gave me some things that I think went in as part of the project later -- one of the original copies of the prayer of the Army nurse that she had written. And I think it was by virtue of listening to Colonel Clark and her service that I reached a turning point. Her service began with Pearl Harbor, as a nurse anesthetist out at Schofield Barracks, and subsequently she went to Japan and served on MacArthur's staff when Korea was invaded. She described how she did her job, with little to no recognition for the magnitude of her contributions. And thinking in terms of what awards were given to Army nurses during World War II, the nurses in Corregidor got some awards, but the majority of nurses were not recognized for their service. And they just kept working.

I think talking to her kind of desensitized me with some of the baggage I had acquired to that point because of what I perceived was the negative environment surrounding me from the IG job. For about two years, it seemed to me all I was doing was fighting the Army Nurse Corps. I was on the wrong sheet of music when it came to them and me. And as I said, when General Slewitzke became Corps chief, at least the overt antagonism disappeared. I wasn't sure I was still back in the fold, so to speak, but at least I wasn't feeling like I was defending myself. And I think after listening to Colonel Clark, I stopped feeling sorry for myself, and said, "Hey, get over this. Get back on track. Pay attention to what's important, which is doing the best you can in support of the mission, in support of the Corps, and the rest is just noise. You don't need to pay attention to it."



Then Colonel Clark maintained our personal relationship -- I told her she wrote me more often than my own mother did. If you've ever seen any of her letters — if she ever wrote to you, she wrote volumes. I mean, down this one side of the paper, and so if you told her anything, you would get a full response from her.

So after leaving the War College and becoming a chief nurse, I continued to correspond with her and told her what I was doing as chief nurse. I wrote about the good things and the bad things, and based on her experience, she would share words of wisdom with me in terms of what was going on in her life. So we just developed a personal relationship, and I saw her a couple of times when I became Corps chief during social functions. As a former Corps Chief, she would be there, and I would seek her out. Then when she died unexpectedly, I had the privilege of giving the eulogy for her at Fort Myer.

We talk now in terms of the core values, selfless service -- well, she lived it. We didn't identify it like that then, but she was that in terms of what she did. And the things she did, when you start looking at the accomplishments in terms of what she contributed, it is amazing.

Q: Some of her ideas were visionary.

A: Yes. She fostered the incorporation of male nurses. She was the Chief of the Army Nurse Corps during Vietnam, and got the nurses to support that war, was responsible for the fact that the nursing shortage never was a war stopper. We were in very difficult times.

She just was a neat person. She never thought about rewards or promotions or anything. That was not part of her lexicon. Even when she was talking about World War II, about being integrated into the Regular Army, and how the nurses on active duty were forgotten when the Regular Army started. Other people were getting Regular Army status, and they were on Active Duty, and people were not following through to make sure that they were being counseled, and picked up, and she just kept plodding along, very determined.

So I really learned from her, and I think in terms of mentoring, she was very important to me at a crucial time in terms of developing me in a more mature way as a nursing leader vice where I was before, which was more what is Nancy Adams doing, vice what does the organization need.

### **Kitty Betz, Another Key Person**

Q: So she really was a very key person in your career.

A: Yes. She was. And she and Kitty Betz, she was another one. She didn't write me as frequently or as many volumes as Mildred Irene did, but Colonel Betz was another one who throughout the years, in my positions, I would write her and she would write back. If I had complained about something, or let her know something was going on I wasn't happy with, she would give me her advice.

Q: She was your cheerleading squad.

A: Yes. So, you know, those people who always had a vested interest in me, I think in terms of who they are and what they've contributed.

Q: They made you what you are, too.

A: Yes.

#### **Assistant Chief Nurse and Chief Nurse, Frankfurt, Germany**

Q: Your next assignment was as assistant Chief Nurse and then as Chief Nurse at Frankfurt. How did that assignment come about?

A: Well, I was assigned while I was at the War College. The assistant position in Frankfurt for some reason was a MEL-1 position. Maybe because it was in Germany and it was overseas. We were changing both the chief and the assistant chief that summer. Because I had had some difficulties with Army Nurse Corps assignments, -- Darlene McLeod was in the branch -- I can remember her calling me and telling me they thought this would be the perfect utilization tour, the assistant chief nurse, in Frankfurt, Germany. But it would be up to the incoming chief nurse, Gail Croy, whether or not she would accept me.

So I asked her who the chief nurse was and she said oh, Gail Croy. Gail and I had been together at Beaumont, and while we didn't stay as corresponding friends, we kept up with each other during the intervening years. I felt I had a good relationship with her. And so indeed when Gail was called and asked if she wanted me as her assistant, she was very happy to have me. Now we are very good friends. And subsequently, Gail and I were talking, and Gail said, "Well, you know, they called and asked me if I would take you," and she said, "It was a little strange, I couldn't understand why they would ask me." And then Darlene said, "Well, you know, she had some problems." And Gail said, "What kind of problems?" And Darlene said, "Well, you know, things weren't going well for her."

So she basically let bygones be bygones, but it was interesting that she was asked.

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So she basically let bygones be bygones, but it was interesting that she was asked.

Q: Did she think they were hearkening back to issues that surfaced with the IG team again?

A: Yes, to the IG team because obviously, many of the senior leaders knew about it, that cohort group. I left the IG team in 1983 and this was 1986, so it was three years later. But fortunately, Colonel Croy was willing to give me a chance.

So I went over there as the assistant chief and worked for Gail for a year, and then I believe we had the change at 7<sup>th</sup> MEDCOM. Colonel Mary Messerschmidt was the Chief Nurse of the 7<sup>th</sup> Medical Command. The following year Colonel Messerschmidt rotated back to the U.S., and Colonel Croy was selected to go to the MEDCOM as the Chief Nurse. They offered me then the opportunity to move up to be the Chief Nurse.

I believe General Adams-Ender had become Chief of the Army Nurse Corps. I know when I moved up, I was already LTC(P) and she came and promoted me. So that was very special for me.

Q: So you wanted that position?

A: I wanted to be Chief Nurse, yes. You know, as I mentioned, I had never been a head nurse, and I had never been a section supervisor. And even though I had been out of clinical nursing in terms of the patient care role because the year in the War College, the assignment in the Pentagon, the assignment on the IG team, I still very much enjoyed the hospital environment, patients, and staff. So I wanted to get back into the clinical environment, and the assistant chief role actually was great because the assistant chief focuses on what is going on in the hospital on a day to day basis, while the chief nurse is doing the organizational role.

So I enjoyed being assistant chief; the only reservation was when I saw things that needed to be changed, I had to go to the chief and talk to Colonel Croy and say, "Well, what do you think." Now, fortunately, Colonel Croy and I agreed 99.9 percent of the time, so it really wasn't difficult. But I thought well, I can do this. I

but commanders only stayed two years while everyone else stayed three years. But Colonel Butler was commander for two years, and then he was replaced by Colonel Ron Blanck. That was at the time he was at Berlin as the commander, and he moved from Berlin to Frankfurt. So he was my commander for a year.

Q: What was the organizational climate there at that time?

A: Well, working with both Colonel Butler and with Colonel Blanck, leaders in their own right within the Medical Corps, was great as they truly worked collegially with the nurses. It was a partnership, and that included the deputy commander for administration who was Bob Fechner, I think, for most of that time, with both Colonel Butler and then with Colonel Blanck. And so the three of us just had a very cohesive, friendly command team. We liked each other as individuals, we socialized with each other, plus we worked very well together. And I think that showed in terms of the organization, because there was an organizational cohesiveness that evolved from that.

### **People Oriented Climate**

Both Colonel Butler and Colonel Blanck were people-oriented, Colonel Butler, in a quieter sort of way than Colonel Blanck. Colonel Blanck was always out and about talking to patients, seeing patients, showing up at unexpected times, while Colonel Butler was a little bit more predictable, I guess. But they were both people focused, enjoyed their work, enjoyed people, valued nursing. So if I had nursing issues, they would support me. I smile because some things don't change, like the relationship between the nurse anesthetist and the anesthesiologist.

There were both anesthesiologists and CRNAs in the hospital, and the CRNAs were doing about 95 percent of the work while the anesthesiologists were not doing their fair share. The nurse anesthetist took all night calls and the weekends, and the anesthesiologists were at home on backup call. And that wasn't fair in terms of quality of life.

I had a husband and wife team who could never even see each other because of the call schedule. I remember going to Colonel Butler at that time saying, we need to make this fair, and he got involved, and indeed made some changes, so that it wasn't the nurses doing all the work while the physicians were kind of saving themselves for the big support role that never came.

Q: Has that always followed you as you've gone along? Are the same bones of contention existing between the anesthesiologists and the CRNAs?

A: Well, it amounts to a command and control issue. Essentially, what the physicians want to do is to keep the CRNA dependent to them. They want them to do all the work, but work under their command and control Monday through Friday, but evenings, nights, and weekends, trust them to be with patients to do the same work, and not be readily available to “supervise” them.

So it was kind of a double standard throughout all these years until recently. And in fact, we got new guidance that has just come out within the past 90 days that basically says that the CRNAs can be credentialed to do ASA class one and class two patients with no supervision. Essentially, as health care professionals, they are trusted to seek consultation based upon their judgment. The previous regulations always alluded to the supervision provided by the anesthesiologist, and the term “supervision” was never defined. So when it was convenient for the physicians to say well, gee, I have to supervise, they would be there to supervise, which usually meant they didn’t do cases in their own rights, the nurses did the case while the doctors were standing by. And then if you got to evenings, nights, and weekends, their supervision was being provided at home, and the remark would be well, if they need me, they will call me.

Well, my approach to that was well, why can’t we do that during daylight hours during the week, and you guys could do cases and such. So there has always been that tension because they want the anesthesiologists to do the work for them, but they want to be able to say that they’re in charge of the anesthesiologists. And, of course, with the credentialing and the independent licensure that they can have now, there is no need -- either from a quality insurance perspective or from a legal perspective, it’s not a valid requirement.

So we are still having that dialogue, and as we try to change to the new guidance, we’re seeing some of the same tensions. In fact, when I became the nurse consultant following my job at Frankfurt, I in-processed with General Scotti, who was the Chief of Professional Affairs and Quality Assurance. He was in the surgeon general’s office as a one-star and he said to me, “Nancy, you and John Parker,” because Colonel Parker then was the surgical consultant, have one problem you two have to fix, this schism between the nurse anesthetists and the anesthesiologists.

### **Fixing the Problem between Nurse Anesthetists and Anesthesiologists**

Colonel Parker and I went through some very tough times, but the two groups love to hate each other, is what it amounts to. And it’s interesting because army medicine can’t function without nurse anesthetists because there are many places the anesthesiologists do not want to go, nor are they needed in terms of the high risk and the complexity of cases. So they want that situation, and then when you co-locate

them, all of a sudden you're supposed to make the CRNA subservient to them. And even here in the teaching environment, the argument needs to be made that they need to learn how to react in a collegial way. In a MEDCEN environment if you're always subordinate to the anesthesiologists, and then you go from Tripler Army Medical Center to Fort Irwin and you don't have that anesthesiologist on site, you need to be independent and function on your own. So you've got to develop those behaviors in a relatively controlled situation, which is what you have in a medical center.

Issues like that demonstrate that both Colonel Butler and Colonel Blanck were very good commanders in the truest sense. They paid attention to all the disciplines, and they brought it together as a functioning team instead of polarizing the different groups.

### **Command Responsibility**

**Q:** You have always tried to get out into the clinical areas and find out what's going on in the past, I know that, and I saw you do it very effectively as well. Are you trying to do that here, too?

**A:** I've tried to do it as a commander. It's impossible to do it as a commander because when everybody sees a commander in their area, they think something's wrong, and they don't want to tell you anything. I think they're afraid if they tell you something you're going to do something about it, which is a commander's prerogative. I tend to react that way. If people tell me something and I have the ability to fix it, I'm not going to tell them okay, run it through the chain of command. But usually, in my mind, that's a beneficial thing, you know, where you say something casual and hey, that's a great idea. I think we'll do that.

That, to me, is a way of getting feedback, as well as being able to fix things expeditiously. So yes, I have tried, and I've been a commander now for -- I started in Beaumont in 1998, I guess, so I'm going on my almost third year here, and I had about a year at Beaumont. When I went to Beaumont initially, I went as the regional commander and did not command the hospital. And I've tried different strategies. First I tried to do it by taking either my chief nurse or my command sergeant major with me, and you get into an entourage. And when you have an entourage, then nobody wants to talk to you. And not only that, when you take one of your deputies, they tend to want to defend their turf. So they want to speak if the nurse is talking to you.

And then this happened to me early on in Tripler and I went up to pediatrics just to get out and see what was going on in peds, and to determine how are things going on a lieutenant's level. They responded with, "Ma'am, you know they're really

working hard and we don't have enough staff." Well, you know, the chief nurse didn't want that lieutenant telling me that. And the chief nurse was working to get more contract nurses. But from the lieutenant's perspective, it wasn't fixed. I wasn't going to fire the chief nurse, but the chief nurse didn't want the lieutenant to finish telling me the rest of the story.

So trying to get out and learn first hand, I finally decided what works most efficiently for me. If I have VIPs in the hospital, or if there's something unusual going on, that's kind of a traditional need to know. So if I go up for a need to know, then it doesn't sensitize people. I can see and talk to patients, I can do their agenda as well as my agenda. So I don't want to say fool them, but I kind of slide into it.

Now I usually go with my aide because the other thing that you'd find as a general or as a commander, you sometimes don't know all you need to know, and it's usually a phone number. Even in TAMC, this hospital is confusing. To find people or places sometimes is not easy. So the aide -- usually I'll tell him I want to do this, and he'll make sure that he knows where I'm going, and he'll let people know, because they don't like to be surprised. So he'll just say General Adams wants to come up this afternoon to see so and so, or to do such and such.

So there's no surprise. I'm not creating anxiety, I guess that's the nicest thing. And I do make rounds with my sergeant major because one of the things I'd like to do is talk to the enlisted soldiers, and I find when the general goes into the area, the officers try to take \_\_\_\_\_. So when I was going with my DCCS to the areas, I was only talking to the doctors. And if I went with the chief nurse, I was only talking to the nurses.

So now the group that has the least access to me, I feel, on an ongoing basis are the enlisted personnel. They are also the ones who are least likely to talk to me spontaneously. So with the sergeant major here they feel safe, you know, and the sergeant major will say, "Well, tell the general about such and such," and that will kind of lead them on.

So once a week, an hour a week, we do sergeant major's rounds, and he decides where we're going, his agenda not mine. So it will get me through hopefully the whole hospital in a period of time. And now I'm getting ready for the joint commission, so that gives me an agenda. And I told people the joint commission is my number one priority. And I'm going to go out and see what I need to do to get ready for joint commission. I tell the staff, and you need to tell me what I as the commander need to fix as a priority to help you be successful, for JCAHO.

So you have to set the agenda or else it doesn't become a good use of time. And also

people then are uncomfortable because they think you're looking for something, as opposed to just wanting to get a feedback check. I mean, basically that's what I want to do. I want to know from a patient perspective or from a staff perspective how Tripler is taking care of you. Why do you like working here at Tripler? As a patient, are you getting what you need?

### **Construction in Frankfurt**

**Q:** Let's backtrack . . . Was the construction going on at Frankfurt at the time you were there?

**A:** Oh, yes, it was a lot of extra work. It was a hopscotch approach. You moved out of an area, you renovated an area, and then somebody who wasn't going to end up in that space as a final resting place would come in and take over the space. And it was kind of discouraging from that perspective because nobody ever got to move into their own brand new space. You're always in temporary space even if it was brand new, it was temporary. And then when you got to move into where you were supposed to be, your permanent unit, it had already been used by somebody else, and it was wearing on the edges. And Frankfurt as a physical plant was very inefficient because of the number of buildings, and the age of the building, so people had to put up with a lot of inconvenience.

A funny story, there was a main staircase at the front of the hospital where you came in, a double staircase that went up, and I had come down that staircase to go do something, and it was like my first month there. I went and did something, and I came back and it was gone, the staircase was gone. They had dropped a plastic barrier down, an opaque plastic barrier that essentially sealed it off, and I thought I was totally lost. I thought, this is going to be interesting.

And then it was interesting, when I was there, for three years, I think, Branch wanted to know if I wanted to stay another 14 months until they "finished the construction." Well, I knew we weren't finishing this construction in 14 months. We were so far behind. But the Germans did an excellent job in terms of the renovation. The sad thing is I think by the time we finished the renovation, we closed the hospital and moved out, so all that aggravation and all that effort was in vain in some ways.

But people put in a lot of extra work because of the moves required in order to accommodate the renovation. And then power failures and things like that that went along, you know, crises that we had that were related to the construction.

**Q:** So the BRAC was going on then and you mentioned that as soon as almost the construction was complete, then there was talk of closing.



A: Right.

Q: Were you there when the talk began about closing it?

A: I heard some of the early discussions, and quite frankly didn't think it was serious because my mind said why would we be spending all this time and effort on a seven year renovation project only to close the hospital. And then, you know, just thinking in terms of where the Frankfurt Hospital was in relationship to Rhein Main Air Base and such, I thought, well, it's positioned pretty well, I would think, in terms of the airport proximity and such. I felt that the 97<sup>th</sup> General would stay open. And at the time we were starting the other closures, mostly of small places, outlying areas. A couple of places were closed when I was there and people were moved. But Frankfurt was not actively mentioned as being closed when I was there. It was more in the rumor stage. We did not actively start planning to close Frankfurt. We were still so much engaged in the renovation and such, it just didn't come up.

Q: At this time costs for hospitalization and health care were really skyrocketing. Was that a problem for you? Was your budget adequate?

A: As Chief Nurse in Europe, most of my nurses were military nurses. I had some civilian nurses. My biggest problem in terms of management was being able to hire civilian nurses, having U.S. licensed nurses available to hire, so that if you had to go back to the U.S., it was a long wait to get somebody to come over.

I remember having a budget in the Department of Nursing of a million dollars, and I only say that because my command sergeant major managed it for me, and I often thought about the magnitude, the sergeant major was managing a million dollars! But it was all pretty well carved out in terms of, you know, medical supplies and such, so there wasn't a lot of demand placed on the budget. But I don't ever remember having to go to the commander and asking for money.

The biggest crisis was in people; for example, labor and delivery nurses, because we had a lot of babies born in Frankfurt, and not having the right specialty nurses to deliver the patient care. But money, I don't remember us having to skimp on supplies, or make decisions about pharmaceuticals, or anything like that. TDYs -- you think in traditional ways you cut money when money is short. TDYs were relatively limited. They were either in-country conferences that were centrally funded, very few trips back to the mainland, but those were centrally funded. For sure we were not in the discussions in terms of the business of health care and what was managed care in Germany.

When I came back in 1989-90 and when I was in The Office of the Surgeon General,

that was almost like an awakening, I guess, to a new world because that was, indeed, the focus. How are we going to be able to afford our health care system.

At the same time, that's when we started talking about the downsizing, so those were the two things that were the agenda items. But in contrast, when I was in Korea in 1969-70, and Vietnam was going on, those were very tough times. We never had the supplies we needed. And, you know, you might have kleenex but you didn't have toilet paper. I mean, we never were in dire straits, but we were always having to make do with a limited amount of supplies -- both sterile supplies as well as the others. But not in Germany. In Germany we had what we needed. When we needed it, we could count on it, and I'm thinking in terms now of medical equipment, too. We had what I would call state of the art equipment, and sometimes it was better than what I had been used to back in the States because we were able to buy some of the German equipment which, of course, was very well done, high tech, and good.

Q: Were any of your staff deployed for any operations at that time? Were you tasked to support different missions?

A: The biggest thing we were tasked to support, both Frankfurt and Landstuhl, were specialty response teams, and we alternated calls for them. I don't think we called them contingency response teams, I think that term came later. They involved about 30 to 40 people on our hospital staff. These were never activated while I was there for emergency missions or contingency missions, but we did periodically do scheduled missions down in Africa. So going down there to do teaching, and giving immunizations and such.

So there were deployments, but they were more training events than actual contingencies.

Q: Some of the nurses went to Africa?

A: Yes.

Q: What part of Africa, do you recall?

A: No, I don't know, because I never got to go. REFORGERs were still very big.

### **Winter Training Exercise**

Q: That happened every year?

A: Well, yes. I think the first year, we deployed to do REFORGER. But I think they

scaled it back while I was there because I remember the first year there was a large group going, and then after that, it was a smaller effort. It was not of the same magnitude that they had done previously. So maybe that was part of the change in the politics as well as the resource issue. I was PROFIS'd as an assistant chief nurse, and I went out with the hospital I was PROFIS'd to for a winter training exercise for a week. So we were doing things like that.

Q: Where was REFORGER held?

A: Somewhere in Germany. I didn't go out to REFORGER. I sent people, but I don't know where they went.

Q: When you went out to your winter exercise, where was that?

A: I think we were out near Wiesbaden.

Q: Did you have host nation nurses on your staff?

A: Host nation nurses?

Q: German nurses.

A: I'm trying to think. I don't remember any. I don't think we had host nation nurses on our staff, and the reason I say that is I remember visiting German hospitals and knowing there was a difference in the level of practice. The German nurses in German hospitals did more of the custodial care type activities. They were still cooking to a certain extent, and they were doing more of the housekeeping chores than what you'd see U.S. nurses do.

Q: So mostly then you had active duty Army nurses.

A: Active Duty Army, GS. The GS, which were the full time positions, and then the When Actually Employed (WAE) nurses. I don't think we had German nurses, or if we did, they were nurses who had U.S. licenses and such because we were then, I believe, throughout all of our hospitals world-wide enforcing the JCAHO standards. And, of course, the JCAHO standards would have required a U.S. license.

So I don't think we had any host nation nurses unless they had had some time in the U.S. and then had a U.S. license and then came back over there.

Q: Could you describe your leadership style there? Was it developing beyond what it was before?

A: I think so, because when I was the assistant chief, that was the first leadership role. My health affairs job essentially involved no subordinates. And when I was on the IG team, I had no subordinates. When I was director of the ICU course, I had an assistant, she was one subordinate. I had the students, but that's kind of a different relationship between a teacher and students than when you talk about the ordinary management leadership.

So I think yes, as an assistant chief I started to develop my own style, learning from Colonel and Gail Croy, who was senior to me. Gail is 65 now, so she's about 10 years older than I am chronologically, and was senior in rank about five years to me. Working with her was a very good experience, because Colonel Croy was an expert in terms of management and leadership. She had a very personable but firm style, which I think is the way I tend to be.

I can remember early on trying to loosen up, or giving people the benefit of a doubt, and then finding that it was much harder to come back strong after you kind of let the reins out a little bit. So I found myself starting out very precise, and then if I needed to give up some control or give more latitude, then that was easier to do than trying to regain control.

And I also started to learn how you delegate work, because when you're the boss, you may be the best and the brightest, but you can't do it all yourself. In those other positions, I was a staff officer of one, so I knew what I needed to do, I did that, and did it well, rather than developing others.

So yes, I think as the assistant chief, and then as the chief nurse, I refined how I did business.

Q: So you felt comfortable with it, then.

A: Yes.

Q: Was the organizational structure for the Department of Nursing there in the traditional Army mold?

A: Yes, it was. Chief nurse, assistant chief nurse, commander, and the supervisors. When I was chief nurse at Frankfurt, I really did not do anything to change any of that. I mean, what I had was what I kept. When I moved into the nursing consultant position, and I started to think in terms of how we utilize our nursing assets, and what is the benefit that we have in the Army Nurse Corps by virtue of having so many Master's educated nurses, what are we doing with these individuals.

I then went back to the organizational structure that I had in Frankfurt because I still -- I knew the positions as well as the people, and then using my Frankfurt organizational structure as a template for what I wanted to do, just to see would it work for me, and it did. In fact, I used that as a nursing consultant when I didn't have my own Department of Nursing to manage. That was how I could talk to people, give them some feel to make it real instead of notional, showing with the same number of people, with the same educational preparation, with this structure, you can be more patient care focused. You have a decreased span of control, but you've increased responsibility because of your accountability for patient care. You're managing assets and such.

For example, in retrospect I have to laugh -- I had an individual who was the medical surgical psyche supervisor and he, oh, by the way, was a former nurse anesthetist. He did a great job, but when you think of it now in terms of how, then, do you mentor and develop the medical nurses, vice the surgical nurses, vice the psychiatric nurses, and oh, by the way, your background is only in surgical, and what do you know about outcomes of care for psychiatric patients vice medical patients?

Well, he wasn't the -- he couldn't be "the" nursing expert for medicine, surgery, and psych, and also that was back at the time when we had all the clinics, you know. Ambulatory care was all together, and I always thought that we should be able to manage people across the continuum of care. So an ambulatory patient who comes in the hospital, just like if you're seeing the cardiologist and he's your outpatient doctor and you get sick, he's going to take care of you in the in-patient.

Wouldn't it be nice if the patients had some of the same feel for the nurses, if not in terms of personalities or seeing a familiar face, at least in terms of subject matter expertise.

So I kind of went back and looked at the talent pool I had at Frankfurt, and I knew their educational background to say okay, if I wanted to rearrange this hospital in product lines, did I have the assets? Would it take more assets, and would it take different nursing expertise. And the bottom line was I could have done it with the number and the people inventory I had. And yes, it would have meant a change in jobs, so the pediatric nurse practitioner probably would have become the nursing product line manager for pediatrics because I needed her more in a nursing expert role than I needed her to be doing well baby, because we had seven pediatricians.

So it would have been a different utilization of the nurses I had. In my mind it would have been a better utilization. But to answer the question, I didn't change anything when I was at Frankfurt. And then later I thought about it and thought, you know, maybe that's part of the problem with our current leadership. You're so close to the

situation, it's hard to be a change agent at the same time you're doing a job.

Q: You can't step back.

A: Right. And unfortunately, that's what we make everybody do. Okay, you come to work, and you take care of these patients, and you do this, and you do this, and oh, by the way, in your spare time, re-engineer yourself. That's not a realistic expectation for people. So I understand why when we look to make change that we don't get to where we want to be very expeditiously, and at the same time, you can't pull all those people out of doing their job and say okay, go in that room and plan.

But that's why we've got to position those assets within the organization, so that you do have a couple of key people who can step back, who could look at the variables that are changing and then rearrange the assets to say "this would work better for us," because you can't do it at the same time you're trying to generate the output.

### **Significant Change by General LaNoue**

Q: But it takes an exceptional person, I think, to step back and to conceptualize all that, and not everybody can do that.

A: And there was another portion of that, which I learned when General LaNoue was surgeon general. He instituted significant change. I mean, he delighted in creating chaos because his approach was -- and I know there are management philosophies that support this -- that if you have that chaos, then that gives you the raw material for change. If you just keep the status quo, then you will not get the momentum you need for change. So General LaNoue was very good about getting that chaos.

Well, when he would start that chaos, and I think this is the nursing part of it, i.e., we try to bring order out of chaos, and I would try to reorder it. And what he finally convinced me of was the magnitude of change that he was going to get to was not going to affect me directly or you directly, but we were setting the template to fall in on the future. And that's where you had to get beyond because if you always thought well, I can't -- if I do this, what will happen to Mary, or if I do this, what will happen to me, you are paralyzed. You don't have that confidence to be able to leap forward. So you've got to depersonalize it. Keep focused on what is the work, what is the mission. Quantify that and then build the template in terms of the people you need -- not the focus you need, but the people you need. Then you don't have to worry about well, gee, will Mary have a job, or will I have a job?

### **Staff Development**

Q: Did you make any major organizational changes in Frankfurt?

A: No. I think that was kind of my time to learn. I was in charge probably because of my IG background, was very much aware of a lot of the regulatory things that we needed to pay attention to, the crash carts and some of the fundamentals of nursing, I guess, is where my attention was more often than not, and documentation.

I spent a lot of time working with the staff. Staff development was important. Captain Tominey, who is now the Chief Nurse of Brooke, was one of my head nurses in the nursery. I can remember her one day saying, "Take me out of this nursery. I'll do anything to do something other than being a head nurse in the nursery."

Q: So did you?

A: Yes, I took her out and put her in a clinic, and then moved her to nursing education and training. I did a lot of that trying to develop people. Probably in terms of changes, I did more with the talent, with the people, than the organizational structure just trying to get the right person in the right job.

Q: Did you wear one or several hats there?

A: No, it was only chief -- one job. It was nice, one job, Chief Nurse of Frankfurt.

Q: That's probably the last time you did that.

A: It was kind of nice. The good old days, yes. And while the assistant chief, I was a PROFIS chief nurse, but when I became Chief Nurse, I wasn't PROFIS any longer.

Q: Were there any other major issues you faced as the assistant chief or chief there?

A: No, I think overall Frankfurt was a very enjoyable assignment, both professionally and just the Europe experience was just very nice. I was very comfortable.

### **Travel in Europe**

Q: Were you able to travel?

A: Yes, except typical me. I always use the first year to get my job organized and get my apartment organized and such, so the first year I did that and didn't travel too

much. And then the first year -- I'll never forget it because it was the first trip I took, and I went by myself because I couldn't get anybody else to go with me. I wanted to go to England because we were having an American football team over there. They were playing in England.

### **The New Chief Nurse**

So I went to England for a weekend to go to a football game, and that was the weekend, when I got back, that Colonel Croy told me that she was going to Heidelberg and I would be the new Chief Nurse.

So then I started another new job, and I don't think I had an assistant right away when I changed. Colonel Clarice Golightly Jenkins came in to replace me as the assistant, and I think I took over in September, and I don't remember Clarice arriving until about Christmas time, so I had those months by myself. So by the time I got my new assistant there, and I was organized and all, I was already starting my last year there, the third year.

But we had a lot of tours from the hospital. The wife of one of our physicians was a professional tour guide, and she would organize these bus trips. Essentially, 50 or 60 people from the hospital would go, often the commander, and I'd worry because half the command group, usually the DCA was there, the commander, and the chief nurse.

Q: Everybody left.

A: Yes.

Q: But you had a good time.

A: Yes.

### **My Successor**

Q: Who was your successor and what advice did you give to your successor?

A: My successor was Colonel Clarice Golightly Jenkins, so she did essentially the same thing -- moved up when I moved on. Quite frankly, if I told Clarice what to do, she would have done the opposite. I know what my advice to her was, you just keep things the way they are. If you pay attention to taking care of the people, that everything else will work out.



But I know things did not work out for her when she was there, and I don't know if it was a change in personality style. She was much more rigid than I was, more controlling, and individuals who worked well with me did not work well with her. And I never got into it really because as a consultant, I did not want to be in the position of soliciting feedback in terms of what was going on. But stories came back, and I know General Blanck subsequently told me that it wasn't the same. And, of course, she had to deal with Desert Storm, and I don't know first hand what it was like there. But I know they got casualties as well as they had to deploy some people over to the desert to fill in for some of those units. I know it was a whole different circumstance that she had to deal with.

Q: What year did you leave there?

A: I left there in 1989, in August of 1989.

Q: You were there three full years?

A: Three full years, yes. To that point, I think that was the longest tour I had had in my Army career.

Q: Did your family get to come over and visit?

A: My parents came once, my brother came -- not as many as have come to visit me in Hawaii. They did not come to Europe. And I was able to get back. I think I was able to come home every Christmas when I was over there; if not Christmas, at least New Year's. So it wasn't like being in Korea where I was gone for 12 solid months. I could get back to the States either for a conference or leave, I'd say about every nine months. A year didn't go by when I didn't see my parents or some of my family.

I went back on an air evac flight once, took a patient back, which was interesting. I took a baby back.

Q: To Walter Reed?

A: To Bethesda actually. So I did that once to get a trip back and then, of course, the Corps would have meetings, and I got to come back as a senior leader. In retrospect, I was not as far away from home in Europe as I am here in Hawaii.

Q: Then you went to the consultant's position in 1989.

A: Right.

Q: And that was under General Clara Adams Ender.

A: General Adams Ender was the chief of the Army Nurse Corps, and, of course, she had been to Europe every year that I was in Europe. She came over for the MEDSURG conference, and her husband was from Europe, so oftentimes she would come over. She would leave and her husband would stay, and so we had a good relationship.

### **Consultant Position, 1989**

Q: And so she hand-picked you?

A: Well, I guess so. You know, it's interesting. I remember when Colonel Croy told me I had been selected to be a nursing consultant, and I really didn't want the job. I wanted another chief nurse job, because I had only been chief nurse for two years, and an overseas medical center is not the same as a CONUS medical center. We didn't have the same degree of complexity or the acuity.

So Colonel Croy called to tell me that I had been selected for the job and I said, "Gail, I don't want that job." And she said, "Well, you don't have any choice." Colonel Croy was much more involved in Army Nurse Corps politics than I ever was. She had been assigned to PERSCOM, and she had been assigned at the AMEDD Center and School, and she had friends in the hierarchy.

My only brush with them wasn't so friendly, and I was kind of on the periphery. And the consultant's job, you know, was a staff job, and I really wanted a hospital again. But Gail talked to me and it was basically, well, if you turn this down, they're not going to make you a chief nurse anywhere. They're going to have to go find you a job, and it won't be a good job, and everything. And I said okay, well, I'll do it.

Q: At that time Gail was at --

A: She was 7<sup>th</sup> MEDCOM. So I said okay, consultant's job it is. I came back, and I replaced Colonel Pat Gorman as the consultant. And, of course, she had been the assistant chief of the Army Nurse Corps for General Slewitzke, and then moved into the consultant's position for about a year or 14 months.

Q: At the tail end of General Slewitzke's tenure?

A: No, after General Slewitzke retired. So Pat stayed on active duty after General Slewitzke had gone. General Adams Ender took over for BG Slewitzke, and Pat Gorman moved from the assistant Corps chief position to the consultant's position.

And, of course, there was another thing I looked at with the consultant's position. It was my experience in knowing who the previous consultants were, that it was their terminal assignment. I remember when Ann Hiers had been the consultant, I remember when Audre McLaughlin had been the consultant, and now Colonel Gorman, and I thought well, here I had only been a colonel, I guess at that time two years. I was a relatively young colonel, so I wasn't really looking to retire. So I went back and said okay, I'll do this. And it was an interesting job in terms of being the nursing consultant to the surgeon general, working with the Chief of the Nurse Corps, and the assistant Corps chief. So I worked more with and for Colonel John Hudock. Mike Scotti was the medical leadership that I worked for initially, and then when General Scotti left, he was replaced by General Blanck who, of course, had been my hospital commander in Frankfurt, so that was good.

Then I was in the consultant's branch and worked first for Jim James, and then for Colonel Jim Peake, who is now our surgeon general. So there were good Medical Corps leaders.

### **Nursing Consultant to The Surgeon General Position**

**Q:** We're talking about the nursing consultant to the surgeon general position. General Adams, this position no longer exists in the organization.

**A:** Right.

**Q:** Many people have no concept of what it's all about. So could you generally tell me what you did?

**A:** Well, in many ways it was a great job because essentially any of the nursing issues, whether they were practice issues or personnel issues, the consultant had something to say about what the Corps should be doing. Now, the consultant was not the decision maker, but the consultant essentially did the homework so that the Chief of the Corps could make a decision.

We looked to make sure that throughout the Corps we had internal consistency when it came to the practice of nursing, to the documentation, to educational requirements, utilization of non-licensed personnel, which has always been an issue because Army nursing works closely with our soldier medics, and as the demands on them were changing, to make sure that we were providing the appropriate training in relationship to the tasks that they were expected to accomplish. So essentially I lived and breathed nursing either from the personnel perspective, which was mostly in terms of job performance, because we did not have anything to do with assignments or anything like that, and then from the practice arena, if there were issues that came

up where we needed to be doing things better or different, what were the needs in terms of the types of nurses that we needed.

A lot of what I did was to host conferences in order to bring people together, to give them working forums to address the issues within the particular specialty area because of the dynamic nature of nursing practice, so bringing the MEDSURG nurses together, or bringing the senior leaders together in terms of management issues and things like that.

You know, I think -- and I don't know if you want to talk about it when we talk about the Corps chief, how Army nursing changed when I was the Corps chief, and did it go in the right direction, but I think the nurse's greatest value to an organization and to patient care is in doing nursing. And there's no doubt that we can do other things.

But the return on the investment is in keeping the profession at a high level of performance, and taking care of patients. To do that you need that nursing input, you need nurses focusing in on nurses and nursing, and that is what that consultant role did. She had that focus, and she would bring the issues to the Corps chief, or she would work the issues that the Corps chief brought to her in terms of whether it looks like we need to do something better or different here. I also maintained good relationships with the professional organizations to make sure that we were staying in sync with our civilian counterparts.

So it's almost a one stop shop for nursing in the Army Nurse Corps, and if there were issues within my sphere of influence, I worked them. If they had to do with other parts of our organization, I knew where my nurse counterparts were down at the AMEDD Center and school. So if we had a training issue, I would hand off to that individual. If I had issues to do with personnel management, per se, I would go over to PERSCOM where we had Nurse Corps officers. So it was kind of like a chief of staff for nursing, too, in some ways.

Q: What were some of the issues that you dealt with? You were tasked with revolving issues between the nurse anesthetists and anesthesiologists.

A: That was -- I was going to say, that was the biggest, and probably I remember that one just because we never really did bring it to a successful conclusion, and it was such a difficult issue. I did a lot with the nursing documentation, nursing forms; I was trying to develop at that time forms and a system for how we document patient care in the field. That remains unresolved even to this day. It's never been brought to conclusion. A part of that is, I think we're a victim of the technology because we're trying to use the computers in the field. We don't have them working yet in

the hospital, but now we want them in the field.

So working the nursing documentation issues and revising AR40-48 which had to do with the expanded roles, the nurse practitioner roles, what level supervision is required for nurse practitioners, the written guidelines, who requires protocols and issues like that.

And then, of course, there were the readiness issues. You had to be prepared for unanticipated events. So when Desert Storm happened, I was nursing consultant, and there was a lot of crisis work. I guess that's what I would call it, you know, the issue of the day.

### **Problems during Desert Storm**

Q: Different every day?

A: Yes. And some of it was not purely nursing, but the consultant's division only had one nurse. We had physician consultants for medicine, surgery, family practice, military medicine, and psychiatry. Also we had a pharmacy consultant and an optometry consultant.

Q: Those were full time positions?

A: They were all full time positions. But the nature of the beast, or I don't know what the reality of it is, a lot of those consultants kept a low profile around the office.

### **Shortage of 91-Charlies**

So the nurse more often than not, typical nurse, goes in the morning at 7:30 and you're there until the work is done. So I would be available often to my boss who, during Desert Storm, was Colonel Peake. And so I would have issues that just kept piling up in terms of Desert Shield/Desert Storm. We ran out of registered nurses. We didn't have enough 91-Cs initially to fill the hospitals that were being deployed. I don't remember the numbers but I believe it was somewhere in the high thirties, the number of hospitals we finally had over in the desert. No, it wasn't nurses we ran out of. We ran out of 91 Charlies, it was a 91-C shortage, because the Reserves had been short all along.

Then we were going to substitute registered nurses for 91-Cs. So then being able to figure out how do you do that, what are the numbers so that you don't end up with too many people and oh, by the way, if you're going to start pulling nurses, where are you going to pull them from because you have issues of unit integrity. So

something like that would take me days to work out a solution, and that would be one of those things that, depending upon what the variables were, the answer might change.

### **Feminine Hygiene**

I spent a lot of time during the war on an embarrassing topic of feminine hygiene, which became a big issue during Desert Storm. Particularly the availability of women's sanitary products surfaced, whether they be tampons or sanitary pads. I mean, you would not believe the dialogue on that subject!

Q: The exchanges couldn't get them over there?

A: Oh, they had them. We had products, but we didn't have all the brand names. So nurses would write to family members and say, you need to send me this and this, particular brand names, and then that was being misinterpreted. And, of course, the presence of women on the battlefield was new for Desert Storm, the large numbers that we had there. So women were kind of a focal point for that. And I almost would think that somebody seized on this because it was a way to discredit women on the battlefield, because it was such a ridiculous issue. In fact, I can remember it was a front page story on USA Today. As the nursing consultant, I had to put together some response so that the Surgeon General could tell the Chief of Staff of the Army what the problem was. And as I say, if it didn't take so much time and energy, it would have been laughable.

We even had people coming wanting to show me they had developed camouflaged covers for tampons and sanitary napkins. Another devised a little carrier that you could wear on your belt, on your web gear, and I said oh, good, and if it's empty we can then say to people oh, well, wrong time of the month for her. It was absolutely unbelievable.

### **The Reservists**

Then I spent a lot of time on the phone fielding phone calls from people primarily in the Reserves who had a reason why they should not be called up to go to Desert Storm.

Q: And how did you respond to that?

A: Well, you listened and then said, "Well, I'm sorry but indeed, when you signed up in the Reserves, part of that requires that in a national emergency, you can be called for deployment."

### Shortage of Anesthesiologists

“Oh, but they only told me it was a scholarship.” Well, one of the requests. Another true story came from an anesthesiologist perspective. I had anesthesiologist call. We didn’t have any anesthesiology consultant in the office or other physicians who could have fielded this call, so for whatever reason I got some of those calls.

We had the air war for three and a half months — the ground war hadn’t started. The anesthesiologist perspective was “Well, send the CRNAs over and when the war gets ready to start, I’ll come. Twelve hours before the ground war starts, you can call me and I’ll get on an airplane.”

I said this is not how it works. You have orders. You can report to fort so and so. You need to be prepared for deployment. But these were real live examples in terms of what I handled. So the period of Desert Shield/Desert Storm, beginning about August of 1990 through early February 1991, was kind of hectic. It was hectic and strange, yes.

Q: But why did that position disappear from the organizational chart?

A: It disappeared from the organizational chart because General LaNoue wanted reorganization and was moving positions to San Antonio — the MEDCOM. When General LaNoue looked at reorganizing Army medicine and we were in the midst of the downsizing, we did not have enough doctors and nurses out there to take care of patients. He wanted to dismantle the infrastructure and get people back to doing core business (c-o-r-e business).

So his priority value for positions was the higher organizational positions where you crossed boundaries, disciplinary boundaries, and the hospital level where you actually delivered the patient care services. So he did not see the value for a nurse consultant position. He did not see its payback, and when I look back trying to figure out how I got to where I am, there were really two ways to have gone.

He could have positioned nursing to be more effective in the organization, or he could take that nursing talent and put it where it would have an expanded role in the organization, and that’s what he elected to do, to move it. So instead of having the return on the investment within nursing, which is the largest group of health care professionals in the organization, and there was valid work for us to do, he wanted a bigger payback. He perceived it as a bigger payback if you were doing other work in the organization than if you were doing your nursing business. And the people he considered important at doing nursing business were not at the organizational level, they were in the hospital. They were out there taking care of patients or doing the

training at the AMEDD Center and School.

So it really was kind of a way to divest nursing of its leadership positions in nursing. He valued nurse leaders enough to say you are too important to only be in nursing. I have a better and greater need for you.

That worked out obviously well for me as an individual. If I'd stayed in nursing, there was not the power base within nursing as a profession, and there still isn't today, to earn us the ability to compete and go on to higher positions in the organization. We level out because of the nature of our work. So we have had to change the nature of our work in order to get promoted.

Senator Inouye, to this day, still believes strongly that the Chief of the Army, the Navy, and the Air Force Nurse Corps should be a two-star general. He believes because of his World War II experiences that nurses are as valuable to an organization as doctors. So if a doctor can get to be a two-star, then a nurse should as well because we are nurses not because we are branch immaterial.

Q: But not many other people feel that way and they don't want to relinquish the power.

A: Right. And if you're going to give power to nursing, it's got to come from the Medical Corps. They don't want to give it up. If you just make a nurse a two-star, then he or she will not have the developmental experience in order to function at that level in the organization.

So in a way, you know, I think we're at a point, and I've told General Bester. I also shared this with General Simmons because I feel during my time as Chief of the Nurse Corps, my job was, in the midst of the chaos, not to lose the entire farm, I guess. And at the time, my other big battle was the downsizing. And that was a life and death struggle because the prevailing attitude in the Army Medical Department was that nurses are something we can buy in the civilian community. So we can civilianize Army nursing positions, save that budgeted end strength and put it in the Medical Service Corps and in the Medical Corps (MSC) because we can't afford to buy civilian physicians and MSCs are operational assets. The physicians are the highest paid commodity in the medical department. So we can't afford enough to buy them, so we need to keep them in uniform.

From the Medical Service Corps, the attitude was that they're so unique, they are the operators, the health care planners, the readiness type job so you don't have the civilian equivalent.

So they rationalized, and oh, by the way, a nurse is a nurse is a nurse. So whether



you're civilian or military, it doesn't make any difference to the patient.

### **The Loss of the Nurse Consultant Position**

Q: You've fought that battle.

A: Yes, and that was my primary battle. That is why we were not looking at the other issue which is the career development of Army nurses. For example, we lost the consultant position. That's probably our biggest deficit today because you look at what is the bench for corporate leadership.

I had the benefit of a Washington leadership position before I was chosen to be Chief of the Army Nurse Corps.

Q: Almost essential.

A: Yes. General Simmons didn't have that opportunity. She came from MEDCOM, but that MEDCOM is not Washington, D.C., and I will tell you, I was not as smart as I needed to be, but I had the benefit of Colonel Kennedy as the Assistant Corps Chief, and Colonel Kennedy had been the deputy at PERSCOM for the nursing branch.

So Colonel Kennedy really knew the personnel business. She knew the linkages between the DCSPER and PERSCOM and such. As we were getting in the middle of downsizing, and we were doing these massive lay downs for the DCSPER, she knew how to do our homework so that when we came to the table, we were well prepared. And even if the AMEDD was trying to do something to the ANC, it had the right messages, and if you talked to the DCSPER, you had a champion. And indeed that is one of the reasons that during my time as Corps Chief, and with Colonel Kennedy, yes, the Army Nurse Corps was downsized, but not as much as it could have been. We went from -- the high was about 4,800, which was post-Desert Storm, and at that time the authorized end-strength was 4,800. We had an inventory of about 4,400. And at the end of Desert Storm we lost those 400 slots because that was a nursing shortage. We were not able to recruit. And physicians who came on Active Duty for Desert Storm wanted to stay on Active Duty. So essentially they filled up those 400.

Then when we went into the downsizing, we were already down 400 and the physicians had been already artificially elevated to 400. Yet to this day when we talk about downsizing, they express that as part of their pain that they lost 1,000 officers!

Well, they didn't. They lost 400 that they never earned to begin with. But that was the game. It was a constant battle. So I and Colonel Kennedy spent our time and

energy battling what General LaNoue was re-engineering, and bringing in task force Aesculapius. He brought in Steve Clemons, MG Jerry Seitter, and Colonel Steve Yenakis. All those guys, and indeed, I hate to say it, but, you know, physicians don't understand nursing. When you come to outside consultants who are trying to address how a headquarters functions, they don't know a nurse from an MSC, from a doctor, from a dentist. And so if you had anything special in your job title -- nursing consultant. "What's a nursing consultant? Well, we don't need them. We don't need a nursing consultant."

Now, it's funny we kept the medical consultant, and the surgical consultant, and some of those other physician positions. Now, granted, for a short term they did move to San Antonio. I think now we've recreated them in Washington, D.C., but we have not recreated the nursing consultant.

So it became a matter of priority, and my strategy was well, to satisfy the surgeon general. If General LaNoue was pleased with me, then that kept my relationship with him on a positive footing, then maybe I could fight some of these other skirmishes that were going on. But the big one was with the budgeted end strength.

While I was there, we still at least had incumbents in those positions, and when I left that was one of my concerns, I told General Simmons, I said, "I've had a holding action up here. But you need to come up with what were the new organization structures, where are the power positions, because I held on to some of the old, but I did not create the new, and that's what needed to be done during her time." But it wasn't done.

I talked to General Bester. Bill and I said we've got to bring the Reserve component into it also because now that the Chief of the Army Nurse Corps is no longer the full time job for the Active Duty general, there is no relevancy to an IMA. You're an IMA to a person who no longer exists in the organizational structure. Some we have got to sit down and sort that all out in terms of where are our leadership positions, and then what is the career development specific to the Reserves.

Don't take this wrong, Bill Bester should be a general, but maybe he shouldn't be the Nurse Corps general. Maybe he was the best of the Branch Immaterial, competing head on head with his Medical Corps peers, but there quite possibly was a better qualified nurse out there who was more competent to be Chief of the Army Nurse Corps, as well as had the potential to develop as Branch Immaterial. To me, Bill is first Branch Immaterial and then a Nurse Corps general. I was Nurse Corps first, then Branch Immaterial and you could argue, you know, which should come first.

But I think the value of nursing to the organization is such that we've earned a Nurse Corps general. Does that individual have the potential to do other things in the organization? Yes, but first and foremost the AMEDD needs him or her to be the best nurse in terms of taking care of the personnel as well as doing the professional business.

Q: General LaNoue came in as surgeon general during the last year that you were chief of the ANC?

A: I was already a general when General LaNoue became surgeon general. I worked one year with General Ledford as the Army Surgeon General, and then General LaNoue came in the second year that I was Chief of the Army Nurse Corps.

### **Policy Setting for the Army Nurse Corps**

Q: So the consultant's position went away. Who, then, is doing all the policy setting and the research activities that you were doing?

A: I think some of it is at the AMEDD Center and School now because there were training issues and such. And there's this pronency business, the regulations business. That's also with the AMEDD Center and School.

As far as the practice issues, there is no place that I'm familiar with, that they are addressed. Of course, I am at a disadvantage because when I left the Corps chief role, there was no communication between me and General Simmons. I mean, I had no idea what was going on in Army nursing except what my chief nurse would tell me.

Q: Did you try to talk with BG Simmons?

A: Oh, yes. I tried everything. I tried e-mails, I tried setting up breakfast, lunch, dinner. I tried everything, and she would never allow it to happen. And even when we would be at things together and I would try to connect, it didn't work. I remember once we were at General Peake's house for dinner in San Antonio. All the generals were there, and Betty and I were talking, and we were in line to get food and there was a table in his living room. Four people could sit at it, and I said, "I'll save you a seat." And I went and sat down, and two of the other guys came over and I had the seat saved for Betty. She got her food and she came in, and she didn't come over and sit at the table.

So I could never establish a personal or a professional relationship with her. And after about a year and a half, I think I finally quit trying, except when I heard Sue

McCall was retiring, and that General Simmons was not intending to replace the assistant Corps Chief. I sent her a registered letter, return receipt requested, because just like what we were talking about with the nursing consultant position, I was afraid if that position went vacant, we would lose it. And to me, with the Corps Chief out doing other things, the Assistant Corps Chief is vital. I think that's where some of the consultant work now falls, to answer your other question, to the Assistant Corps Chief who, by the way, also is the chief operating officer for the Army Nurse Corps, too, because the Corps chief is not available to do it.

So I was lucky. As I was doing the branch immaterial work for General LaNoue, I had Colonel Kennedy, who was essentially running — she was, in effect, the Chief of the Army Nurse Corps. She and I communicated very well, and also we were co-located in Washington. So when General LaNoue became Surgeon General, I had to move from the Corps Chief office. I kept a desk down there. While I still had the Corps Chief office, Colonel Kennedy still stayed in her Assistant Corps Chief office, but he moved me up front in what had been the executive officer's office. The TSG had the corner office. I was next to him, and then the deputy was on the other side of me. So that was kind of his way to say okay, you're going to do my work instead of doing your work.

I always thought I was doing a pretty good job of going up to the headquarters talking to him and such, but he wanted me moved. And then Terris had a consultant at that time, Bonnie Jennings. But I tried to let Betty Simmons know that these were the things she needed to watch out for. She did not want to hear it from me.

### **Major Accomplishments as Consultant**

Q: What were your major accomplishments as consultant?

A: I have to look in my OERs and see what I did. I know I did a lot. I know I revised AR40-48. some may not consider that an accomplishment.

Q: And an AR40-48 is –

### **Revision of AR 40-48**

A: That was the Non-physician Health Care Provider, so it was the regulation that --

Q: That's for the physician assistants?

A: No, that was for anesthetists, it was also directed at nurse practitioners.

Q: You must have worked long hours. Well, you always did.

A: But I worked right next door to –

### **Answered GAO Audits**

Q: Where you lived.

A: Yes, so I could walk to work. Oh, I answered GAO audits. I forgot about that.

### **Congressional Investigations**

Q: Did you get many congressional investigations or similar queries?

A: No, you know, we never got that many. Most congressionals had to do with assignments, and they went right over to PERSCOM. We didn't get any congressionals about practice issues.

Q: The standards of practice -- you upgraded that?

A: Yes, because they had come out, I believe, under --

Q: General Hazel Johnson.

A: Right. I knew I worked hard.

### **Establishing Relationships with People**

Q: And, of course, all this time you were establishing relationships with people --

A: You know, I hesitate to say it was my greatest accomplishment, but I did spend hours with CHCS. In fact, I was on a committee -- I was the Surgeon General's representative on something called the OTERG, the Organizational Test and Evaluation Review Group, and I spent a lot of time, in fact, with Colonel Yip defining requirements for CHCS and work groups, finding the specialty talent that needed to come to Washington to be a part of that, just being involved in making CHCS a reality. But when you say accomplishment, it's not yet developed today to what we were promised back in the early nineties.

Q: Do you have any other regrets about your time as consultant, other than those you mentioned?

A: No. You know, despite not thinking that was a good job, or liking the job, I think I did a lot. Maybe this is part of my management style, but I found the higher you go in the organization, the fewer things you can take credit for yourself because things seem to be a corporate effort. You may have a great idea, but somebody else makes it happen for you, or they bring you the great idea and you make it happen.

So when it comes to ownership and saying well, I did this or whatever, I guess I don't tend to think that way. I can think how I was part of an overall effort at making something happen, but I don't think of it in terms of well, I did this, this -- though I will say as Corps Chief, I found this the other day, notes of 1991.

When I became Corps chief, I started looking in terms of what is it that I want people to know me for. And so I wrote goals while I was the Corps Chief. For the consultants, I think I basically completed the agenda that was before me, and I can't think of anything innovative or off-line. I was a supporting character, I guess.

Q: You coordinated and found the right person to do the job.

A: As I said, kind of like the chief of staff, where you just keep all those things moving.

Q: And the consultant's job really prepared you to be chief and for those responsibilities.

A: Well, I think -- I think at the time that wasn't what I thought I was doing. And in fact, when I was in the consultant's division, the chief nurse job out here in Hawaii came open because Diane Butke was supposed to come out here to be the chief nurse. And the plan was for her to come as assistant, and then she would become chief. She refused to move, and then she got caught in the Desert Storm freeze where she couldn't leave Active Duty. And so they needed both a chief and an assistant chief out here at Tripler.

I was going to go to General Adams Ender and beg her to send me to Hawaii because I wanted to be a chief nurse. But I had only been back from Europe then about a year, and Hawaii was far away from family, and I didn't think that was fair. So I said well, no, I'll do this for this Corps Chief and then when the new Corps Chief comes in, I can move on and hopefully my reward will be to go back into a hospital.

But in retrospect, being at that level of the organization, knowing what the issues were -- in fact, when war was declared for Desert Shield/Desert Storm, General Adams Ender was on leave and John Hudock was in California. "Oh, now what do I do!" We were starting retiree recalls and all that stuff.

I remember I was never so glad when two people came back and I could hand it off. But at least I had a comfort level, I think, with the key players in the surgeon general's office. I didn't get much exposure to the Pentagon as the consultant. I did not deal with them at all really, but indeed, felt comfortable within the AMEDD hierarchy, the surgeon general, the deputy surgeon general, and the key people that were up there.

### **Working on LPN Licensure in Chicago**

Q: Anything else we need to talk about, about the consultant's position?

A: No, I think that's one of those things that in terms of the legacy of who had been the nursing consultant, and the work they have done, the body of knowledge that they have collated, that is a legacy within the Army Nurse Corps that has value not only for us as Army nurses, but also to the nursing profession as a whole.

I was trying to think -- I was involved in something that had to do with that group that's out of Chicago about nursing licensure and I can't remember now what it was. You know, there's the group that works out of Chicago that the council, the state boards of nursing -- I spent a lot of time up there talking to them, and I can't remember now why I did that.

Q: As a consultant.

A: As the consultant, yes. I had to go up there. I can't remember now what the issue was. Maybe it had to do with LPN licensure of some sort. That's the only thing I can think of, but I can't think now.

### **Enlisted Issues**

Q: Were you involved with the enlisted issues as well?

A: Yes, because the LPN -- 91C is so important in terms of nursing care and the number of nurses we need in the ANC.

Q: The time when we were requiring the 91Cs to take the LPN exam?

A: I don't think -- Maybe that's what we were working on at that time because that licensure requirement, I think, came in in the late nineties, because initially they weren't covered by the DOD regulation that required the licensure -- or that initially they were covered, but yet all states did not have licensure for LPNs. I think that was part of it.

Q: That was the problem.

A: And then how do you retrospectively get these individuals licensed. I wish I could remember more. Maybe I'll go back and look in some of my papers and I can figure out what the issue was. But I know I did spend time going to Chicago for that meeting on a quarterly basis.

I do have lots of papers. Back in the time when we used to generate carbon copies of things, I had the habit of keeping things, especially if I authored them and I thought they were pretty good from a writing perspective. So I do have some of those files, and the same from the Corps Chiefs job.

Q: I'm glad you do.

A: But I don't know what to do with them.

### **Gateway to Care**

Q: Send them to the Army Nurse Corps archives.

A: I guess I did get involved in Gateway to Care.

Q: I don't remember what that was.

A: That was General LaNoue's idea when he was at the MEDCOM and actually, you know, if we had done Gateway to Care instead of Tricare, we would have been further ahead, where the hospital commanders were given the discretion to recapture workload.

Q: Good.

A: I did a lot of presentations, I guess, as a consultant.

Q: At professional meetings?

A: At our professional meetings, yes. Talked on the expanded role.

Q: So you really had a lot of interface with the civilian community.

A: Yes.



### **The Interagency for Federal Health Care Executives**

Q: The NLN, and the ANA, and the AORN, etc.

General Adams, could you briefly describe your experiences while attending the Interagency for Federal Health Care Executives?

A: That was a very interesting course. And I think I recall, I went back in '90, which was -- I want to say it was just as the Gulf War was beginning. We were involved in that, because I think that was one of the reasons I got to go. I was in town, and everybody else was preoccupied.

It was a good program. I enjoyed the content. Probably, most importantly, I remember Ken Bloch and I had a very good time together socializing. We became fast friends as a result of that experience. I can't remember where Dr. Bloch was at that time, I've kept in touch with him over the years. In fact, Beaumont called and asked him if he would like to come out and be the DCCS. He tried to get him out of the Washington area, but he wasn't willing to do that.

I don't remember much in terms of the content. It was just a very refreshing break after working in Washington, D.C., and doing the staff work, to go over and talk about health care administration, and what's going on in the world of health care for two weeks. So it was kind of like a sabbatical in terms of the other work that we were doing at that time.

Q: Where was it held?

A: Over at George Washington University in one of the main buildings that was over there. Dr. Southby, of course, I think he was the director.

### **Chief of the Army Nurse Corps**

Q: Okay. So then really we move into the time when you become chief of the Army Nurse Corps. Did you always want to be chief of the Corps?

A: No, and in fact, I think it would be dishonest to say at the time, I really wasn't thinking at the time of becoming chief of the Nurse Corps. I had been chief nurse at Frankfurt, and then, of course, I came back to a staff job in the Office of The Surgeon General, and my immediate goal was to get out of the Office of The Surgeon General, and to get back into a military treatment facility, to be a chief nurse again. Because while Frankfurt was a good experience, it was rather limited in that it was an overseas environment. So you didn't have the same complexity of

challenges that you would have in a U.S.-based medical center, quite frankly. We didn't have GME. They had the interns and residents, and Frankfurt didn't have the full scope of services that you would have at other medical centers. We didn't do cardiovascular surgery, for example.

So I really wanted to get back into a medical center environment, in a leadership position as the chief nurse. So I was the consultant for two years when General Adams-Ender was leaving, and in fact, at one point the chief nurse job out here in Hawaii was vacant, or was becoming vacant, because Diane Butke was supposed to come out here as the assistant, and then move into the position as chief.

Well, she didn't want to come as an assistant, and as a result of that had to submit her retirement papers. Then the Gulf War intervened, so she was held on Active Duty because we wouldn't let anybody retire during that. So when the war ended in June 1991, she was still on Active Duty, was still supposed to go to Tripler, and was still saying no, she wasn't going to go.

So I had almost made up my mind I would go to General Adams-Ender and beg her to send me, but two things stopped me. One is I had been overseas for three years in Europe, and looking at the distance between the East Coast and Hawaii. I had family concerns — my parents were in their late seventies, and I thought, I don't really want to go that far away again. And then thinking in terms of the new Corps chief, that it would be best to let him or her get settled in the job, and let me do my job, and then go to that individual site. So when it came to thinking about what comes next, I was really thinking what is my timing then to approach that chief nurse position again.

So I was thinking in terms of who the next Corps chief would be. I was really not thinking in terms of gee, I would like to do that, and why not me. In my mind, my time had not come, and I had other professional goals that were more exciting to me, I guess, would be the way to put it, than the Corps chief's job.

Q: So you didn't expect this.

A: No.

Q: So you were surprised when you were selected.

A: Oh, yes.

Q: How were you notified?

A: Well, I was officially notified by General Redford, who called me the day before the

announcement was made. But General Adams-Ender, before she left, basically let me know what I needed to be prepared for. While she was talking, I was thinking about what I was going to say to her, and then I kind of missed it the first time around because she came to my consultant's office.

She left early, I think in July 1991, because she was taking command of the military district of Washington. So the Corps Chief Board had met in June, but she was leaving in July. I remember sitting in the office, and she came over and closed the door. Well, she had never come over to the consultant's office. If she wanted me, she would send John Guliac or call and say, "Nancy, you need to come over." She never came over.

So she came over and she closed the door, and I thought it was just going to be a handshake, good-bye, good luck, whatever. She started talking, and I must admit, I don't think I was listening to her. And then when I started to listen to her it was oh, okay. And basically what she said is, you know, "When things start to come together, give me a call and we'll sit down and we'll talk." It was over in a flash. She got up, she left, and I just kind of sat there and thought, did this really happen? Did she say what I thought she said?

So that was initially, and then subsequently, John Hudock had been given — John knew that he wasn't going to be the Corps chief, and we thought back then John had a really great chance, because he was a fantastic assistant. He was doing the work for General Adams-Ender when she was doing other things, and he was doing a good job. John knew basically, he and I, and I think the third person who knew was Dottie Clark, because I remember working with them during that summer.

Q: Did you have any ideas of refusing the honor?

A: No. I figured well, I guess I can do this.

Q: You always have had a can-do attitude.

A: Yes, right. I think I can read, I can write, and I've got good people who know what's going on. So no, refusing didn't even cross my mind, I guess.

### **Transition To Chief, Army Nurse Corps**

Q: What was your transition to being the chief? Did you get any preparation?

A: Most of the transition was through John Hudock, and essentially John knowing who was going to become the Corps chief. He stayed in his job as the assistant Corps

chief, but I believe he stayed until the end of September 1991. So he was there through the summer, and for, I'd say, about six weeks before we knew who the Corps chief was, and then the announcement was made early in September. So I had about a month officially working with John where everybody knew what was going on.

And, of course, in terms of issues and things of the nursing business per se, I was pretty much in touch with that because of the consultant's role. What I wasn't in touch with was the Washington portion of the job, interaction with the other federal Corps chiefs. So the expectations in terms of dealing with the Congress, those type of things, and then the personnel job, because that was the Corps Chief's other hat, the Assistant Surgeon General for Personnel. And so John really didn't have any visibility of that. But there was a very good MSC, now deceased, John Sierra. He was the assistant to General Adams-Ender, and John was very good in terms of getting involved and bringing me up to speed.

Q: Did the Surgeon General orient you at all?

A: No. General Ledford was, I'd say, a very low key kind of guy, and I would say that was back when nursing was in its own lane, per se. If indeed we worked for the Surgeon General, it was when we would go to the TSG and say, "Hey, Sir, you need to get engaged." But the TSG in the persona of General Ledford, really did not make demands on the chief of the Army Nurse Corps.

Q: The old school meaning.

A: Right. He had his doctor's business and we had our nurse's business, and probably the most overlay I had with him was in terms of the personnel business, which was the Surgeon General's work. But again, you know, it was up to me to know when to go to him. And a very nice man, and very gracious, and it was a pleasure working with him and for him. He did not make any demands that I can remember in terms of the personnel. That was the beginning of the drawdown, and we probably could have used him to get more involved so that things did not get so parochial or confrontational.

I remember getting more interaction, if you will, from the Deputy Surgeon General, Ted Bussey, at the time. He was more engaged on a day-to-day basis.

### **The Drawdown in the Military, 1991**

Q: In the drawdown, how did things get confrontational?

A: Well, it was essentially because we had a total in-strength number that had to come down, so each corps had to aggressively defend its requirements, is what it amounted to. And if anybody gained, somebody else would lose, is the bottom line. We started out with something that was supposed to be an unbiased process, which was called the TAPSM, Total AMEDD Personnel — I'll have to look it up, but it's TAPSM, and that was a model that was developed by the AMEDD Center and School, and basically it had different pillars in it. You'd count the readiness pillars, and then you would count the infrastructure you needed to support education and such.

So there were defined pillars that ran through all the Corps, and you got a certain amount of numbers based upon what you earned. The problem was who made the definitions of what went in those pillars, and it was essentially done out of sight, which was done at the AMEDD Center and School, and it was basically done by the Medical Service Corps.

Quite frankly, because of the civilianization of nursing that has been historical in the Army Nurse Corps, they have always had -- 40 and 50 percent of what we needed to take care of patients has always been civilian, the prevailing attitude was well, we'll just go buy more civilian nurses. So we're not giving up nurses, we're just trading in Army nurses for civilian nurses.

So we proportionately paid a higher price, and certain things happened that in the long run hurt us. For example, the end of the Gulf War, that was the beginning of a nursing shortage. I think our budgeted in-strength was 4,900. We only had around 4,200 in uniform because we were having a problem recruiting back then. When the Gulf War finished, we had physicians on Active Duty who were reservists, who no longer had practices to go back to. The Army Medical Department allowed them to stay on Active Duty as physicians. They used the Nurse Corps' budgeted in-strength to accommodate those physicians.

When the drawdown started, the nurses started in an artificially low position, the doctors started in artificially high. So when the physicians say they've lost between 5,200 at the end of the Gulf War, down to 4,200, more than 700 of that thousand was not their legitimately to begin with. That was nursing in-strength. No indeed, we lost 1,000 between 4,200 and now we're down to, I think, 3,301. We lost a real thousand plus that Delta that was taken over by the Medical Corps at the outset.

There were things like that where the nurses never got full credit, or were disadvantaged because we were not the ones who were manipulating the numbers. And so it became very confrontational. And the Medical Corps is gaining, the Nurse Corps is losing, and the MSC's are essentially brokering a deal that keeps the doctors happy. The MSC's, the secondary gain for that is they kept their numbers up. And

I guess the real telling part of it, and I don't remember the exact numbers, but if you went down and you looked at what your readiness requirement numbers were, and what your in-strength was, the Army Nurse Corps was within 100 of what our readiness requirements were versus what our in-strength was.

The Medical Corps, it was a figure of about 2.5 times readiness versus what was actually in in-strength. Now, over half of that difference is because of GME, and I have no problem giving legitimacy to GME. But there was still another sizable chunk in addition to the GME that brought their numbers up to where they were.

The Medical Service Corps had this built-in rotation where for every person they had out in the field on a TO&E, they had to have two TDA positions. It was called the rotation base. And the thinking was if you have a lieutenant out at Scofield Barracks, he can't stay at Scofield Barracks for a career, so he's got to have a job to come to in the hospital. Well, that was built into their in-strength requirements.

Whatever reason you used, the bottom line was Army nurses stayed with minimum essential requirements; Medical Service Corps physicians had more than minimum essential. They had a career development wedge built in, in terms of their numbers. The AMSC's, the vets, and the dentists, their numbers were relatively small and strictly based on terms of requirement. So they were not an issue, and they didn't have the numbers to play, and there really was very little that you could do. But the nurses were, I would say, the swing vote in that, and the in-strength went to the Medical Service Corps, and went to the Medical Corps.

And now, and I hate to say it because they said it back then, I'm going to say you're going to end up short of nurses, and I'm going to say I told you so. There was another — and this is probably the bane of my existence or the bane of General LaNoue's existence with me. I think he got so tired of me talking about nurses that he could have pushed me down a flight of stairs if possible. But he just didn't want to hear it anymore. But I felt that if I didn't champion it, and I felt that I had the facts on my side, and it was up to me to champion it.

But in the long run, we lost. In fact, we've lost 400 more since when General Simmons was Corps Chief, to when she finished there was another 400 that were lost because I even battled back, I believe, about 3,690 I think was the number I finally had, with a promise to relook. I had made the commitment to put 150 nurses in nurse practitioner slots. So in terms of when we were looking at primary care and such, the promise or the expectation was that if the Nurse Corps put 150 into nurse practitioner slots, which are essentially primary care physicians, they're not hospital-based nursing positions, that we would get additional in-strength to cover those people.

Well, we never got that, and we do now have the nurse practitioners. The investment has been made in nurse practitioners, so they are there. But we never got that fullness of 150, because in my mind, from what I knew in terms of professional development, the good number for us for budgeted in-strength I thought was around between 3,800 and 3,900, and now we're down to, I think, 3,300. And now we're short. And oh, by the way, we can't buy civilian nurses either, so we're twice as short. But unfortunately, I think we dug this hole. It doesn't help us to get out of it. And it's not one of those I take any glee in saying I told you so, and especially now as the Medical Center Commander, it doesn't give me any pleasure. I'm short 40 on the Nurse Corps officers here alone. That's a significant number.

Q: You took those nurse practitioners and put them into primary care positions. Was that part of that demonstration project that was going on at Fort Bragg?

A: Well, Belvoir I think more — because I remember Warren Todd was very much committed to that, so working with Warren Todd, and then there were other sites that were developed as part of that, to get nurses as part of a care team, or to show that — because we didn't get physicians' assistants either. They were grossly short in terms of the number in the inventory, and most of those were going out to the field.

And there is another area where you've got to ask the question. You know, historically physicians fill those positions out in the TO&E units. Well, we added 500 PA's. They went into the Army Medical Specialist Corps. We didn't decrement the Medical Corps 500 doctors. So, you know, you go back and you kind of look at it in context, and now as we're in this midst of optimization and trying to have the right team members that are most effective in terms of health care delivery as well as affordable, we still don't have the right mix. We've got a lot of doctors in certain areas, and we don't have enough support staff or enough people to see the acute minor illness routine type of problems.

I don't think we've ever gone back to really level the playing field to say okay, if we're going to build a health care system, we've taken our historical base, which has been weighted heavily in position, and very much committed to the specialty care, so now as we're into the optimization as a whole for primary care, we're still struggling with it. We still don't have the right people.

### Selecting a Staff

Q: Let's go back to the beginning period of your tenure. How did you select key officers who would assist you as chief, for instance, your assistant chief and what-have-you?

A: The assistant chief — it was the key decision — was basically talking to Colonel Hudock and talking to Dottie Clark, who was the Chief, Army Nurse Corps Branch, in terms of professional development, who were the people I should consider. I didn't really have any in my mind. I knew some people, but most of the people I knew, quite frankly, were senior leaders, and it was kind of hard to look at peers and say, "Well, you should be assistant Corps chief or whatever," because you really want somebody who balances you in terms of your qualifications, and that's what I was looking for.

So basically Dottie Clark pulled some files and names John Hudock had given her, and names that she had come up with. I can't remember anybody by name. Your friends are your friends, I guess is the way you say it. So I didn't have anybody in mind, or didn't want my best friend to come work for me or whatever. So they picked five or six files, and then I took those, sat down, and made a decision matrix in terms of the qualifications and what I was looking for. I made a decision, and then I think the way the reg says is you have a board. So then I had a board that consisted of John Hudock and Dottie Clark. And the funny thing is because of the secrecy involved in general officer selection and everything, you couldn't really talk to anybody about what was going on. And we had to be careful about meetings, because everybody was looking for signs and signals of who is doing what to whom.

So we met under a tree, an organization bay in one of the local parks, and that's where we made the decision. I remember it was Cameron Station Park.

Q: So it was very informal, and then did you discuss each one and what their qualifications were?

A. No, actually, I told Dottie and John who my preference was, and they validated it, and it was Terris Kennedy. John Hudock knew her very well, I think she had been the deputy over in PERSCOM for a while. I did not know Terris very well personally. I knew more of her. She had a real good reputation in the Army. When she was over at PERSCOM I really didn't see that much of her, though I do remember at her farewell party, for some reason General Adams-Ender couldn't go, and so General Adams-Ender had asked me to make the Corps Chief presentation to her, as she was going to Korea. So we had less than maybe six months together in Washington when I came — we had some time together. But Terris and I weren't what I would call friends. I knew of her rather than — hadn't worked with her. But anybody who ever worked with her thought highly of her, and she had an outstanding record.

What I was primarily interested in when I looked at the Assistant Corps Chief, because of the downsizing that was starting, was the personnel piece, and because



of my job as Assistant Surgeon General for Personnel, that and the Corps downsizing, I really wanted somebody who understood personnel. And she had time over in Branch, so I knew she had that component. She had also worked in Recruiting Command and been a counselor, been at the AMEDD Center and School. So she had all the key jobs. She was currently enrolled in the War College. She finished that by correspondence.

So she really, I thought, had the right blend of knowledge and skills that I needed, and plus everybody said what a terrific, nice person she was. So that was my choice, and then, of course, I then had to wait until the Corps Chief announcement before I could approach her.

Interestingly, she was already slated to go in to be the Chief Nurse of Recruiting Command, so she was on her way to Chicago to do that job, coming out of Korea to go to Chicago to do that. So when the Corps Chief announcement was made, she was on leave in Houston. So I called her in Houston and basically, out of the clear blue, I said, "Hi Terris, this is Nancy Adams. I'm glad you're home." And then I just launched into it. She was a little stunned, as I was, and I said, "Well, you need to think about it, because you were going to Chicago." And I knew she had a husband, and I didn't know how he played in the equation, and if he was going to Chicago. I knew Jim was a lawyer, but I didn't know what their personal plans were. But she called me back within an hour and said she would love the job.

The others I don't even remember now --I know there were other people that were equally — Sharon Richie was, because I think Sharon was then the person that we asked to go up to Recruiting Command. There was another individual that we asked to go up to Recruiting Command, and then found out that that individual had some issues and we could not send him.

### **Vision and Agenda for the Army Nurse Corps in 1991**

**Q:** You've already talked about the downsizing concerns, but what, other than that, was your vision and agenda for the Army Nurse Corps as you came in in 1991, and did it change and evolve over the four years?

**A:** It probably didn't change. It took on more definition. Where I was always coming from, I really wanted to get clinical — I wanted to empower nursing in the clinical debate, and what I was seeing in my career was the power and the authority for nursing leaders was away from the bedside. Part of that is a function of structure, how you define power. For us, the power which equates to rank is how many people do you manage? How many OERs do you write? What is your scope of supervision? Not what is your scope of duties in terms of patient care. And I really wanted to get

back to defining nursing in terms of clinical responsibility — yes, had management and leadership, but management and the leadership as it was defined in patient care responsibility. So to define those roles, not only to articulate them in terms of duties, but then also to develop the nursing structure that would give legitimacy to it, and express that level of authority.

So try and really — couldn't do it as Corps Chief. Our limiting factor as Corps Chief, we started to do it as Corps Chief, but in order to do it, one of the things you had to do was to be willing to give up the traditional nursing structure. And coincidentally, that's when General LaNoue took over, and he was ready to give up everything and anything, and to kind of wipe the slate clean. So that was good. We had an agenda for action, an agenda to change.

The bad news is the authority for change then rested with the Medical Treatment Facility commanders, and they took advantage of nursing. I was on record as saying we need to change the structure of nursing. Nursing is too hierarchical, too unilateral. Some people read that to be too independent. Yes, independent when it comes to nursing, but what I was trying to communicate is there had to be a collaborative relationship when it came to patient care, and independence when it came to nursing. Nursing practice is a function of the nurses.

Well, we were taken advantage of. The next thing I knew, the people had eliminated departments of nursing, made the chief nurse the advisor to the Commander for Nursing, took the nursing assets and parceled them out among the department, so we gave the Chief of Surgery nurses and corpsmen, and we gave the Chief of Medicine, so we fragmented the nursing organization, and yet said to the chief nurse, you're still responsible and accountable for nursing care in this hospital.

Well, you can't do that. I mean, he or she had no basis in which to enact what they needed to do to provide organization to care, to meet standards of care, to manage resources, to plan for career development. So as we started the dialogue to okay, how do we metamorphous nursing to make it more clinically focused, then we had to almost stop in place and fight a survival battle because what they were doing in terms of the nursing leadership was not acceptable. So kind of for four years then we walked that tightrope and tried to work with them, and that's part of the limitations of the problem of the Corps Chief position. I have to laugh now because when people introduce me and summarize me, they refer to me as the Commander of the Nurses. Well, I wasn't the commander. I'm more of a commander of nurses as a hospital commander than I ever was as Corps chief. There is no command and control authority as part of the chief of Army nursing. You're a proponent, which means you can make recommendations in terms of the manning of the Corps and how we do business, but no line authority, no ability to tell a nurse, with the

exception of the assignment process in terms of even getting directly involved.

So I spent four years not giving up the vision I had in terms of how do we empower nurses within the context of patient care services. That was still our goal, and still worked it, but then I had to fight a defensive battle which then left less time in order to be proactive in terms of let's be creative.

And then, of course, General LaNoue also — I was the Assistant Surgeon General of Personnel, and then about two and a half years into my Corps Chief role, I then also took on the Commander for the Center for Health Promotion and Preventive Medicine. So I was deluded in terms of my ability to do the nursing agenda. And my assistant Corps Chief, Colonel Kennedy, took on most of that, but she was also doing the operations type thing in terms of Corps business, so she was more than fully occupied.

### **Branch Immaterial Positions**

Q: What was your input into the development of the concept of Branch Immaterial positions?

A: I was probably the poster child, and that was a hard one. You know, here General LaNoue said it. Where he came from, and he started with the general officers because he realized he had, in his mind, too few generals to do the Army Medical Department's work. And so his prejudice, his bias was you could not afford Corps chiefs as general officers, so the Dental Corps Chief, the Nurse Corps Chief, and the Medical Service Corps Chief.

His perception was Corps work was cheerleading work, it was not corporate work. Now, I would argue that. I would still argue it today, because I think when you look at the constituency that's represented, there is work to be done to keep the people — to fill the people requirements, to keep the standards up and such. Whether or not it requires a general, if you can't afford a general, then I guess you can't, and then you've got to find another way to do it. So that was one of those, I think it was an intellectual debate, and he was a three-star, so his vote counted.

My preference would have been to develop nursing to have the equivalent responsibility, but that was not affordable. So then the Branch Immaterial comes on. And quite frankly, I'm not sure that that is wrong. I think the 0-6 work for proponentcy and such is irrelevant. I think you still need a GO champion, and that's what I see the Corps Chief being nowadays, the General Officer who comes to the table with the Surgeon General and the other general officers so that the Medical Service Corps, the dentists and the nurses have that voice because of the role we play

in the Medical Department.

So I have no problem actualizing it that way. And the Branch Immaterial to me then became a level playing field. So the best and the brightest gets to be chosen as the Medical Service Corps and the Nurse Corps Chief as an O-6, and they say you have general officer potential, you are a role model, you can do the work of your Corps, and now we see you as having the potential to do the work for the Army Medical Department.

The logic doesn't work for the Dental Corps because the two-star is the Corps chief, not the one-star, which I would use that as a reason to argue why the chief of the Dental Corps should be a one-star, but that's another area.

So I have no problem with that, saying okay, I can compete with these guys. I can do their work. And that was just the matter of doing it, is taking on the duties and responsibility. And then also as the Assistant Surgeon General for Personnel, because this was listed as a personnel action. And I think the gender part of it came in as a woman, and figure we're going back to 1992-93, and women were not as prominent in terms of key positions as you see them now. General LaNoue kind of put me out on point on this figuring. The Army would look at this beneficially because we're doing something for women, and we were entering into a different realm of function.

So I think more for your money in terms of the overall functioning, and oh, by the way, this will benefit women. So I had several opportunities to go over and brief the chief of staff of the Army, General Sullivan, on Branch Immaterial, and of course, there was some prejudice in terms of nurses. Nurses as commanders? How can a nurse command? Nurses don't command. Part of that I think got back to our duties, the perception that we only do what the doctors tell us to do, and again, back to the gender issue. All these women are going to be commanders?

So where I started from was looking at the career development of the nurse, and showing the chief that while we're not called commanders, in terms of how we arrange duties and responsibilities, in authority, with the exception of UCMJ, we are commanders. We are commanders when we're head nurses, we are commanders when we're supervisors. We are a commander at a brigade level when you're the chief nurse in a medical center. When you look at the dollar value, the risk, and the people, we only had 5,000 people. Now, we probably have closer to 1,000. But the work is there. The only thing that is not there, and I took full ownership, was UCMJ authority, and that wasn't within our realm.

So a couple of those briefings, and then showing them how we leader-developed the

talent pool, that we had a career plan. And you look at the expectations in terms of military education, and oh, by the way, we have more nurses with CGSC and with MEL-1 than the physicians did. But we had no career ladder that gave us credit for that military education. And it was a slow progress, and we had to go through all the Army leadership — the Secretary of the Army, the DCSPER, all those guys had to have their questions answered. But it was finally General Sullivan, as the Chief, who finally signed off on Branch Immaterial before he left office, and then turned it over to General Riemer.

By then, I was still on — I had finished my Corps Chief role, and was still on Active Duty because General Riemer had a crew going out to William Beaumont to be the Regional Medical Commander, and we still had yet to have our first Branch Immaterial Board for general officers. That was still pending. But I think we had had our first command board already, and the nurses had scored real well on that. So despite never having commanded at the company level, when you started looking at their overall qualifications, they did very well. I can't remember the numbers — I'm sure Branch has them — but it seems to me it was like nine out of 30 or something for that initial board.

Q: And then they did move into command levels?

A: Right, at the 0-6 level, and now we're — I don't know if we have any 0-5 commanders yet. I have moved into it at the 0-7 level. But I think we had the preparation all along. We just did not have the diversity and the utilization. It all stayed within nursing. It didn't mean it couldn't or shouldn't have been us, and we had Baylor education, and when it comes to hospital administration, we had military education. And we had the leadership skills. We provided leadership to the largest department in the hospital. And quite frankly, I think if a chief nurse does it right, he or she also leads the other patient care components, at least as an informal . . . .

### **Non-Physician Health Care Provider Certification Pay**

Q: Non-physician health care provider certification pay — how did you advance that effort, and what specialties were involved, and who supported it, and who opposed it?

A: The CRNA, that was the big one, but that had already been on the books. I think when I became Corps Chief, it was a matter of increasing the amount, I want to say from 3,000 to 10,000, it seems to me it was back then. But, of course, that was just a matter of how do you stay competitive with your civilian counterparts. And then I think we were able to raise the idea, and I basically have to credit the fellow in the office, Senator Inouye, for the nurse fellows who were over there. But they basically,

from a political perspective, I think developed that idea in terms of nurses who had certification, that we would be able to . . . [skip in tape]. . .

I never paid too much attention, since I wasn't eligible for it, but it seemed to make sense in terms of rewarding clinical expertise, and the expanded responsibility of these individuals who were indeed taking on accountability for patient care. And I think now we're looking at it, again, within the context of the nursing shortage, to get it down to those who are just in the clinical fields, i.e., clinical nurses.

It was explained to me, and I didn't know this until I was the Assistant Surgeon General for Personnel, that the bonuses for physicians are essentially comparability pay, is what it is. So how much would you have to spend to buy a cardiologist in the civilian community. So it's not rewards for their additional education and training, it's really just in terms of what would this individual cost you if you had to buy him or her on the civilian market.

Q: Mostly it starts with the anesthesiologists and works down --

A: Right. Anesthesiologists for the first — I think that was the precedent setting one for other than physicians, and that was kind of worked collaterally with the physician pay at the time, as I recall. But then subsequently we started looking at other clinical specialties within nursing.

### **The PROFIS System**

Q: Did the PROFIS system get developed and expanded during your time as chief, or was it before?

A: I think it was before. I think it's been developed — I think the reliance on the PROFIS system has changed, and I think the Gulf War kind of brought home that message to us that this is more than a notional way of doing business. We have to be prepared at a moment's notice to move out, and we were.

The Gulf War was a good time. I mean, everybody did what they should do and they did it well. We just weren't real efficient in some areas, and I think one of the lessons learned from the Gulf War was to focus on the PROFIS, and that was kind of — I remember that day, if I went back and looked at my OER support form or something, a priority of mine that we would stay trained and ready in peacetime as the demand was going to be made on us if we had a deployment.

And, in fact, that's quite relevant to me today being here at Tripler, because of our mission to Korea. We just celebrated the fifty-first anniversary of the Korean War

on the 25<sup>th</sup>. That still has a potential to change overnight, and we provide several hundred backfill from Tripler. So to me, it just makes sense as well as validates why we have to wear the uniform, why we just can't go totally to the reserves, or like World War II we went to a hospital and mobilized them and said, hey, go take care of the sick soldiers and sailors. So that PROFIT requirement to stay trained and ready, to stay familiar with the unit that you're part of, I think every year we get better at it, because that's now a priority.

At one time I think it was a — you've got to fill in the blanks, so we filled in the blanks, but we didn't pay that much attention to it. Now it's the way we do business on an ongoing basis.

### **Education as an Issue**

**Q:** What do you see as your contributions during your time as chief, to education, or was that an issue?

**A:** Yes, education was an issue. I really tried to tie the education to what were the core clinical needs, because it was my perception that a lot of people were going to school to fill their own personal agenda, and we were not anticipating from an Army Nurse Corps perspective what we needed. So we started putting out guidance, trying to channel them in terms of the programs where we needed the expertise. And I know initially there was some resistance to that, and then people realized there were still enough options that they could meet their personal objectives, as well as we could satisfy what our core needs were.

But I saw education as key and essential in terms of the professional development of Army nurses. I also wanted it, though, to have a return on the investment for us as a Corps, because if you look at the numbers we sent to school, 60 to 70 for Master's, and six to seven for Ph.D., and that really was a luxury, especially with us fighting the battle for downsizing, when the reality was — I don't know what the numbers are now, but we were able to hold fast to the numbers that were going to school, even during the downsizing, and I didn't know when that was going to run out on me, or run out on the next Corps chief, but it wasn't challenged then.

There was one educational issue that continued to confront me, and I still have mixed emotions about it, and that is the Uniformed Services University and the development of nursing programs over there. I was not a strong supporter of those programs for two reasons. One is the limitation in Washington of clinical nursing experience, and I did not see it adding nursing programs over there. As I mentioned earlier, I went to Catholic U and had to find my own clinical experience. And Bethesda and Walter Reed, which are the two big hospitals there, they were saturated

with civilian students as well as military students. So adding clinical nursing issues I thought was problematic in and of itself.

The other thing is my perception, and I never validated it with anybody, was they wanted to increase their scope in order to decrease their vulnerability, because as a medical school they were vulnerable, and the previous administration, the Clinton Administration, tried for four or five years to shut down the medical school. And I believe it was a deliberate attempt, by including the nurses, that they would get a broader basis of appeal.

Quite frankly, President Clinton's mother was a nurse, and I don't know if it was that cold and deliberate or whatever, but it sure made sense, and it couldn't hurt them. So I really — and the reality of it is — and they are making demands on me as a Corps Chief for faculty, and I didn't have nurses prepared — at the time I'm facing a drawdown and I'm losing 500-600 nurses. I did not have those type of nurses to be able to put over at the nursing school, for an idea that was still fledgling, or one that I didn't quite agree with. And so I drug my feet on that one, and I didn't send anybody over there to the faculty.

I think subsequently General Simmons did, and I know now they have more nursing programs than they used to have. But I guess I am not convinced that it is still worth the invested time. The value, I think, of the programs that we had available to us was the diversity of the universities and degrees that were represented in terms of the expertise. And maybe for something like CRNA's phase one, all didactic, it would make sense that you should — family practice nurse practitioner. Again, I think you can make your nurses in the image and likeness of a physician, and how many family nurse practitioners do we need. I would much rather us be a little bit more diversified, I think. Nursing Informatics — that's very important in terms of the 21<sup>st</sup> Century. And we know we're all competing for the same pool of people and dollars.

So probably from an education, USUHS in the school of nursing was an ongoing issue, because Senator Inouye and some others really wanted it, Dr. [Faye] Abdellah, of course. But I was not on record as being a champion.

The other two Corps Chiefs, Sue Turner from the Air Force, and Mary Ann Stratton, they were not as negative as I was, but they were not strong supporters either. So we were — and maybe part of it was a wait and see attitude. But even today I still — I think we can do better by sending military students to civilian universities, and functioning in terms of recruiting value. Look at these outstanding men and women. And to have that caliber in an individual in school, I think that pays dividends to us in sending this to our own school.



Q: What do you see as your contributions to research?

A: I'm a supporter. I tried to get the research dollars developed when I was Corps Chief, and the Army did very well in competing for those. I think making the most of that from our perspective. Now, I still think we have not shown the return on the investment. I keep asking okay, we spent these dollars. What are the changes in practice? What are we doing better or different because we had one, three, five million dollars for nursing research, and I don't think we've marketed that message. At least I haven't seen it. In fact, I have a similar problem here getting congressional dollars for other than nursing research out here. We're not making the linkages with clinical practice. And if they're in a university, you can afford to do the gee whiz and what if's. But we have some real time needs that I think we've got to look at and say okay, having the research and being able to validate ways of taking care of patients and new equipment has a return on the investment.

So I see research as a great enhancement of how we take care of patients, and I wouldn't ever want to send the message that I don't value it or I've given up. One of the things I've done here with the research in the medical center is clinical investigations, which is direct support of GME, but really focused on the support that clinical investigations was giving to my physicians who were in training, because they were kind of muddling through on their own.

So I think we have to support the research, but the key is how you integrate it into the overall practice that we do. And I don't think we do that well, yet.

Q: I think that's a problem in the whole world.

A: And part of it is the nature of research. I have this same discussion when it comes to how much money I spend for automation. I just don't see I'm getting ==

### **Contributions to Recruiting while Corps Chief**

Q: What do you see as your contributions during your tenure to recruiting, General Adams?

A: From the Corps Chief perspective?

Q: Yes.

A: Well, of course, a lot of the Corps Chief role is to get out there and be seen, and to talk about Army nursing, which I did more than my fair share of, either in ROTC, or graduations and things like that. I went out on the circuit and I went with the chief

of recruiting, the chief nurse recruiter when Sharon Richie was there. I would go to the meetings, like the ANA meeting, the Student Nurse Association meeting, the big venues. There was a nurse practitioner group meeting that we went to each year to tell the Army story and get it out. Relationships with the deans of the School of Nursing so that they would see us as peers, keeping that communication open.

Q: Over the course of your four years, was recruiting a problem, or were you getting enough numbers of people?

A: During my term, my recollection is we did not have a problem with recruiting. Part of that was because we had very robust numbers coming out of ROTC, and I believe we started then looking to starting recruiting not just nurses, but specialists; for example, ICU nurses, nurse anesthetists, because we were short in those numbers. But overall, in terms of the numbers, the market was pretty good for us. We were competitive in terms of salaries. I believe Colonel Richie — Sharon, I think, was in charge for most of the period of time I was chief nurse. The numbers came in if not right on the numbers, you know, within five or six. It wasn't like we were short 30 or 40 or 50.

Q: So it was okay.

A: It was okay. And we were downsized. So you have to realize the numbers were not as robust because we were doing SERBs during the four years that I was a Corps Chief, so we were eliminating lieutenant colonels and colonels. We still had the need for the younger people, but the numbers had decreased somewhat, and we had robust numbers in ROTCs there for a while. I think there was an imbalance in terms of where we were. That's why we had so many ROTC, and we weren't getting as many people recruited.

### **The SERB [Selective Early Retirement Boards] Process**

Q: Do you think that the SERB process was a good process for getting rid of the top?

A: It was a good process. It was just a very negative way to have to do business to people who had chosen to serve the Army as their career. So it would have been much nicer if the individuals had decided yes, I think I've maxed out and it's time for me to leave, rather than for us to summarily dismiss people, which is essentially . . .[skip]. . . they were doing okay, were all of a sudden told, "No, thank you. You need to leave now. There are other people who are doing better, and we have decided we want to keep them. You need to leave."

I don't know if that was part of the strategy and the general officers had to

communicate to people within their command those people who were selected for early retirement. So I had the occasion to have to deliver that message several times to individuals who were just — people I knew, people who were friends, people who — and early on, the SERB — the first round of SERBs there were people who had deficiencies in their records, and probably would not have made colonel in the current environment when they started the SERB, because they were either overweight, or lacked the educational credentials and such.

But after the first round, we really got rid of anybody who had any deficiencies. And then it was a matter of looking at people who were competent and qualified, but they competed with their peers, did not do as well as others did.

### **Operation Restore Hope**

**Q:** Operation Restore Hope took place in Somalia during your time. Can you discuss the conduct and the impact of that operation from your viewpoint?

**A:** The only two real — it happened so quickly, it happened so far away, and it involved relatively few US forces, but the two things that I remember was one, going out to Andrews Air Force Base after, I think, the first fire fighting. We were bringing wounded soldiers home, and I believe General Soloman, Chief of Staff of the Army, was out there, and I was out there also on the flight line to greet those people who were primarily from Fort Bragg, because I remember they stopped at Andrews to be off-loaded, and then they were being put on the plane to take to Fort Bragg, because Fort Bragg was home.

So from a personal perspective, realizing that was is still very realistic whether it involves 10 people, or 10,000, or 10 million, and knowing we were, again, doing a very difficult job in less than ideal circumstances, but people were doing it well, and as a result, people were being killed, and people were being hurt.

From a medical department perspective, what struck me most is subsequent to Somalia I went down to Fort Campbell and visited the combat support hospital that was down there, that was deployed to Somalia. I went down there to say thank you for a job well done, and also I wanted to speak to them in terms of their experience, to get a first-hand report. And what I remembered from what they told me was overall they were disappointed in their performance in Somalia. And the source of their disappointment was because they were in the midst of such austere and horrible circumstances in terms of help, and they were overwhelmed by what they could and what they were allowed to do.

Part of it is the mission change. When they got over there initially, it was restore

hope, help people get food, and it wasn't a threatening environment. Doctors, nurses, and corpsmen don't like to do nothing. They don't like to sit around. So they started volunteering their services and taking care of the local nationals. And then there were also some patients they had to take care of. So if a patient was run over, say, by a U.S. jeep or something like that, they took care of them.

Then all of a sudden hostilities broke out, literally in a day, as I recall, and they had to totally disengage from the civilian population. Disengagement meant stopping treatment on some patients because you had to clear out the hospital and send them back. Well, that was a very hard thing for them to accept because they knew if they went to a hospital — there was nothing that met the definition of a hospital in Somalia. I saw pictures afterwards. There were stone rooms with no medical equipment and such. So they felt like they were abandoning their patients. They were going back and there was no hope for them.

So that call added to their dissatisfaction with the job they were doing. And then after the hostilities broke out, they were limited in what they could do because they had to be primarily there to support wounded soldiers, and so therefore they couldn't — they didn't have the capacity to engage with the civilians, but yet they were still surrounded by this abject need.

So they felt that they hadn't done what they should have done over there, and realized then — and we still have the problem to a certain extent today when we go into a humanitarian mission. We don't know how to define what is the mission for the medical. It is different than going in there as a security policeman or as an infantryman because of the nature of your ethical responsibilities to do good. And we put people in circumstances where we don't allow them to do that good in accordance with their own professional standards. And, you know, we still walk that crosswalk no matter where we go.

I guess those were the two things I remember from Somalia, the fact that how the condition of an American soldier can literally change from life to death overnight, and that indeed, what are the expectations of the medical assets that we put in that environment. And we talk now — at least we send them in with OB kits because we realize if a pregnant lady walks in your door with a baby coming out, you're going to have to do something about it.

But I think there still is a very — there is a doctrine piece that we still have not looked at, and the reality of it is there's more demands in terms of peace keeping and humanitarian assistance to let the medical pave the way for other types of a relationship. But we still don't have the — we haven't given the mandate — we haven't defined the mandate for what it is we want from the medical in those

circumstances.

Q: That's not a new issue.

A: No.

Q: It's been going on forever.

A: And I guess it's, you know, if we're war fighters, then what's our definition as war fighters. But I think the definition of war fighters changed, and we seem to be able to do it within the context of we're going to be lighter in terms of a standing army. But we haven't said okay, what does this mean in terms of medical capabilities. And I'm lucky being here in the Pacific. I've got a commander . . . Army Pacific who realizes his two biggest assets in the Pacific from a war fighter perspective as his medics and his engineers. I mean, that's who he tends to ask for and where he sends people.

But still, I don't think the Army has given us credit yet. If they would, then I don't think we would have as many struggles as we have in terms of justifying our size and why we're needed, and then the medical department, too, has not yet said okay, what do we need to do in terms of — how do you define success in humanitarian assistance? How do you define success in terms of peace keeping? It seems to be a situation we derive each time we go in.

### **Operation Provide Promise, Bosnia**

Q: Similarly, in Operation Provide Promise, I guess we ran into some of the same issues, but that began during your time as well.

A: Was that Haiti?

Q: No, that was Bosnia. Do you remember anything about what our Army Nurse Corps involvement was in Bosnia right there at the beginning?

A: At the beginning it was mostly — it was a mostly European mission, so our role became if Europe couldn't support it, then backfill to Europe in order to keep them full up.

Q: And did you have to backfill to Europe?

A: I don't remember that being much of a demand on us. And most of that also comes, you know, the tasking goes to FORSCOM, FORSCOM to MEDCOM. So really I

did not get visibility of it in the Office of the Chief, from a personnel management perspective.

## **Haiti**

Q: Haiti was another similar situation.

A: Haiti, I think — that happened when I think I was consultant, just before I took over. Quite frankly, that happened so quickly, it was over, I think, before it started, and again in Fort Bragg, the medical assets in Bragg went down. And I remember Haiti only because it happened around Christmas time as I recall. But that didn't really make too many demands on us.

I did visit Haiti as Corps Chief when we still had a hospital down there. In fact, General Lester Mantinas was the hospital commander. And I remember going down, and I believe that was the same hospital that had been in Somalia, because it was Colonel Martinez, and he had come out of Fort Campbell. And they did real well in Haiti, and I think part of that was because they were isolated from the downtown area. They were almost on a — they were on a military compound with barbed wire around them, and they were set up inside of a warehouse. So they did not have the TV masses coming to their doorstep. So that kind of put a barrier between them and the local environment.

So while they did deal with trauma, accidents, and things like that, it wasn't as overwhelming as what I remember being described to me from their Somalia experience. And in fact, they were probably more bored than busy, but content with what they were doing. And then on occasion, they would go down into the community and volunteer their services, or help out at the local hospitals and things like that. So that was, I think, more routine, but they were what I would call austere conditions, and Haiti certainly is not the place you would go by choice.

## **Other Organizational Changes**

Q: No. Now, you did talk about the downsizing, but did you make any other major organizational changes in the Army Nurse Corps, and were these initiated by you, or did you just have to go with the flow?

A: I didn't make any other organizational changes. In fact, I deliberately tried to not make organizational changes because General LaNoue and his enthusiasm for Branch Immaterial, I saw him trading in key nursing positions for Branch Immaterial, and I still thought there was value added to the organization from the nursing positions. For example..... [skip in tape].....left the Corps Chief role, we still

had those jobs. Some of those, to include the chief nurse position at MEDCOM, I think, had been traded away or been homogenized into other type positions.

One of the things I asked General Simmons to do soon was to sit down and to look at those key positions, and if we were going to lose them, then to identify other equivalency type positions. Colonel Kennedy and I, when we looked at our senior nursing talent folder in those four years, we essentially kept a roster, and knew who our I'd say key 15 or 20 nursing leaders were, both in terms of developmental assignments and the military education, and that was to plan for succession, quite frankly, whether you were looking at the MEDCOM chief nurse position, or USAREUR chief nurse position, or you're looking at the AMEDD center and school position, or you're looking at the assistant Corps chief, the Corps chief.

To me those were still validated positions that needed the right talent in them. And while I was able to hold on, and I don't remember — I had people in all those positions, because I think I left Bonnie Jennings in as the nursing consultant, and Bettye Simmons had been the chief nurse of the MEDCOM when she was chosen to be Corps chief.

So we had incumbents in all those positions. The only position I thought I had lost, and I didn't think I had lost it as long as we had the assistant Corps chief, was the Corps chief position, because of demands being made on me as Corps chief, that I was essentially lost full time to the Army Nurse Corps for the nursing business. I really had to rely on the assistant Corps chief to kind of use me to the best in terms of what were the priorities, and she did, Terris did that very well.

So I had not lost any of those positions, but I thought they were threatened, and one of the things that I asked Bettye to do was, you need to get a grip on these and make sure that we hold on to them. And along that line, the other sensitivity I had that I told her she needed to look at was the relationship between the reserve leadership positions and the active component, because my concern was that you've got a reserve BG who is the IMA to the Chief of the Army Nurse Corps, and the Chief of the Army Nurse Corps is no longer a TDA position, then what does that mean for the IMA.

Then that got further confused because of coming on line of the 3d MEDCOM down in Atlanta, and that had a designated chief nurse position, and initially did not have a GO, but then wonders of wonders, they were able to get a GO And interesting, the person who was the IMA to the chief of the Army Nurse Corps turned down that position, so they went and selected another GO

So at one time we had four nursing GO positions because we had the National Guard

position, two in the USAR, and plus the active. But my concern, and I talked to General Simmons, was someday somebody is going to say, "Hey, wait a minute. How did this happen?" And then because we hadn't done our homework, we would lose everything. So that was kind of what I left on General Simmons' plate to deal with, the career ladder and the key positions for career ladder, and the nursing leadership in the active component, as well as looking at the interface between those GO positions we had in the reserve component and the active component.

To answer your question, no. Organizationally, I tried to hold the line. See, I never saw Branch Immaterial as being a replacement for nursing leadership. I saw it as being an addition to it, not a replacement for it. That was not the other thinking of the organization, and all you have to do now is do a head count and see how many nurses are in key positions. But we're not there. We don't have the numbers.

Q: And I believe a lot of people are coming out of Branch Immaterial positions now.

A: Yes. And then part of it is okay, when you've been a commander as a Nurse Corps officer, what do we do with you? Would I want to go back to being chief nurse after I've been a commander? I don't think so. So somebody has got to — you know, we had a career track before, and we knew where it ended in chief of the Army Nurse Corps. Well, now we've got a career track with a branch, and I think we've got to be able to — no more take them as you get them. We've got to know what are the steps, and we haven't done that yet. In fact, I talked with General Vester about that, too.

We've got to regroup. Or someday somebody will regroup us by default because we haven't come up with a better plan in the interim.

Q: I know there was a demonstration project out here at Tripler that involved Senator Inouye and Colonel Edith Walsh. Could you briefly describe that and tell me if it's still ongoing, or what the outcome was?

A: It's not ongoing, and basically, you know, when you mix politics with the military, it can either be very bad, or at best it can be problematic, and I guess that Colonel Walsh convinced Senator Inouye back in those days that she didn't have enough manpower in the nursing. So he essentially asked her what she needed to do what, and she articulated some non-nursing roles where she needed to hire people to do patient transport and some other areas. So I think she got \$2 million for two years or something like that, and they used it at that time, and augmented their staff and such, and the money did not continue. Did it help for the short term? Yes. And there's probably some long-term legacy that's now been incorporated into our base, if you will. I have a patient transport service now which interestingly enough, is



totally volunteer, Red Cross Volunteer.

So I think some of the things that you spent money for in the auspices of nursing we now have, and will continue to have, and the money was beneficial, but it really was — it was a luxury for the time.

Q: Did they keep statistics of any kind to see whether it improved, the delivery of care?

A: I think that you'd have to ask Colonel Roehr or Colonel Yip, probably Colonel Yip. Colonel Yip was probably here at the tail end. I think Thea Mitchell was here following Colonel Walsh. That is essentially, you know, the Senator is very supportive of Tripler, and he says, and I continued — what do you need, what can I do for you.

Well, today's environment is much different than it was 10 years ago because we had been specifically prohibited by the Secretary of Defense from lobbying on our own for service initiatives. So service initiatives are identified by the Chief of Staff of the Army to the Secretary of Defense, and that's supposed to be the vehicle for working the Army budget in the Army agenda.

Now, that said, if the Senator decides to do something, nobody is going to object, especially if money comes with it. So we answered — when the Senator and his staff asked us questions in terms of, how are you doing here, or what's going on, we give him the information. But we are careful not to couch as a request or a need. If I have a request or a need, I go to the Army Surgeon General. But I take all gifts on the part of the husband.

### **Relationship with the Other Federal Chiefs**

Q: What was your relationship with the other federal chiefs? Did you interface a lot?

A. I had a great relationship with. For the most — Sue Turner was with the Air Force for the majority of the time, and Mary Ann Stratton was with the Navy. And I can't remember the lady in public health — Julia Plotnik. So the four of us got on real well and were very close professionally as well as socially. We made the attempts to get together at least quarterly to go out to dinner, as well as we usually would do the national meetings together, so we would go to the ANA together. We've seen the AMSUS together. And, in fact, we had a program that we did, Federal Nursing \_\_\_\_\_ program, which I notice has subsequently disappeared. They haven't done that in many a year.

But we did that — we took great pride in it, coming up with different ways of doing

it. The first year we did it when we didn't know any better, we did the traditional, you know, this is the Corps update for each of us. And then next year I think we chose a common theme and we each presented, so we tried to work that agenda and make it exciting.

Then when Admiral Stratton left, Joan Engel — Joan was also a very friendly, professional and worked real well with us. So I had a good relationship with her, and then Linda Sterly came in in the Air Force. But the Public Health one kind of trailed, and I think it was because there was an underlap between Admiral Plotnik and her replacement. They didn't replace her immediately, so I don't have any name or face recognition of who came in there.

The other person who was a strong player, but I can't remember her name, was the Red Cross nurse. There was a full time nurse in charge of the Red Cross, and she was so that, say, for most of the time it was the five of us, because she was part of the programs and . . . [inaudible] And, you know, the big issue that I believe developed then where the federal chiefs kind of got together and we worked it subtly but hopefully forcefully. It had to do with a homosexuality issue, and our American Nurses Association, the constituency, you know, their membership somehow passed a resolution that condemned the military and said that they would have no more affiliation with us because of the service stance on homosexuality, which always don't act with . . . . .

The Board and the ANA still work very friendly and directly with us as federal chiefs, and let us know that they understood where their membership was coming from, but they also understood that in terms of how we took care of patients, and our respect for patients, that there were 0 patient care issues in terms of homosexuality.

So they were willing -- the leadership was willing to let it remain status quo. And then we did discuss with ANA at that time — of course, our timing was lousy, but a federal section within the ANA, I think that has happened subsequently. I don't go to the ANA meetings anymore. Still a member, but don't go to the meetings, but I think there is a federal section now where you can be a member of the federal section as opposed to the state affiliation, because that was always a complaint. Our interests — we really weren't represented. We paid our money, but no visibility for the contribution. I believe Linda Sterly has worked that through with the ANA as part of the Air Force.

Q: What was your relationship with the former chiefs of the Army Nurse Corps?

A: It's always been friendly, but it's interesting. The one I had the most relationship with, and it's because she's still relevant to the times, is General Dunlap. General

Dunlap seems to understand the dynamics of what we're dealing with as opposed to some of the others who keep wanting to go back the way things were, and take it personally if you've got to tell them how things have changed.

For example, when General Adams-Ender was dual hatted as the Assistant Surgeon General for Personnel, they seemed to think that was something that she wanted, so they kind of excused it. When I became Assistant Surgeon General for Personnel, they kind of took it as well, you don't think nursing is important, you want to do something else. They did not realize it was an expectation of the Army Medical Department. It was no longer nice to do, it was now a must do. And then when I took on the Center for Health and Emotion, then they really got into now what are you doing.

But most of them stay — even though you say you want to communicate with them, and we did things like send out the newsletter and such, there's really not a lot of feedback from them except if something they perceived was going wrong, with the exception of General Dunlap, who would carry on in periodic communication dialogue. And when things were changing at the height, I went to General Dunlap to help her to get the word out, to let people know what was going on, because I thought with the Branch Immaterial, too, the first thing they would say was Adams was selling out. She doesn't want to be chief nurse, she wants to be surgeon general. I wanted to let her know that I was trying to do the best I could to balance both agendas.

### **My Immediate Predecessor(s)**

General Adams-Ender, interestingly enough, is my immediate predecessor. I had almost no contact with her, and part of that, I think, was a function of her busyness. So it was John Hudock who basically did the transition, and then afterwards — and I did on occasion try to get ahold of General Adams-Ender— of Clara and say hey, what about this. And I can see it now that I'm removed from it. Once those issues aren't on your table, it's almost like you've got to do what you've got to do.

**Q:** Except some seem to want to keep their fingers in, and keep running the Corps.

**A:** Yes, they want to keep their fingers in it at a 1970 or 1980 level instead of taking the new information and moving on, and General Slewitzke is probably the one that's most guilty of that. General Hazel Johnson Brown, except for social interchanges, I hardly ever hear from her, and, of course, General Parks has been so sick. I always send Christmas cards just to keep up with him. Until she died, Colonel Clark stayed in contact, would write voluminous letters and everything, but basically as a support. She did not want to get down to the nitty-gritty of what was going on in the Corps

chief business. She was more of a personal support, I think.

So I guess what I — the Corps chiefs are there if you need them, and I was happy to see Bill Bester. We had a meeting and were all over at the Marriott. It was early on when he took over, and it was a good meeting. I mean, very cordial, and they were all there, and they were happy to be there. There were about six of us, I guess. But I think that's the key, you know. No chief of the Corps ever — we all realize we're former, but we don't ever want to be forgotten, I guess, is what it amounts to. So I would look at the Corps chief group as being very supportive personally as well as professionally, and yes, they'll let you know their opinions, and sometimes you agree and sometimes you don't, and you move on.

It's never been done with prejudice, that's what I'd say. It's always been with the best intent of the Nurse Corps, and being there for the Corps chief, because I think they really do see themselves as a power.

You know, there's a big delay in my announcement as Corps chief — not the announcement, the approval of the nomination from Congress, and they're beating up on the Surgeon General and everything.

Q: Besides having your personnel responsibilities when you were the chief of the Corps, and besides being Commander for the Center for Health Promotion and Preventive Medicine, did you have other major responsibilities outside of the Nurse Corps responsibilities, or was it mostly those?

A: That was plenty.

#### **Areas of Concern Left for Successor**

Q: That was plenty, right? As you left the job, what areas of concern did you leave for your successor?

A: I think we can mention two: the downsizing definitely, because I was afraid, and Terris Kennedy was expert in keeping track of the numbers and who was doing what to whom, and between Terris and I, I think we did hold the line, and even there we were not happy with the outcome. And my feeling was if we didn't watch it closely, it would continue to go down.

Then the career ladder for nurses, because of the Branch Immaterial, the fact that we were moving nurses from what were recognized positions in nursing, to the Branch Immaterial, and there was nothing — there was no backfill of the nursing positions, and to me, that would take its toll in terms of the professional development and the

quality of nursing care. If you don't have those key nursing leaders paying attention to the . . . [skip] . . . work of nursing. Those were the two things.

Q: I don't know if you want to answer this or not, but I think that the general feeling across the Corps was that Colonel Kennedy would have made an excellent chief of the Corps. Everyone was quite disappointed. Help out with your feeling about that, if you can say.

A: Yes, I was disappointed. Terris had my utmost confidence, and of course, we wouldn't have had the relationship as chief and assistant chief if, indeed, I didn't think she had the abilities to replace me. And I told people at the time, as well as subsequently. She was doing the traditional Corps chief role. She had all the duties and responsibilities, because I was diverted to these other things.

So yes, it's kind of like the vice president. Usually, in this day and age, the person that's sitting there should have the catbird seat for the replacement. But just like the nation chose somebody else the last time around, we have a board process, and I was one of — I can't remember the number on the board, but it was either seven or nine people who sat aboard, and I was the only Nurse Corps. And a board is a board. We have a strict process, we evaluate people's records, and the records speak for themselves, and we had — we have and had a number of equally qualified and competent people, and the board made a choice.

So yes, while I was personally disappointed because it was my friend and my colleague who wasn't going to be the next Corps chief, we had a very competent and qualified person. There is no way I could say that General Simmons didn't have what she should have had in order to be qualified to be the chief of the Nurse Corps.

Heaven knows, I have absolutely no visibility of who my competition was back then, who I disadvantaged. I could have disadvantaged somebody who was equally close to General Adams-Ender. John Hudock was equally close and, you know, everybody says, "Oh, yes, we know why John didn't get it," because I don't think he had ever been a chief nurse, and he didn't have War College. So there was an intellectual reason for him not to get it, but that said, he still did a superb job.

Q: Speaking of John Hudock, after he retired, did you have cause to ever go back in and ask him questions or consult with him?

A: I would have liked to. He kind of disappeared.

Q: He went to Hazleton, Pennsylvania.

A: Yes, Rolling Rock or something. He was very hard to get hold of. And there does reach a point, you know, in a comfort level where okay — and in fact, Terris went into the assistant chief's job about 1 October, and as I said, I wasn't confirmed until mid-November. So Terris was essentially functioning as assistant Corps Chief/Chief because I was the nursing consultant, and was in the office up there. I could hear and see everything that was going on. But I think by the time I got sworn in, which was just before Thanksgiving, we were kind of comfortable in terms of the work, and the roles and stuff. And the person that we did go to a lot because she knew what was going on was Dottie Clark over at PERSCOM.

### **Your Greatest Accomplishment as Chief**

Q: What accomplishment in your four years as chief makes you most proud?

A: I think I started people thinking in terms of how do we redefine the role of Army nursing. Now, part of that definition did not go the way I wanted it in terms of, I think, Branch Immaterial got more definition in the long run than the clinical empowerment role, but I still see vestiges of that out there, and I think we're moving in the right direction. There was a time when I think we were losing our interest in patient care, and I don't perceive that anymore. So I hope I turned that around by saying okay, there is value in nurse, and that value will be recognized.

Some people think the value is being realized as Branch Immaterial, which may be true to a certain extent, so you could question about whether that's going in the right direction. And the fact that nursing leadership — nurses are now recognized as corporate leaders. I think that's a big legacy of who and what I was about, that whether I agreed or not, I did what was expected so I was okay, so there must be other nurses who are okay. So I'm very proud of that.

I'm very proud of the talent pool that Colonel Kennedy and I developed. We spent lots of time doing that, and I think we left a good bench for not only the immediate four years, but there are some now that are now becoming colonels, who were majors who worked with us in the Office of the Corps Chief — Pat Salisbury, Bobby Sherb and those people who are now commanders — Diane Pumonek. So the talent development.

I think we had a good — there was a good feeling tone in the corridor in the four years. People felt good about being nurses. Even though they were feeling beat up, they knew that I was champion and that Terris was champion, and they were fighting a good fight. We weren't winning all the battles, but we were fighting a good fight. So I think I'm very proud of that in terms of the shape that we left the Corps in for the next four years in order to meet the needs.

Actually, I don't have any regrets. At one time I had some doubts that could have turned into a regret. And I guess part of that goes back to the fact that Colonel Kennedy did not replace me, and there was a different leadership style that came in with General Simmons. But there was some talk that went on at the time that I was too harsh or strident, and because of being — I was perceived as being negative within the Office of the Surgeon General.

Q: By whom?

A: Well, somebody in that seat — there's not nurses there. I mean, it was the Medical Service Corps. I can't even say the Medical Corps because I hate to say this, but quite frankly, I don't think they get vested enough in what's going on in the long run with their patients.

So primarily, because I did a lot of battle with the Medical Service Corps, and if it wasn't going right, then I would go to the Surgeon General. So we had a lot of point and counter-point type discussions. And so there was kind of a suggestion that there was going to be pay-back to the Nurse Corps about when I left. And General Simmons, on a couple of occasions, I did talk to her early on because when I was hearing things about strength or whatever and I would try to get ahold of her and talk to her, and she basically let me know that she was having to do some healing because of the void or the attitude that I had created there.

So I kind of thought well then, maybe I should have been a little bit more accommodating or gentle in my approach. I didn't want my approach to leave somebody in a deficit position. But I don't know if me getting away from it or seeing where we now are — I don't have any regrets now. I think I did what I had to do for the times. And yes, Bettye — General Simmons had a luxury, and the new surgeon general came in, set a different attitude for the headquarters than when I worked with General LaNoue. So if there was a backlash, it was short-fused because General Blanc came in, and then it was more of a collegial team approach.

General Blanc and I go back a long way, and I don't think I would have been a two-star today if I hadn't worked for General LaNoue, but I think if I had worked for General Blanc as Surgeon General when I was Corps Chief, we couldn't have had so much turmoil. So it's kind of hard when you add it all up.

I don't regret any of it. I think I made the most of the opportunities that were there. We had a lot of good to show for it, and I enjoyed it all. I can't say there was any time when I would say hey.

### **Letter of Resignation**

- Q: You weren't ready to quit at any time, like before.
- A: Once during my tenure, and I won't go into details, I did have a letter of resignation written and I was going to hand it over.
- Q: You can tell that later when you write your book.
- A: I went to bed and woke up the next morning, and not only that, I don't know if you have ever known General LaNoue, but he could tell you one day that you were a piece of crap and he didn't want you beneath his feet, and then the next day he would say, "Nance, have you thought about--" and it was kind of like --
- Q: Best friends again.
- A: So I tore up that letter, and said okay, I'll try again.

### **Relationship Between the Chief and the Assistant Chief**

- Q: What did you think of the ANC's direction after you left the chief position — for instance, losing some of those slots at AMEDD Center and School, and moving the chief down to San Antonio, and then ultimately to Fort McPherson, and leaving the assistant chief up there at Belvoir or wherever she was?
- A: And you could go back and you could look at each one of those decisions and find either yea or nay for them. General Simmons knew from the outset what the problems were that we were having because she had been chief first of the MEDCOM, and so we worked closely with her, so she knew what was going on. But her style was different. As I mentioned, she thought it was a time for healing, and to re-establish friendly working relationships. And I had nothing against being friendly. What I had against was I wasn't going to pay the bill for everybody else's game. I never felt bad personally about individuals. It's just that I wasn't willing to give up my agenda.

So in terms of those decisions, and both Colonel Kennedy and I sat down with Bettye in the outset, and having Bettye stay at the AMEDD Center and School was not bad, because that's where we were shifting lots of the Corps work. So that, in and of itself, wasn't bad.

I think what was bad, and for whatever reason, the relationship did not develop between the chief of the Army Nurse Corps and the assistant chief because



Washington is important. Oh, I know, and I now think of the other thing I was thinking of when you asked in terms of what am I most proud of. I'm most proud that the Army Nurse Corps had a visibility and a reputation that went over to the Pentagon, as well as to the Congress.

We had visibility during the downsizing. That's one reason why our numbers, while they weren't where I wanted them to be, they weren't as bad in the whole as they subsequently began because we briefed the Secretary of the Army — I went over and briefed Secretary West, I briefed the DCSPER, I briefed the DCSOPS, who was General Tilelly at the time. We were invited over to do that because first of all, we looked for the opportunity, and second, we had a good briefing with a valid message.

So we had credibility. So having credibility that went beyond that which the Surgeon General could convey — credibility in our own right as Army Nurse Corps officers. Even sometimes there was a joke, we've got more nurses than we have Army officers, but I can tell you why. And we did that. So we had that rapport, we had that identity, and that was one of the things I told General Simmons that she needed to work at maintaining, because those guys can help you. Things may not be going all right in your immediate back yard, but if there is another higher level who had an interest, they can't go as far or as fast as maybe they would do ordinarily.

Q: And that's hard to do from San Antonio.

A: Well, it's hard to do from San Antonio, and Bettye had never had a job in Washington, D.C. At least I had been the consultant. But I will credit Colonel Kennedy, from her PERSCOM experience, knew how to develop those linkages that allowed us to work that campaign plan, essentially, to okay, let's keep the nurses before somebody else's perspective there, not just the Army Medical Department, the DCSPER, Secretary of the Army, and such.

That was part of Terris' smartness, her political astuteness, and she made it happen for me as Corps chief. Usually when we went over there, I took her with me because she'd help develop the briefing, plus if I wasn't in town, she would be the one there. So we really worked to do that.

Bettye never came up with her own concept of operation. And one of the decisions might have been to move the assistant Corps chief down to San Antonio so that the relationship was there, and then figure out how to do the — you know, the Washington piece can be done TDY. The Washington piece is the federal nursing chiefs. The Washington piece is Congress; to a certain extent the surgeon general, but really the business in nursing is not done by the surgeon general, it's done in the AMEDD Center and School, it's done in the federal nursing sector. So that could

have been done, and we left that decision to Bettye because at one time I had even talked about okay, Terris, how about we'll move the assistant Corps position to San Antonio.

Two reasons we didn't do it — one, I didn't know what her future was, so I didn't want to disadvantage her by the PCS move, and the second was to give the new Corps chief the ability to make his or her own decision. So I didn't want to lock them into something. But it should have been addressed. It should have been addressed, and in no actual way where Susan McCall, and Bettye, and her other nursing leaders should have sat down and said, "Okay, how do we do Nursing Corps business?" Now, today I can tell you, I still don't know how we do Nursing Corps business. I don't know the San Antonio connection, and I've got Stephanie Marshall here. Stephanie used to work real closely with General Simmons but yet there was an assistant Corps chief up in Washington, and I think that's how we ended up with Susan McCall saying, "Hey, good-bye, good luck, I don't need this."

Q: It must be very frustrating.

A: She wasn't in the loop. So I think the lack of the grand design, how do we do the business of nursing, and one thing if I didn't --

I think the key point that I learned from General LaNoue in terms of organization, reorganization is define the work. Ask what is the work that we have to do, and then after you know what the work is, then where have you positioned the individual to do that work, and then ask who should do it.

What we tend to do is start with a who and take care of the people, and then we lose sight of what then was the organizing framework, and I think that's what happened subsequently. And I think the biggest — she made a big mistake when she did not fill the assistant Corps chief position in terms of disability in that headquarters.

Q: After Colonel McCall left.

A: Yes. To say that job is not important, I mean, when you can't do it full time and you don't have anybody doing it full time, so nursing became fragmented. I think it was difficult from the field, then, to decide where is the nursing leadership. For whatever, you know, reason with me, I think Terris and I were like that equally, you know. One was a general, one was a colonel, but both of them were together at the top. So if she went out to do something, people were not lamenting because the chief wasn't there, and, you know, when I went out, I felt empowered 100 percent. I never felt she was taking anything away from me, or anything — they say, "Well, Colonel Kennedy said this, what do you think?" And it was well, yes, I know, because this is what we

think, because it was a shared agenda.

I don't think that shared agenda was ever articulated. So yes, I think --and unfortunately, you know, I don't think it paid off for Bettye. I think she didn't have the satisfaction of the nursing role, and on those other jobs, did not make her competitive. She did not get to a medical center.

### **Input into Affairs of the Army Nurse Corps after Leaving the Position**

Q: General Adams, were you able to retain some input into the affairs of the Army Nurse Corps after you left the chief's position?

A: No, not really, and quite frankly, I didn't look to retain any influence per se. I let General Simmons know I was available, but I found, especially with my move out to William Beaumont in El Paso, that I really wasn't relevant to what the ongoing issues were. I really didn't have any knowledge base, I think. You could ask my opinion, but other than that, I don't think I was really germane to the issues that they were working on.

Q: So you were really --

A: Out of sight, out of mind.

Q: And you had other things to concern you.

A: Yes. I had started off as a lead agent, regional medical commander, and then eventually moved into the hospital command. So I was fully engaged getting a new set of priorities and problems.

Q: Briefly describe your assignments and your promotion after leaving the chief's office. Did you at that time expect to retire right after the chief's?

A: You know, it was kind of left open-ended. The requirement back then, I believe, and the rule was that you could serve 30 years of Active Duty, or five years in grade, whichever was later, and I have to go back and figure it out, but I think I was about at my 28<sup>th</sup> year when I went out to Beaumont. So I still had two years in terms of the numbers, but I really didn't have any visibility of when the first Branch Immaterial promotion board would happen, and I believe it happened in September 1997.

So I went out there knowing that I had two years to serve for maybe a promotion board, and was just willing to trust it and see what happens. I wasn't willing — if they had asked me to retire after the chief, I was willing to do that. But General

Withers said no, for me to keep working, so I said okay. So I was “flexible,” and I stayed that way until about December of ‘97 when the board had met, no results had been announced. That was my mandatory retirement date, and I called GOMO and said, “Okay, guys, tell me what to do,” and they just told me to hang tight until they told me what to do. They didn’t give me any hint, but basically said that I could continue to work, I guess is what they told me.

### **Life After Chief, Army Nurse Corps**

Q: Would you tell us what GOMO means?

A: General Officer Management Office.

Q: So you went out to El Paso as a one-star.

A: Right.

Q: Spent a couple of years there?

A: Yes, I got there in December of ‘95. The same . . . [skip] being chief of the Corps, and General Simmons was signed in. That happened . . . stayed until March of ‘98, I guess. The . . . board came out in February of ‘98, so it was in February ‘98 I found out I had been selected.

Q: And you were lead agent?

A: I was lead agent for Region VII for Tri-Care as well as the Southwest Regional Medical Commander, and then eventually also the commander of William Beaumont.

Q: Was that a challenge for you?

A: Oh, yes, because it was the first time I got to command a hospital per se. It wasn’t a challenge in the sense I didn’t know what I was doing or the work was unfamiliar. It was just a different scope of responsibilities than what I had previously. Probably the toughest part was the UCMJ portion of the commander’s job because that was just something I had not been exposed to. . . .you have soldiers as well as — you have officers as well as enlisted who run into difficulty, you’ve got to deal with it.

So from our nursing side of the house, we’re used to nurturing and caring for people. On the commander side of the house, when they make mistakes, you can’t carry them. You’ve got to take action, which essentially affects the rest of their lives, and

it's usually punitive. So that was hard for me to get used to.

Q: How did you teach yourself at UCMJ?

A: Part of it was we had a course for general officers. It's a course that's meant to be a refresher course, because most generals have commanded throughout their career. So there's a general officer legal course that's given by the JAG Corps down at the JAG school, in fact, a one-day program, and I went to that. And then also I, quite frankly, just relied very closely on my JAG and she knew — I had a lady at Beaumont and I was very honest with her and said, "I'm a novice in this area. Do not assume that I know it. Tell me from the beginning what I need to know," and she did. I mean, she was very good, and most of it is straightforward. I mean, it's very well prescribed in the courts martial manual and all the other documents we have. It's just knowing the range of — and to make a decision whether somebody did or didn't do something, that was relatively easy. It's the range of options in terms of what type of discharge that a person — whether or not there is punishment involved, whether it's Article XV, or you need to refer them to another higher level for courts martial.

### **Promotion to Two Stars**

Q: So then you realized that you were going to get a second star and be promoted, and were you still at Beaumont when it happened?

A: Right.

Q: And then you got orders?

A: Oh, yes. When you get promoted --

Q: Did you negotiate that?

A: No. In fact, I found that I was promoted from the e-mail because it had happened over a weekend. I think it was the president's birthday holiday weekend, and I had come in to do some — because I figured one way or another I was going to have to be moving, and if I didn't get picked up for a promotion, I was going to be retiring, and if I got picked up for a promotion, I would have to move.

So I think I was trying to get things wrapped up in about February figuring, you know, sooner or later someone was going to make a decision. And I came in to work on a holiday weekend, and the announcement was on the e-mail to be — usually we release general officer promotions and assignments Tuesday and Thursday. That's

the way they do business. And so this was a Monday and the announcement was prepositioned, and since it was medical, they had sent it to the Medical Department early, and that's how I found out. I read it on e-mail.

### **Assignment To Tripler Army Medical Center**

**Q:** So you saw your name on the list.

**A:** Yes. And then also I had my assignment that same way. It came out on e-mail. And, you know, there are relatively few options in the Medical Department. There are five validated positions for major generals, and, of course, I had no problem with coming to Hawaii. And I had had some inkling.

It was interesting, because General Todd, who was my predecessor, had written me this strange note at Christmas time asking me if I wanted to buy his air conditioners, and I said, "What? I don't know anything." Warren said, "Well, I think you're coming out here." I said, "Well, that's very nice, and I certainly wouldn't be opposed to doing it." And I kind of left it with, "Well, if I come to Hawaii, I'll buy your air conditioners. Don't worry about it."

But you know how rumors get started, so it was kind of — well, it was flattering that he thought so, and I didn't know if he had asked all the one-stars to buy his air conditioners or what.

**Q:** How has your time been out here at Tripler?

**A:** It's been fantastic. Location aside, it's just that Hawaii is a very friendly place to work in terms of the civilian work force as well as the relationships between the military and civilian community. Senator Inouye, who has always been a champion of nursing, of course was very happy to have me out here in this position, and has kept up both the personal as well as the professional relationship in terms of when he comes to Hawaii we see him; when I go to Washington, I see him.

In terms of how he takes care of the military in Hawaii, he takes care of Tripler as he takes care of the other military functions here, so we're very well supported. Tri-Care, the managed care program for DOD, got its start out in Hawaii and California, so we're a mature environment. Hawaii is a managed care state. Tripler has a readiness mission. We are the backfill for Korea.

So when you look at the resourcing of this command, as well as you look at the missions and how we're prepared to do them, we have — it's a very good assignment, and it's a pleasure to be a leader of such a relevant organization, I guess

is what I would say.

### **Attitude of Medical Corps Officers and Others on Your Stars**

**Q:** Have you had any difficulties dealing with the Medical Corps officers who some might perceive that you have bumped out of a star?

**A:** You know, I have never had any problem. There has never been any confrontation or challenging of my authority. There's never been any negative vibes is the way I put it. So that said, I can tell you there are senior Medical Corps leaders who have told me to my face that even though they like me and they respect me, they do not appreciate the fact that I was a one-star or a two-star.

There are some Medical Corps who didn't think nurses should be a general, period, that there is nothing that nurses do that would earn them general officer status, and they have expressed that. I don't know how that speaks for them, but they felt the need to convey that to me.

**Q:** How do you respond to them?

**A:** Well, basically talk to them in terms of the capabilities and the qualifications for the job, and the fact that physicians who are generals are not practicing medicine. Nurses who are generals are not practicing nursing. We have the skills and the knowledge and the talent to do the corporate level work. So I should not be prevented from being a general because I'm a nurse. I should be allowed to compete. And those, though, have been relatively few. I think I could count them on one hand. I don't forget them. I know who they are, and I know where they are.

I had one physician who I considered to be a friend of mine, who knew me and I thought I had a good working relationship, who called me an aberrancy. We were talking about nurses and promotions, and he didn't begrudge it for me because he knew and he liked me. He made this comment, and I never forgot it — "You are an aberrancy." I put it in the context of like an extra beat in your heart, you can eradicate it with Lidocane. So I wasn't sure what his message was, but I never got it. "Well, Nancy, you're an aberrancy." He meant it as a compliment, by the way, because, "Well, you're not like those other nurses." But I didn't take it as a compliment.

### **After Retirement**

**Q:** What do you plan to do after Tripler?

A: I'm not going to go look for a job. I have been working since I was 16, and I've enjoyed all my jobs, but I want to just take time to look at options, I guess, as opposed to go seeking out a job. And I know if I sought out a job, I'd probably get one, and I would probably have significant responsibility. And in addition to doing the work, would be the whole learning curve that goes along, especially leaving military life and going into civilian life.

So I just want to take care of personal priorities, and then if within that context something develops, I'll look at it. But I'm not going to play hard to get. I'm just not going to be pro-active and go after the job opportunity.

Q: But you do see another job somewhere down the line.

A: I see me doing something. Whether it's part time and it's consulting, or teaching, or — I wouldn't mind working somehow in government, but I don't want to take on another organizational leadership role. I think that's just too consuming, and I don't need to work 14-16 hours a day. And I know the nature of the jobs that come with that level of responsibility, they're not eight hours a day jobs.

It's interesting, because people know now, I've told them I'm retiring a year from now, and I've already had a couple of people say oh, well, talk to me first, and I smile and say, "If I talk to anybody, I'll talk to you." But I'm not going to put together the effort to go get a job.

Q: Is there any possibility you might get a third star?

A: No, I don't think so, and I am very comfortable with that. I think in terms of when you look at the Army as an organization, they are developing women as leaders, and the line Army has competent two-stars that are prepared in that career track. I'm special branches, I am medical department. The job I could compete for is the surgeon general's job. I had that opportunity the last time around, and indeed, they chose the best person for the job — the person who had the better credentials, the person who had the better qualifications, and that's the way it needs to be.

Q: How do you make hard decisions?

A: Well, I do my homework. I guess that's the best way to put it. Or actually, what I sometimes do is make the decision very quickly and then do my homework, and revisit the decision before it's made public. So I usually have an idea where I want to go, and then depending upon — and I consult people. I think that's what my deputies are for, that's what my JAG is for. I don't try to do things unilaterally. When you're the boss, you can't know everything about all things all the time. So



I don't hesitate to get information either from people or documents, and I tend to, if it gets very complicated, to do my own little decision matrix with pluses and minuses, or scores, and just to see what the alternative course is, you know, are there big differences or little differences, and then go from there.

Q: And that has worked well for you?

A: Yes. I have to put — some people think I'm reactive, and I am reactive. I can't stand people who don't make decisions, I mean, that will just — you know, even when you ask them, they tell you why they do it, and then they talk themselves out of it before they finish their conversation. So if we're in situations like that, I will usually rush to make the decision and then see if they will try to convince me to change my mind.

But indeed, there are very few things, when it comes to resource manager, and when it comes to people, those are probably the two big areas where you have the most difficult decisions to make. I usually do the homework. Most of those are not yes-no decisions. It's crafting out the final solution with the variables that were given to you.

### **Advice to Other Military Women**

Q: What advice would you give to women who hope to follow you and break even further through that glass ceiling that has been in the Army?

A: Well, and there still are ceilings out there. And I'm not too sure, in retrospect, whether gender is now as much of an issue as professional preparation, because quite frankly, the role of women in business, in industry, and in the military is fairly well established now, so that your female identity, I'm not so sure that that is as much of a barrier. It may be for me and people of my generation because we had to break that absolute barrier, but for the younger generation, because I've talked to the captains and all, and they've played on sports team with women now, they've had significant numbers of women in their courses.

Most of what I did, I was usually the only woman in the group, or one of two, or one of three. Now the numbers are such that the men are used to seeing the women and vice versa. But I'm almost beginning to think the stigma or the baggage we carry is the nursing label, because we still don't have a positive image of what is nursing and what are the professional responsibilities, and how accountable is nursing in terms of health care delivery — not just nursing patients in the traditional sense, but health care delivery.

So I think that's more — because I look in the Army Medical Department. There

should be a female physician promoted to general officer. I know, because I've sat the boards in the past. They have not been as competitive as the men, and primarily because they have elected to have families, and that is a limiting factor. There are only so many hours in the day. So if you want that career, you're going to have to plan it within the context of your spouse role, or your mother role, as well as your professional role.

Probably when it comes to gender specific advice, that would be my most — and that's what I tell the younger officers, you have to plan for it, because if you don't, you're going to run out of time to do it, and especially now with the requirements for military education, and the jobs that you have to have. And if you do want to have a baby and all those things that are going to have to be managed by the lady who wants to be a full careerist as well as to be a full time mother, or be able to do the spouse role, it's . . . [skip]

You know, I think the key is to have the plan, and then to know what the requirements are for you to be competitive, because no woman is going to get a job if she is less competitive than the male. I think we have at least gotten to the point where if you're equally competitive, you have a good chance of getting it.

I would say from my perspective, I felt I always had to be better in terms of what I offered than the men I was competing against, so they couldn't ignore me. And I think the women who were first in doing things, that is the track record that they have, that they were so good at what they were doing, that they outshined the competition, which coincidentally was all male, so they got the nod.

So it wasn't because of any equality or accommodation. It was because the woman had what the organization needed, and yes, they were taking a chance because a woman had never done it before, but it looked like the woman had a better portfolio and could be more successful than the guys who were competing with her.

### **Humorous Incidents While in the Army**

**Q:** You have a good sense of humor. Can you remember any number of humorous things that have happened, that struck you as funny over the years?

**A:** I guess when you say I have a good sense of humor, what I have found is sometimes being in unique situations, you can desensitize it by using humor. And probably the thing — and to some it's humorous — I used to get very angry, because it still does happen, that people will see me in uniform with two stars on my shoulder and ask me if I'm a real general. I used to get really agitated, and now I try to — and one I thought was humorous.

I was in an elevator in Atlanta as a one star, and was going to a function in mess dress, so obviously was a part of the organization, because you're surrounded by hundreds of other guys in a similar uniform. A gentleman on the elevator asked me if I was an honorary general, and I looked at him and I said, "No, I'm a general in the United States Army, but I am honored to be a general." So he kind of, you know — and so things — and I guess the other one, and I had only been chief of the Nurse Corps a month.

I had gone to Chicago to see the chief of Recruiting Command because I had taken Colonel Kennedy away from him, wasn't going to be his chief nurse, and we were in the process of finding the other person. So I went — no, I guess Sharon Richie was there because I remember going to lunch or dinner with Sharon. Sharon was already in place, and we ran short of time, and I get to the airport, and I was going back to Washington, and I was still in uniform — one of the few times I traveled in uniform. I got to the airport early, and it was like at night, between 8 and 9 o'clock, and I didn't want Colonel Richie to wait with me. So I said, "You go," and I just went to the lounge and started reading.

Well, this lady came up, and first she asked me what time was the plane to Washington, and I told her, because I figured — that's what I was waiting for, the plane to Washington. And then I went back to my book, and she still stood there. I looked up and she said, "What time is the next flight after that?" And I said, "Well, I really don't know." And she said, "Well, don't you work for American Airlines?" And I said, "No, I work for America. I'm in the United States Army."

To this day I don't think she understood. She said, "Well, you weren't any help," and she walked away. And here I thought I was being so smart, I work for America. Not American, but America.

- Q: You seem to turn it around every time somebody comes at you with something.
- A: Well, you know, when you're in certain positions, you can't react with — you can't be negative, so you try to desensitize it.
- Q: So you do create quite a sensation walking down the street.
- A: Yes, people still argue, or don't put it in context, I guess. I went to buy a plane ticket last night at the airport and I was in uniform, and the guy kept calling me "Miss," and then he looked at me and he said, "That's probably not what I should be calling you." And I said, "Well, Miss will work, but I'm a major general in the Army." And he said, "Oh." And then, "You're new at Scofield." And they understand Army and all, but they look at me and it just doesn't compute, I guess, is the modern — you

know, we're not the stereotype. If I was a guy, and they would see stars, and a guy in a green uniform, they would say Army general. But it just does not compute yet in terms of the women. Another 30 years and it will come.

When you say funny stories, I remember going out to the ANA in Las Vegas and speaking, and it was being held at the Hilton Hotel, and I was in uniform. I got in the elevator, and this lady — it took me a year to know what she was actually saying to me, and her comment was, "Well, I didn't think they were going to allow you all back in the hotel." And this was like June, and it had just developed — I had no idea what she meant. And I thought oh, casino, daytime, military, maybe that's what she's talking about. And I said, "Oh, I'm here for a conference."

Maybe a month later when I started reading about Tailhook in the Hilton I thought, oh, that's what she meant. "I didn't think they would let you all back in the hotel."

Q: You could draw all kinds of weird conclusions from that.

A: Being in the military has been fun. I can't complain.

### **Honors and Awards**

Q: And you do see the humor in things, I know that. What are some of the honors and awards you've gotten?

A: The typical career ones, and I guess it's interesting because I don't think you appreciate awards when you get them. I think in retrospect, and then when you're in the position to give others awards, you realize how fortunate that you were that your bosses took care of you at the time. So the award of Military Medical Merit was important to me — and is important to me now, and I received it when I was a major, and now I just marvel at the fact that somebody took the time and attention, and oh, by the way, I got it as a major. But that happened when I was on the IG team down at Fort Sam Houston, and I think a combination of Colonel Jackson, who I worked for, as well as General Bishop — Ray Bishop, who was the CG of Health Services Command Department. I did a good job for him.

And then the professional aide designator in Medical Surgical Nursing, because I've always been very proud of my clinical career, and I got that when I was in Health Affairs, after I had come off the IG team, like I did with the intensive care course, and the fact I had published and such. So that has always been important to me. And then most recently, when I was Corps Chief, being selected to be a Fellow in the American Academy of Nursing because it essentially represents a career's worth of contributions.

Sometimes it's interesting when you asked about physicians and their acceptance of me, their basic question to me is if you wanted to be a general and if you wanted to be a hospital commander, why didn't you become a doctor. Well, what I said to them, "I never wanted to be a general." That wasn't a career goal per se. Hospital commander, no, that wasn't really a thought of mine either. What I wanted to be was the best nurse I could be. So the professional recognition in terms of my credentials and qualifications as a nurse, that is the important part of my identity. This other happens to be, I think, coincidental, not instead of. It is because I'm a nurse.

I think the nursing preparation, the experience and everything has given me those credentials to be competitive for these other jobs, but the other jobs are sort of an end in themselves. So the nursing rewards — so those three, I think, being a Fellow, and . . . because that's over. . . [skip] Army, and then a designator, that's most important.

I . . . [skip] up there the distinguished alumni from Catholic University and Cornell, which I think are just coincidence of the other success. That's very nice that they took the time to do that.

### **Legislative Changes**

**Q:** In your career there have been a lot of legislative changes, things like rank, pay, dependents, the nurses having dependents, pregnancy, women in combat. What is your opinion of some of these? You can pick a few, or talk about whatever you want.

**A:** Well, I think basically those that eliminated discrimination, and provided equal opportunity, equal pay for equal work. I think those are the — those same themes that are relevant to society are very relevant to the military. In fact, the military has taken the lead. It's a cumulative effort, and you talk to the youngsters today and tell them well, gee, there was a time if you wanted a baby you had to get out. They look at you like, where did you come up with that. They think it's fiction. They don't even believe it was real. Or the fact that during the second world war, the chief of the Nurse Corps had 57,000 nurses on Active Duty, and was paid the pay of a major because they didn't think she earned the rank and the pay that went with the rank.

So a lot of these things I think are just — I look at them today as common sense, or today's generation looks at them as common sense. And I think we have eliminated the quantifiable barriers, and I think it's just a matter now of the cultural and the behavioral barriers that are still there, because of either experience or stereotyping that we need to work with.

Probably the only one that I continue to have, and it's not heartburn, it's just that I've

seen both sides. I'm not sure we have yet come up with the best way to handle the pregnancy issues within the military. There are limitations on a woman when she elects to have a baby. She's got to take care of herself, she's got to take care of the baby. You can't compete that with the demands of military life, and I'm not sure yet we — the Coast Guard, for example, allows a lady to take a leave of absence, and then come back and resume her career at a time of her choosing. And while she's on a leave of absence, the organization is not penalized for her pregnancy condition. And I think we need to look at something like that because we're a young organization. Lots of people have babies. And if you have — and I see the numbers coming out of the division at Scofield, and if you're in a support battalion and you've got 18-19 percent of your people who are disabled, and I don't care if it's pregnancy or broken legs. If it's broken legs, you'd try to figure a way to prevent it.

Well, you can't prevent the pregnancy. You've got to accommodate it. But it's a very significant price that we have to pay, and as the military gets smaller and we don't have extra people, and everybody is in a definable position, I think we've got to have the ability to handle the pregnancy issue without having it have a penalizing effect on the institution that has the woman or group of women.

It's going to be hard to get to that point because every time we try to talk about it, people start screaming, "Discrimination."

But if a man had a condition where every year he or she was absent for six weeks to two months, we would medically board them. We wouldn't tolerate it. Now, if it was an illness that he or she couldn't control like hepatitis or something, we would try to accommodate them until it totally interfered with duties and then we would medically board them. But we're not using the same common sense approach to pregnancy because it becomes an emotional issue, I think because of the gender implications.

But it doesn't do the woman any favors, and it doesn't do the organization any favors, so I would hope that someday we could sit at a table and come up with a better way to deal with it.

### **Smartest Choice in My Life**

**Q:** Resolve it some way. What is the smartest choice you ever made in your life, or in your Army career.

**A:** Probably the smartest choice was staying on Active Duty back in 1970 when I had intended to get out of the Army coming back from Korea, because it was not, in my way of thinking, a satisfactory professional experience. In retrospect, it was probably

more personal — my personal life that was disrupted rather than my professional life. But then going to Fort Jackson and then deciding hey, I really do like the organization, I like the people, I like the work, and then making that commitment. . . [skip]. . . joining the Army. It was — I didn't have to do it, and it was the world I lived in that kind of stimulated me in that direction. It was a win-win because of scholarship money, but also because of the turmoil of the '60s, the fact that the military, to me, seemed to be honorable at a time when everything else was if not dishonorable, at least it wasn't based in good values at the time. And I couldn't have articulated my values back then, but obviously because of my background, my personal values were compatible with the organization.

### Mistakes

Q: . . .[skip] . . . I assume you've made some mistakes.

A: I don't know whether I've been lucky or good, but I've never made a mistake that couldn't have been undone, I guess is the nice way of putting it. When I look back at my personal life in terms of not being married, I didn't miss any great opportunities. There were people who I cared about that cared about me, but for whatever reason, that wasn't a good decision in the long run — it wouldn't have been a good decision in the long run, and I say that in retrospect because seeing where my joy from life has gone. So I don't feel that I've missed the love of my life, or gave it up because of the Army.

When it comes to education, I made a conscious decision that it was better for me to do the military education than to do civilian in terms of going for a doctorate. So I don't really — I guess I'm very content. I don't wish I had done something better or different, and I have never felt sorry and said oh, boy, I really messed that up, how do I regroup.

Q: You probably haven't made the big, big, bad choices that some people do because of poor judgment.

A: I made one poor decision that had ethical implications, as a general officer. I got visited in terms of IG being involved, and was counseled for it, and the good news is I learned from that mistake, and the Army accepted that and said yes, your judgment was clouded for a moment, but you recouped. In a short period of time I realized the implications and said, "Hey, I shouldn't have, and I need to deal with this," and I dealt with it. I dealt with it above board, and the Army, you tell them you did something, they've got to do something with it. What they did was appropriate.

I got promoted to two stars with that in my record, and part of it was because, I

think, of the ownership of saying hey, dumb thing to do, but learn from the dumbness, and I can honestly say I have learned from the dumbness. It helped frame some issues in terms of your obligation to an organization versus your obligation to a person, and it helped me to sort some things out in a larger context.

Q: So you learned from it.

A: Yes.

Q: And I think if you're lucky, you're around people that realize that people make mistakes.

A: And at this time, the only person who knew I made a mistake was in senior leadership, and they did what they had to do from a mentoring counseling as well as document it and move on.

### **Importance of Physical Fitness**

Q: What do you know now that you wish you knew as a junior officer?

A: That physical fitness is important. I keep telling people if they had gotten me physically fit when I was 35 instead of 45, I might have had a chance in life.

Q: Is it difficult for you now?

A: Oh, yes, and it's become a personal — I don't think I can be a commander and not do what I require my troops to do. And it's much better now. I can remember when I was chief nurse and — well, actually Gail Croy was the chief nurse at Frankfurt, and I was her assistant, and we went out to do the PT test together, and it was kind of insinuated that gee, the chief nurse and the assistant don't do the PT test. I said, "Oh, why not?" Well, it hadn't been done before at that particular assignment, so we did it there and, you know, I can honestly say — knock on wood — ever since — I've passed it each time and I've done it each time, no profiles and such, and it's work. It's hard work.

And I talk to people, especially the younger officers. It's not as much of a problem now as it was five years ago because there used to be an implication that well, we really need doctors and nurses, and we don't care if they're bad or not physically fit. But that's not the attitude anymore. So when I talk to people about their professional credentials, I talk to them about not only having civilian education, but also having the military education as well as physical fitness, because it's a total package. It's not being board certified, and not being physically fit.



And I was lucky, I think I had people — either people or circumstances that made sure I did the right things when I was younger, but I did not know they were the right things. And I don't think today you have the time to waste that maybe I did. And especially if you're looking at the larger context of successful women today are also married.

My peer group tended not to be married, or they got married later, in their late thirties and such. But letting the youngsters know that they need to plan for their future, because — and I think I was more open-ended about my future than what people need to do today. I really did believe I would get married and be a housekeeper in a new home by the time I was 30. But I didn't waste my time in the meantime, so therefore I was making progress in my career. But I think today we need to educate men and women in terms of planning for their personal goals and their career goals.

That would be my advice. I didn't plan. My career was, for the most part, a happening. It wasn't planned. It just happened very fortuitous, I think, for me. I can't complain. And in fact, in all my assignments in the Army Nurse Corps, I never asked for a particular job or a place. I let branch make the decision, and the only time they ever countered a decision, or expressed my opinion was coming off the IG team when they wanted me to go to Europe for the NMA job, and I just didn't think that that was it. But everything else was within the context of what the Nurse Corps required.

### **Attributes of a Good Nurse**

**Q:** What attributes do you think make a good Army nurse?

**A:** Well, I think probably the same attributes that go into the Army values, because when you look at it in terms of what you expect of your nurses in terms of selfless service, and integrity, and respect, I mean, those are the cornerstones of how we were taught to take care of patients, so the values to begin with.

Second, you have to be willing to put an organization — you have to be willing to let the organization take the lead. If it's always going to be me, me, me, you're never going to make it. And that's probably true whether you work for Ford Motor Company or the United States Army. You've got to be willing to look at yourself within the context of the organization and not try to frame the organization around your own personal needs. So flexibility, and accommodation, and being able to have more than one choice so that if you don't get the first choice, the second or third choice will also fit in, in terms of your career goals or your planning. So I think that's important.

And the rest of it is, you know, Army nursing, I think, in terms of taking care of patients, doesn't require any more of you than civilian nursing. What does require more of you is the officership meeting the military requirements, being able to leave a location or job after three years, so that type of accommodation.

### **Key Attribute for the Chief of the Corps**

**Q:** Would you say similar things are needed by the potential chief of the Corps, but what other things would you think the chief of the Corps would need?

**A:** Well, I think the key attribute for the chief of the Corps is a global picture of the Army, and not just the Army Medical Department, and that was something I think — you know, when I was on the IG team, that's when I first appreciated first of all how does the Army Medical Department work, and then second, how does the Army work, because prior to that, my focus was very limited. It was how does William Beaumont Army Medical Center work, and then I really didn't care about how the whole medical center worked, it was just the ICU.

So it was just my small slice of it, and I think as you progress within the organization, you have got to expand your horizons. And while you may not work issues that are the rest of the organization, you have to have an appreciation of what are the organizational priorities, and you have to be on the look for where your work interfaces with the organization.

There are some people who just stay in their own lane, and they're very good in their own lane, but we cannot work in isolation in today's environment because of the scope of responsibilities as well as communication. So you've got to start making those relationships in terms of not only linking the functionality, but also the people. And I think that's another key — paying attention to the people who are in the leadership positions. So it's not just a matter of knowing a name and a title, but if you're in a work environment, to interact with the leadership, because you all contribute to the leader's success because I have no problem with meeting anybody and talking to anybody.

I told one of my — I think it was a lieutenant who came to talk to me — all of the lieutenants want to know how to become generals, which is interesting to me. And you tell them, you've got to be the best lieutenant there is, and work it incrementally, because there's too many variables of how you become a general. But I've told them rightly or wrongly, from my first assignment in the Army, I have always been known on a first and last name basis to the general officer who was in charge of the organization. And it's not because I was in trouble, or I wouldn't be here today. It's because of the work I was doing, and the fact that, you know, I thought he had a need

to hear from me, and those people always accommodated me, I guess would be the nice way of saying it, that they tolerated the dialogue, and there was a basis of an identity, I guess, would be the best way of saying it.

I was comfortable in Washington, D.C., when I was chosen to be the chief of the Nurse Corps. I still had some knowledge deficits, but at least I knew those areas where I needed to get that information in order to be ultimately successful in Washington.

Like the current chief, General Lester, his experience in the TO&E environment, working in Europe as a chief nurse, and then ultimately as a commander, having that relationship with the line Army because of his position over there, War College graduate and all those other things, Work and Recruiting Command, I think, back when he was younger. So he had expertise in a variety of areas that were all relevant to being a general officer. And he never segregated himself. He was perceived as being a generalist, or global asset in terms of how he did his job, whatever that job was, and I think that's probably the key.

When I was chosen to be chief of the Corps, I had enough nursing in my background to make me credible as being a good nurse, and then I had the rest of the story in terms of the other Army experiences, being in health affairs, which was a DOD job at the time, being in the IG team, which had relevancy to the organization. But I think it's that global perspective.

So yes, you're an expert. You can be the best nurse in the world, and that's the starting point, and that's what I try to tell the youngsters. You can't give up being the best nurse in order to be the best company commander because the Army wants you and needs you as a nurse, and that's where you're earning your living initially, at least. So you've got to validate your credentials in that realm, and then put out the other extensions to enlarge your scope of influence.

### **Final Comments**

Q: What, if anything, that we have not discussed would you like to include for posterity?

A: I don't know. I think we've . . . .[skip]

Q: . . . a lot.

A: I don't know if I was saying it to you. I guess yesterday I was saying that the good news is the history of the Army Nurse Corps is all positive. I don't think we have

any skeletons in our closet, or secrets we need to keep.

I think overall the only thing I would say is I think my career in the Army has been much more — you know, the slogan used to be “Be All You Can Be.” Well, for me, I would say that the reality is that I’ve been more than I thought I could be. The opportunities were there. I was able to make the most of those opportunities, and then other opportunities were presented.

The big lesson is for those who come after us is just try to do your best, and if you do your best, the organization will do the best for you. And there are many ways to define what is best, and being a general officer is a rare and unique opportunity, but it’s not the only definition of success when you look at a career . . . [skip] . . . relationships, places you’ve been, the educational accomplishments, all that, to me, is equally as important as the general officer status. Officer status, to me, is a humbling experience. It’s not a reward, it’s just — I’m very lucky to have been able to have this opportunity.

My parents, as I get closer to retirement, wonder how I got here and what’s most important. My father started off in the Second World War as an army aviation, Army Air Corps, and a bombardier, and he met my mother, who was an Army Nurse Corps officer, who gave up her career because she was pregnant with me. I don’t know if genes had anything to do with it, but I used to tell people — a funny story, you wanted a funny story. When I was very early as a GO and I went out to do something for nurses and was talking to people, and I remember making the statement, telling them a little bit about myself, because people wanted to know about me, that I was conceived on Active Duty. And I told about my mother and father and all that.

We go back to the office, and one day the Corps Chief office in old Skyline, and the secretary was outside, and the chief, and the assistant chief, and I’m hearing the secretary saying, “Well, I don’t think General Adams is pregnant.” And I’m sitting there, and I went out and I’m standing there going, “No, no, she’s doing fine. I don’t think--”

So she hung up and I said, “Who are you talking to?” She said, “Well, somebody thought that they heard you say you were pregnant.” And I said, “No.” And I went back into my office, and I sat there, and it was someplace I had been recently, and I thought, how in the heck — I’m not fat. I looked at myself. I hadn’t been sick in the morning. So I went through a lot of things that I could think of why somebody would think a woman is pregnant, and I couldn’t come up — and then finally a couple of days later it dawned on me. I had told I was conceived on Active Duty. So I didn’t tell that story anymore.

Q: You know, speaking of your parents, they must be very proud of you.

A: Yes. Unfortunately, my mother has probably mild Alzheimer's. She still knows her children, but she has no recent memory. And she kind of, when she talks to me, says how is business and things. So I don't think she really can put it in the context anymore. But I think it's like any parent. As long as you're happy and by their definition successful, they don't need to quantify it. So it's working. And when I was chosen to be the Corps chief, she knew all that. And quite frankly, for both my parents, and my father's memory is sharp as a tack, it was much easier for them to put in context me being a general and being chief of the Army Nurse Corps than it is to put in context Branch Immaterial. He understands promotion from one star to two star, but his attitude was well, yes, of course you could promote it. He doesn't realize the context, which is fine. And they both realize — he realized he went through all of World War II and never saw a general.

Q: And now he has a daughter --

A: Yes, right.

Q: Well, General Adams, thank you so much for all the time that you spent.

A: Not as much time as the Army spent with me, so they got equal opportunity.

Q: But I really appreciate it, not only for that, but for all the support you've shown me over the years, and writing this history.

A: I think the work you do, and I've got five copies down there — I've actually given away one. When Stephanie \_\_\_\_\_ and I were at Wharton, that book is in the library that's part of the \_\_\_\_\_ Penn because I got the Penn Press. So it was sitting there right on the bookshelf. I got the Medical Service Corps history and that's not nearly as interesting, though they managed to mention in there the first Branch Immaterial.

Q: Well, thank you very much.

A: You're welcome.

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**Acronyms/Words**

AMC	Army Medical Center
AMEDD	Army Medical Department
AMOSIST	The use of algorithms to diagnose and treat patients
AMSC	Army Medical Service Corps
AMSUS	Association of Military Surgeons of the United States
ANA	Army Nurses Association
ANC	Army Nurse Corps
AORN	Association of Operating Room Nurses
ASA	American Society of Anesthesiologists/Another Stupid Acronym
BDU	Battle Dress Uniform
BRAC	Base Realignment and Closure
BS	Bachelor of Science
CCRN	Critical Care Registered Nurse
CCU	Coronary Care Unit
CGSC	Command and General Staff College
CHCS	Composite Health Care System
Comsat	Used for communications services involving an artificial satellite
CONUS	Continental United States
CPA	Certified Public Accountant
CPR	Cardio-Pulmonary Resuscitation
CRNA	Certified Registered Nurse Anesthetist
DAIG	Department of Army Inspector General
DCA	Deputy Commander for Administration
DCCS	Deputy Commander Clinical Services
DCSOPS	Deputy Chief of Staff, Operations
DCSPER	Deputy Chief of Staff, Personnel
DOD	Department of Defense
ECG	Electrocardiogram
EMS	Emergency Medical Services
ER	Emergency Room
FAMC	Fitzsimons Army Medical Center
FDU	Faculty Development Unit
FORSCOM	Forces Command
GAO	Government Accounting Office
GI	Slang expression for Enlisted Men
GME	Graduate Medical Education
GMO	General Medical Officer
GO	General Officer
GS	General Service/ <i>schedule</i>
HSC	Health Services Command

ICU	Intensive Care Unit
IG	Inspector General
IMA	Individual Mobilization Augmentees
IV	Intravenous
JACO	Joint Actions Control Officer
JCAHO	Joint Commission on Accreditation Healthcare Organizations
LPN	Licensed Practical Nurse
LTC	Lieutenant Colonel
MD	Medical Doctor
MDW	Military District of Washington
MEDDAC	Medical Department Activity
MEDCEN	Medical Center
MEDCOM	Medical Command
MEDSURG	Medical-Surgery
MEL-1	Military Educational Level 1
MFSS	Medical Field Service School
MG	Major General
MICU	Medical Intensive Care Unit
MILSCI	Military Science
MSC	Medical Service Corps
MTF	Medical Treatment Facility
NG tubes	Naso Gastric Tubes
NICU	Neonatal Intensive Care Unit
NLN	National League of Nurses
NMA	Nurse Methods Analyst
OB	Obstetrics
OER	Officer Efficiency Report
OJT	On the Job Training
OTERG	Organizational Test and Evaluation Review Group
PA	Physician Assistant
PCS	Permanent Change of Station
PERSCOM	Personnel Command
Ph.D.	Doctor of Philosophy
POI	Program of Instruction
PRN	According as circumstances may require
PROFIS	Professional Officer Filler System
PT	Physical Therapist
PT test	Physical Training test
REFORGER	Return of Forces to Germany
ROTC	Reserve Officer Training Corps
SERB	Selective Early Retirement Board
STRAC	Strategic Army Command

RN	Registered Nurse
SICU	Surgical Intensive Care Unit
TAC	Training, Advising, Counseling
TAMC	Tripler Army Medical Center
TAPSM	Total Army Personnel (Data Base)
TDA	Table of Distribution and Allowance
TDY	Temporary Duty
Tet	Chinese New Year
TO&E	Table of Organization and Equipment
TRADOC	Training and Doctrine Command
TRICARE	Three Services Medical Care
TSG	The Surgeon General
UCMJ	Uniform Code of Military Justice
USAH	United States Army Hospital
USAREUR	United States Army, Europe
USAR	United States Army Reserve
USUHS	Uniformed Services University of the Health Services
VIP	Very Important Person
WAE	When Actually Employed





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