Part Three

The Concluding Decade of a Century of Service

Chapter Fourteen

The Post Cold War Period

The 1990s witnessed extraordinary transformations within the Army, the Army Medical Department (AMEDD), and the Army Nurse Corps. Unchanging, however, was the Army's fundamental mission of organizing, training, and equipping soldiers to execute ground combat operations, to deter aggression and—when required—win the nation's wars.[1] The AMEDD's core mission and functions also stayed constant as it provided world-class health care for the Army and, as directed, for other agencies, organizations, and sister services anytime, anywhere, and under any conditions.[2] Core functions required an ability to deploy a healthy force, to deploy the medical support force, and to manage the care of all beneficiaries.[3] Likewise, the role played by Army nurses was unaltered as they provided quality nursing services to active, retired, and family members in peacetime or contingency operations within the professional military health care system. Army Nurse Corps officers executed their mission by functioning within the four pillars of professional nursing—clinical practice, administration, research, and education.[4] While most of these fundamentals remained constant, momentous change predominated all around.

By the early 1990s, the Soviet Union had disintegrated, the Iron Curtain had collapsed, and the Cold War along with its strategy of containment ended. With the threat seemingly eliminated, there was significant political pressure to reduce the U.S. national debt and balance the federal budget by a comprehensive wave of military retrenchment. The nation sought to apply the peace dividend of previously committed fiscal resources from the Department of Defense (DoD) to other areas of national need, such as welfare reform and health care. In 1993, President William Clinton, with the approval of Congress, cut the DoD budget, which had peaked at $303.6 billion in fiscal year (FY) 1989, to a belt-tightening $255.2 billion by FY 1994. In this austere climate, the Army struggled to maintain its combat edge while navigating a precipitous downsizing from an 18-division, armor-heavy organization to a 10-division, light, highly mobile force. Army lead-

ers developed new doctrine, Force XXI, which emphasized use of innovative technology to implement information age warfare that—it was expected—would enhance the speed and precision of combat. The Army honed a new military strategy focused on dealing with two regional threats simultaneously with forces garrisoned mainly within the United States by means of strategic deterrence and defense, forward presence, crisis response, and reconstitution.[5]

While the Army was changing, the AMEDD too was undergoing a startling transformation, some facets of which reflected the revolution exploding within the national health care industry. One of the most significant determinants of the crisis was the exponential rise of health care costs. Between 1970 and 1990, health care spending escalated at a rate greater than twice that of inflation. In 1980, health care expenditures represented 9 percent of the gross national product. By 1990, this figure rose to 12.5 percent. Health care costs soared again in 1993 to 14 percent of the gross national product and economists projected they would consume 17 percent of the gross national product by 2000.[6]

Overwhelming pressures for a major overhaul of the nation's health care system resonated in the military health care system. Issues such as excessive costs, limited access, inappropriate allocation of scarce resources, unnecessary care (often implemented to protect against a potential lawsuit), and high administrative and overhead costs added to the confusion. Richard Southby summarized the pervasive challenges faced by the military health care system: the need for enhanced health care quality and better administrative management, the need to contain exorbitant costs, the difficulties in recruiting and retaining personnel, the mandate to accentuate health promotion and disease prevention, the necessity to expand discharge planning and patient education, the imperative to develop and pay for new technology, and the requirement to expand information management systems.[7] Another dilemma centered on the massive personnel and budget reductions imposed on the military and the Army and in turn on the AMEDD at a time of expanding responsibilities, a rapidly changing health care environment, the transformation of health care into a business model, and a significant revamp of the AMEDD organizational structure.[8] The AMEDD had to do much more with much less.

To survive and thrive despite these many challenges, the AMEDD revitalized itself into a more efficient, cost-effective organization in September 1991, adopting a new delivery approach called Gateway to Care (GTC), as conceived by the Surgeon General, Lieutenant General Alcide LaNoue. The exclusively Army GTC model, based on the concept of managed medical care, involved using specific primary care clinics to coordinate beneficiaries' health care requirements within a defined catchment area and to arrange for specialized care for patients when appropriate.[9] Thus, the responsibility for obtaining and coordinating care shifted from the patient to the larger comprehensive health care delivery system, with the local hospital commander determining whether the care would be provided in a military or civilian facility. If civilian care proved necessary, the commander would negotiate with the civilian provider for the most reasonable fee.[10] Within

months after the Army's launch of GTC, expenses incurred by local medical commanders for nonmilitary civilian-based medical care (through CHAMPUS) saw a significant decrease. During March 1992, reductions in Army CHAMPUS claims totaled $4.1 million, while in May 1992 claims were $33.4 million less when compared to the corresponding months in the previous year, 1991.[11] Evidence of improved access appeared in the dramatic reduction of patient waiting time for appointments at Army hospitals. GTC, however, was an interim measure utilized only by the Army until the implementation of DoD's Coordinated Care Program (CCP).[12]

Congress mandated the next-generation health care delivery model—DoD's CCP—when it directed DoD to maintain access to quality care for its beneficiaries while stabilizing costs and maintaining efficient use of resources. CCP replicated many of the provisions of GTC.[13] Its major features were decentralized control and administration by local medical commanders, patient enrollment, utilization of primary care managers, employment of utilization management and quality assurance measures, the establishment of specialized treatment facilities, and increased emphasis on health promotion and disease prevention activities.[14] As the CCP became the model for DoD's managed care system, Colonel Bonnie Jennings, the Army Nurse Corps consultant, articulated the need to develop and define the role nurses would assume in this new care delivery model. She devised five potential templates to define nurses' participation. These templates involved using nurse practitioners as primary care providers, explicating bedside nurses' patient care roles, delineating ambulatory care nurses' unique responsibilities, maintaining the contributions of clinical nurse specialists, and fully utilizing nurses as case managers.[15]

In March 1995, DoD initiated an aggressive implementation plan that transformed CCP into TRICARE, an updated umbrella program for all managed care programs. DoD subdivided the TRICARE organization into 12 geographical regions, each administered by a lead agent who was a flag/general officer assigned to a military medical center. Implementation began on the West Coast and gradually migrated to the East. All TRICARE regions were operational by the end of FY 1998. TRICARE merged the precepts of managed care; the joint resources of the Army, Navy, and Air Force medical departments; and civilian contractors to provide health care for all DoD beneficiaries. Choice was a key concept, and patients could opt to receive their care from a military provider or a civilian subcontractor, participating in one of three options: (1) TRICARE Prime, a health maintenance organization; (2) TRICARE Extra, a preferred provider organization; or (3) TRICARE Standard, a fee-for-service option.[16] By 1998, the Department of Veterans Affairs, the Army, and TRICARE agreed to share selected resources to provide more efficient, less costly care. Moreover, some VA facilities participated as TRICARE providers.[17]

Change also was a hallmark within the profession of nursing in the 1990s. The dramatic increase in health care costs was a major factor precipitating change. Skyrocketing costs motivated health care administrators to implement measures

Colonel Bonnie M. Jennings (left) made many contributions to the Army Nurse Corps and to the world of professional nursing. The American Academy of Nursing recognized her substantial accomplishments and inducted her as a fellow in November 1991. Nancy Fugate Woods, PhD, RN, FAAN, then-president of the organization (right), presided at the induction ceremony.
Photo courtesy of Colonel Bonnie Jennings, Evans, GA.

such as programs affecting nurse-patient ratios, decreasing patients' length of hospital stays, downsizing staff, merging functions, and replacing registered nurses with unlicensed ancillary workers.

In 1990, the American Medical Association was actively implementing plans to introduce a new breed of health care worker, the Registered Care Technician, who would carry out physician orders and return control of bedside nursing to the physician. This movement, vehemently opposed by organized nursing and the military nursing services, threatened patient safety, health care quality, and nurse autonomy. Ultimately, the American Medical Association's Registered Care Technician proposal failed, largely due to opposition of the American Nurses As-

sociation and the Army and Air Force Nurse Corps.[18]

Simultaneously, health maintenance organizations proliferated in the civilian sector and managed care became a standard delivery format. Hospitalized patients were usually acutely ill, while many patients with less serious conditions who formerly were cared for in hospitals received care in skilled nursing facilities or at home. Because hospitals had downsized nursing staffs, the numbers of critically ill patients overtaxed the fewer nurses who remained as hospital employees. As patients shifted from the acute care hospital environment, more nurses practiced in outpatient settings. The nursing shortage of the 1980s gave way in the early 1990s to a brief period of surplus, while predictions of a higher demand for nurses to care for victims of the AIDS epidemic, the growing geriatric population, and the increased need for community-based care seemed ominous. However, the reversal of the shortage was brief, and deficit conditions returned in the mid-1990s.[19] All these external phenomena influenced conditions faced by Army Nurse Corps officers on a daily basis within the AMEDD.

Reductions in forces have followed every war and the end of the Cold War and conclusion of Operation Desert Storm proved no exceptions. In a series of incremental waves, the Clinton administration cut a swath through the strength of the Army that affected the AMEDD and the Army Nurse Corps during the 1990s. By 1994, the Army Nurse Corps had forecasted that its budgeted year-end strength would fall 13.4 percent, losing 615 officers from 4,576 in FY 1989 to 3,961 in FY 1998. Since the Army initially planned an overall decrement of 25 percent, and the AMEDD's downsizing would be at least 19 percent to as much as 22 percent, the Army Nurse Corps leadership accepted the inevitable downsizing as their share of the overall Army decrement.

Brigadier General Nancy Adams, the chief of the Army Nurse Corps, and her assistant chief, Colonel Terris Kennedy, worked prodigiously to stop or at least moderate the losses beyond that level. They explained to the surgeon general, the chief of staff of the Army, and the secretary of the Army the serious consequences the cuts would exert on Army nurses' ability to care for patients. They noted that the Air Force and Navy Nurse Corps would sustain significantly fewer personnel losses than the Army Nurse Corps even though the smaller Army Nurse Corps cared for the largest population of beneficiaries in comparison to its sister services and had the fewest active duty assets to fill authorized deployment (Table of Organization and Equipment [TO&E]) positions. The few cognoscenti privately acknowledged that internal politics could have worsened the situation even further had Adams not battled to maintain nurse authorizations.[20] Most of the lost positions resulted from the closure of hospitals in Europe and the United States as a result of the Base Realignment and Closure (BRAC) Commission recommendations. This served to mitigate slightly the deleterious effect the drawdown could have on the delivery of health care.

Over time, however, even deeper, previously unimagined cuts loomed on the horizon, and Army Nurse Corps apprehensions intensified. Some predicted reductions of almost 30 percent by 1998. The reality was only slightly less alarming,

because by FY 1998 the budgeted year-end strength of the Army Nurse Corps fell to 3,405, a decrease of 1,171 authorizations, or about 26 percent from FY 1989 numbers.[21] Of all the AMEDD officer branches, the Dental Corps sustained the highest percentage of cuts, at 31 percent at this time, followed by the Army Nurse Corps at 26 percent and the Army Medical Specialist Corps with a 20 percent decrease.[22] The decrements threatened the Army Nurse Corps' ability to provide safe, quality care both on the field of combat and in the peacetime setting and also affected morale.

In the early 1990s, the Army contemplated the use of several measures to adjust its numbers to conform to declining strength authorizations and personnel fiscal constraints. These included limiting Army Nurse Corps accessions, restricting the numbers of officers who would be selected for career Voluntary Indefinite (VI) or Conditional Voluntary Indefinite (CVI) status, lowering the selection rate for promotions (meaning fewer promotions) convening yearly Selective Early Retirement Boards (SERBs) for senior officers, obtaining legislation for severance pay for specific officers who would voluntarily separate, and waiving the three-year lock-in for promotion requirement among lieutenant colonels and colonels.[23] To one degree or another, the Army Nurse Corps used all of these measures, along with the rest of the Army, to downsize its personnel base.

Limiting accessions to support the drawdown—an Army-wide concept—was pointless in the early 1990s because in FYs 1991 and 1992 the Army Nurse Corps failed to recruit enough new Army nurses to meet its recruiting goals.[24] Recruiters identified disparities between civilian wages and those paid to new second lieutenants as a primary cause for recruiting failures.[25] Perhaps because of the difficulties in recruiting direct accessions (fully educated and qualified registered nurses), the Army Nurse Corps shifted its emphasis to the accession of students, who incurred an obligation to serve by their participation in Army civilian education programs, such as Reserve Officers' Training Corps, the Army Nurse Candidate Program, and the AMEDD Enlisted Commissioning Program. In FY 1993, the Army Nurse Corps met its recruitment target of 580; however, projected accessions were lowered after that time as a consequence of the Army drawdown.[26] Accessions continued to decrease from FYs 1994 through 1998, totaling 497, 457, 310, 290, and 300, respectively. Retention of junior officers, however, was at a five-year high, which Adams considered an outcome of these officers' appreciation for the collective worth and vision of the Army Nurse Corps.[27]

During the 1990s, as the Army Nurse Corps recruiting mission decreased, the size of the recruiting force correspondingly diminished. In FY 1994, the director of Health Services Recruiting for the Army Medical Department, Colonel Sharon I. Richie, expected the recruiting mission for active duty Army Nurse Corps officers to fall by approximately 75 per year.[28] Consequently, the Army made plans to reduce the numbers of recruiters from 148 to about 88 recruiters, nurses, and support staff.[29]

On comparable issues, the Air Force Nurse Corps (AFNC) presented a somewhat divergent picture. In FY 1992, the AFNC exceeded its recruitment goal

of 425 new accessions, but the specialties of those recruited did not match the AFNC's requirements. For example, while the AFNC set a goal of recruiting 15 Certified Registered Nurse Anesthetists, it accessed only two. At the same time, the AFNC had only 71 percent of its requirements for Certified Registered Nurse Anesthetists. The AFNC also hoped to recruit pediatric and obstetrics/gynecology nurse practitioners but here again accessions failed to meet its expectations. The entire AFNC's retention rate also slipped during FY 1992. In response, Air Force nurse leaders planned to implement a strategic marketing plan to help improve the retention of quality, career-oriented professional nurses and reverse the unwelcome trend.[30] The Navy Nurse Corps picture also varied slightly from its sister services. From FY 1985 to FY 1991, the Navy Nurse Corps was unable to fill all its recruiting requirements. This state of affairs improved significantly in FY 1992, when the Navy fully met its recruitment goals and welcomed 400 new ensigns into the service.[31] The Navy achieved this about-face by expanding the numbers and increasing the types of scholarships to support nurse recruiting. They offered Health Sciences Collegiate Program scholarships, formerly restricted to Navy Medical Service Corps officers, to potential Navy nurses and augmented the numbers of Navy Reserve Officers' Training Corps scholarships. Additional incentives included specialty bonuses for nurse anesthetists and bonuses for new accessions.[32]

Another method to contribute to the drawdown involved reducing the selection rates of VI boards.[33] The Army intended this strategy to limit the numbers of junior officers who passed from their first obligated tours into VI career status. In FYs 1994 and 1995, VI selection rates were 85 percent and 60 percent, respectively. The 1996 VI board had a selection rate of only 35 percent. The remaining 65 percent of those requesting consideration by the board for VI, but passed over, were involuntarily released from the Army Nurse Corps. The 1997 board had equally stringent guidelines replicating the 35 percent selection rate. This harsh process cost the Army many fine junior officers with excellent potential. Many nurses felt betrayed and frustrated because they could no longer have an Army career. A few transferred their commissions to other federal nursing services.[34] The dismal and demoralizing VI board results were better in 1998 when the targeted selection rate rose to 49 percent.[35] In 1999, the selection rate doubled to 98 percent and the Army Nurse Corps leadership declared that the drawdown was completed, signaling the end of a particularly painful era of Army Nurse Corps history.[36]

The SERBs took place annually from 1992 to 1995, resulting in the involuntary retirement of a small number of senior officers. In FYs 1992 through 1994, for example, 12 Army Nurse Corps colonels were SERBed annually. In FYs 1993 and 1994, 33 and 23 lieutenant colonels also were SERBed.[37] The AMEDD planned a SERB that would involve Army Nurse Corps officers for FY 1998 as well but canceled it when sufficient officers voluntarily retired.[38]

The details of the SERB that met in December 1993 for FY 1994 offer a picture of the collective process. In a manner similar to promotion boards, the SERB convened to consider colonels, certain lieutenant colonels, and majors for involuntary

retirement.[39] The Army planned the numerical officer losses to size and shape year groups that would in part support the smaller Army Nurse Corps projected for FY 1996.[40] Those Army Nurse Corps officers selected by the FY 1994 SERB received a mandatory retirement date of 1 July 1994. Certain Army nurses holding critical specialties, such as anesthesia nursing, were exempt from the SERB involuntary retirement.[41] Although the number of those required to retire involuntarily was small, the impact of this initiative was enormous.

The SERB process had disturbing overtones both in its human dimensions and its effect on readiness.[42] Receiving notification of a pending SERB was shocking and painful for virtually all those selected and frequently carried unfounded negative connotations about the officer's career, contributions, and personal characteristics. In January 1993, when the Army Nurse Corps notified officers affected by the FY 1992 SERB, the leadership stressed the need for all Army nurses to maintain the confidentiality of the process, respect the individual's privacy, be sensitive about the gravity of the news, and support those involved when indicated.[43] Nonetheless, the aftereffects of all the SERBs were noticed. Institutional morale suffered and the process cast a pall over units with involuntarily retired officers. The focus of everyone's concern was the loss of the SERBed officers, the curtailment of working relationships, and the end of career dreams and confidence in the organization by everyone involved. The SERBs did bring the actual numbers into alignment with strength objectives and contributed to the rightsizing of the Army Nurse Corps.[44] The SERB also eliminated a number of senior officers who were less than effective. Without the SERB program, retained ineffective senior officers had the potential to tie up promotions, send a negative message to junior officers, and adversely affect the organization.[45] The SERB process did result in some positive effects but at a measurable cost to morale, trust, and unit cohesion.

Other avenues for officers to leave active duty also reduced Army Nurse Corps personnel numbers. One option was the 15-year retirement. Officers usually had to serve a minimum of 20 years to become eligible for full retirement benefits. The new program available in 1993 allowed those who had at least 15 years of active service to retire with reduced benefits. Eligible officers had to be serving in the grade of captain through colonel and meet certain criteria to take advantage of the program.[46] By October 1993, 31 officers had requested retirement from active duty under this program. One anesthetist applied for the early retirement but was denied.[47] The early retirement option continued for several years. By 1997, the Army Nurse Corps assigned priority for approval of the 15-year retirement to majors and lieutenant colonels not selected for promotion. All other majors and lieutenant colonels with at least 15 years of service also could apply on a first-come, first-served basis.[48]

By FY 1994, it was clear that the Army Nurse Corps needed to reduce its strength in the company grade levels, that is, the ranks of lieutenant and captain. To achieve this objective, the Army offered monetary Voluntary Separation Incentives and the Special Separation Benefit to certain Army Nurse Corps officers to encourage them to leave active duty.[49] One of the criteria was that eligible officers

had to have more than six but fewer than 20 years of active service, with five of those years continuous service prior to separation. Army nurses passed over by the selection board that considered them for VI career status were among those eligible to apply for the bonus. Also, the Voluntary Separation Incentive Program targeted captains who were passed over one time for promotion to major. By April 1994, 22 Army Nurse Corps officers took advantage of the Voluntary Separation Incentive Program, and the Army expected 128 more applications before the program expired on 15 June 1994. The Army Nurse Corps used this initiative to rightsize its force structure and to provide "a compassionate system" that facilitated Army nurses' departure from the service, allowing them to enter the civilian job market with some financial security.[50]

The Army staff repeatedly proposed the unacceptable alternative of replacing more Army nurses with civilian nurses and converting the existing Army Nurse Corps authorizations to positions in the combat arms. Army Nurse Corps leaders regularly rejected this idea, believing that it threatened to degrade overall unit readiness.[51] Furthermore, the Army was having problems filling the authorizations it currently had for civilian nurses. In 1992, for instance, the civilian nurse vacancy rate exceeded 24 percent. At the same time, civilian nurse authorizations comprised about 40 percent of the peacetime nurse strength in the Army. In spite of several liberal programs that authorized special salaries, greater positional authority, and educational benefits, civilian nurses seemed uninterested in Army employment in the 1990s.[52] Further complicating the picture was the fact that an unknown number of civil service nurses also were reservists, which represented another threat to readiness.[53] By 1996, the picture became bleaker because civilian nurses accounted for even more—50 percent—of the Army's total nursing assets. Yet by 1997, the Army staff inexplicably planned a 32 percent reduction of civilian nurses. When viewed together with the proposed 30 percent reduction in numbers of Army Nurse Corps officers by 1998, questions arose whether there would be sufficient personnel resources to support the "redesigned, resource-efficient, wellness focused health care delivery system."[54] Simply put, conditions were approaching the point where the level of readiness as well as the delivery of safe health care services was open to serious question.

The large-scale drawdown of the 1990s created unexpected consequences of enormous proportions. It cast grave doubts about the AMEDD's capacity to field successfully the most effective medical forces to support future medical operations in foreign lands, either combat missions or Operations Other Than War. It created uncertainties about the AMEDD's ability to provide health care for its large group of beneficiaries in the United States and overseas installations.[55] Numerous other undesirable repercussions with implications for force readiness are thought to follow large-scale organizational downsizing.[56] Typically, the members of the affected organization demonstrate plummeting morale, a dulling of initiative, more guarded behavior, and an overall risk avoidance. Loyalty to the organization suffers, productivity drops, recruiting becomes onerous, public image tarnishes, and stress-related symptoms proliferate.[57]

When rumors of downsizing spread in the late 1980s, individual Army nurses felt threatened by the potential loss of their jobs and their accustomed Army way of life. Army Nurse Corps leaders sought to allay fears across every echelon of the Corps.[58] By 1995, the drawdown was creating even greater tensions within the ranks of Army Nurse Corps officers. Incoming chief of the Army Nurse Corps, Brigadier General Bettye Simmons, and her assistant, Colonel Susan McCall, implemented a transition survey and polled a sample of Army nurses and noncommissioned officers. The results confirmed that the ongoing drawdown was the most important and most frequently identified concern of 33 percent of the study sample. Many thought its effects carried over to the clinical setting. Numerous survey participants articulated the belief that the drawdown had negatively impacted patient care, while others asserted that they were short-staffed and rarely had the time or opportunity to mentor junior staff. The respondents expressed the feeling that the Army considered them expendable cogs and that they were approaching the breaking point of no longer being able to "do more with less." Others commented that even outstanding officers had doubts that they could advance in their Army careers. Still others believed that the Army Nurse Corps had degenerated into a cutthroat operation. One officer observed that the downsizing did not promote the retention of the best and the brightest soldiers. Neither did it increase productivity. Instead, it fostered an atmosphere of detrimental competition and a stressful working climate.[59]

Nurses, their fellow officers and coworkers, and their patients all tried to cope with the stress engendered by the drawdown. Some used euphemisms to put a positive spin on the cuts, referring not to the "drawdown" or "downsizing" but to "rightsizing," "force sculpting," or "force tailoring." Others used black humor, labeling the "downsizing" as a "capsizing." Some coped by openly acknowledging their pending involuntary retirement status, focusing on their work and staff responsibilities, or planning for their future career or family obligations. Social support, in the form of encouragement and assistance from peers and family, facilitated the adaptation process. Many found sustenance in spirituality or by framing their involuntary retirement with various philosophical attitudes and approaches.[60]

With the dawning of 1998, Simmons announced that the Corps had successfully met its downsizing targets, although the accomplishment was fraught with "uncertainty, professional challenges and disappointments and hard decisions."[61] She added that "the chaos and turmoil" were "a reflection of the shift in national priorities" and the upheaval in the country's health care system and acknowledged that the drawdown had been "personally hurtful to many." Simmons called for a fresh start, observing that "it is now time to dust ourselves off and move into the new year."[62]

In a complementary approach to the personnel drawdown, DoD also implemented the mandates of the BRAC Commission to further decrease infrastructure costs. Political appointees of the BRAC Commission recommended various base closures and adjustments and forwarded them to DoD. The secretary of defense

then released to the president and Congress the list of facilities to be closed, realigned, disbanded, or relocated. Congress reserved final approval authority for the BRAC lists and had to either accept or reject the secretary's recommendations in their entirety.[63]

Consistent with the new doctrine of posting fewer troops overseas and emphasizing regional deployability, the U.S. Army, Europe (USAREUR), instituted significant reductions. From September 1991, the end of Desert Storm, to 30 September 1994, USAREUR planned a reduction of troop strength from 214,000 to 92,200 personnel.[64] Although the Army cut almost 60 percent of its troops in Europe, USAREUR 7th Medical Command (MEDCOM) was to lose only about 40 percent of its personnel inventory.[65] As a part of the overall plan, however, a number of 7th MEDCOM facilities would close.

The BRAC Commission recommendations degraded the 5th General Hospital at Bad Cannstatt, near Stuttgart, Germany, to a clinic in the summer of 1992, and many of the 46 Army Nurse Corps officers assigned there were uneasy about their immediate future and concerned about their next assignments. Change and uncertainties were among the few constants.[66] Moreover, fears were not confined to Bad Cannstatt or to Army Nurse Corps officers. Civilian nurses, frequently spouses of military personnel assigned to Europe, also voiced their apprehensions. Many worried that they would be laid off without any warning.[67] By 1993, the BRAC Commission mandate closed Army hospitals at Bremerhaven and Augsberg, Germany, and Brussels, Belgium, or downgraded them to clinics, giving rise to similar concerns. Hospitals located in Nürnberg, Berlin, and Frankfurt, Germany, and Vicenza, Italy, also were scheduled for potential downgrading or closure. TO&E units faced comparable uncertainties. The 128th and 32nd Combat Support Hospitals (CSHs) were pegged to deactivate in November 1991. The 30th Medical Group would cease operations in January 1992.[68] By the fall of 1993, the 502nd Mobile Army Surgical Hospital (MASH) would be shuttered.[69] Whether going through closure or radical alterations, the staff of all these units lived with ambiguity and uncertainty in their personal and professional lives.

The few hospitals that remained in Europe underwent a transition from TO&E units with Table of Distribution and Allowances (TDA) augmentation to the configuration of CSHs.[70] The drive to improve readiness was the impetus for this large-scale transformation. By 1998, the Army wanted all its TDA assets to be unequivocally related to the TO&E either through the Professional Officer Filler System or the U.S. Army Forces Command (FORSCOM) Nurse Programs.[71] Medical Force 2000 doctrine guided this transition, intending to make hospital TO&E units more mobile and deployable. The restructuring of field medical support was an outcome of lessons learned during Operation Desert Shield/Operation Desert Storm.[72] Accordingly, the Nürnberg Medical Department Activity (MEDDAC), formerly the 98th General Hospital, became the 3rd CSH, staffed with nurses who were assigned based only on mobilization areas of concentration.[73] This raised the question of who would provide care for the existing specialty cases, such as maternal-child patients, represented in the statistic of an average

of 42 births monthly.[74] Army nurses with the medical-surgical specialty doubtless stepped in to fill the void and likely some had a background and experience in the required specialties. Several years later, the Nürnberg hospital closed permanently. Another facility undergoing transformation was the Frankfurt Army Regional Medical Center, formerly the 97th General Hospital, which became the 51st CSH. It, too, subsequently closed. The Würzburg MEDDAC merged into the 67th CSH.[75] At Heidelberg, the 95th CSH was integrated into the existing MEDDAC.[76] The Landstuhl Army Regional Medical Center, previously the 2nd General Hospital, remained a fixed facility and the only Medical Center in Europe. The first of a group of 288 Air Force personnel augmented the Landstuhl Army Regional Medical Center staff in April 1993, and it became known as Landstuhl Regional Medical Center.[77]

As of 1997, three fixed hospitals and 29 health clinics remained in Germany, Italy, or Belgium. Many Army Nurse Corps officers assigned to Europe had dual responsibilities and divided their duty time between fixed medical facilities and TO&E units. Army nurses assigned to the 212th MASH at Wiesbaden, Germany, for example, filled positions at the Heidelberg hospital when not deployed or participating in training. Similarly, Army nurses of the 67th CSH worked at the Würzberg MEDDAC. A contingency plan, Operation Backbone, stipulated the process for maintaining fixed facility operations when the TO&E staff deployed. It identified backfill requirements by rank and specialty when staff deployments with their TO&E units exceeded two weeks. The Army implemented Operation Backbone in 1995 and again in 1996, when it mobilized hundreds of reservists from across the United States for 140-day rotations to backfill the Landstuhl Regional Medical Center, the Würzberg MEDDAC, and the Heidelberg hospital.[78]

Change likewise occurred in Korea and the 18th MEDCOM. The 121st Evacuation Hospital in Seoul continued to operate a 150-bed fixed facility that was expandable to 500 beds using Deployable Medical System equipment stored in country. The 43rd MASH, a TO&E unit whose mission was to provide far forward resuscitative surgery in support of the 2nd Infantry Division, retired its colors in March 1997. In its stead, the division activated the 127th and 135th Forward Surgical Teams (FSTs) to provide a far forward, rapidly deployable, urgent, initial surgical service. Both of these FSTs were attached to the 121st Evacuation Hospital. Two medical-surgical nurses, two nurse anesthetists, and an operating room nurse served on each team along with other AMEDD personnel.[79] Army Nurse Corps officers also were assigned to multiple roles in the 168th Medical Battalion. They provided ambulatory care in Troop Medical Clinics throughout the peninsula and were also chief nurses for headquarters support, A Company and B Company, answering to the 18th MEDCOM commander and chief nurse for administrative and clinical management of the Area Support Medical Companies. They were also principal nursing advisors to the company commanders. One Army Community Health Nurse was assigned to each company in the 168th Medical Battalion. Additionally, Camp Casey, 40 miles north of Seoul, was the worksite for a handful of Army nurses who supported 2nd Infantry Division soldiers. They served in

positions such as chief nursing consultant to the division surgeon, head nurse of the Camp Casey Troop Medical Clinic, obstetrics/gynecology nurse practitioner, or community health nurse.[80]

Other overseas installations also closed. The USA MEDDAC Panama, Gorgas Army Community Hospital, was inactivated in June 1997. This institution's roots reached back to 1882, when the French government opened a hospital on the same location. The French hospital later became the Ancon Hospital and then the Canal Commission Hospital. Finally, it became an Army hospital named in honor of Major William C. Gorgas, who eradicated yellow fever within the Panama Canal Zone from 1904 to 1914, making it feasible for Army engineers to construct the Panama Canal across the Isthmus of Panama.[81]

In addition, the BRAC Commission dictated that several major hospitals within the continental United States (CONUS) close. Throughout the 20th century, historic Letterman Army Medical Center, situated on the Presidio of San Francisco, remained a robust, busy hospital. At the turn of the century, it received and cared for soldiers evacuated from the Philippines during and after the Spanish-American War. It cared for sick and wounded soldiers who arrived from the Pacific theater during World War II. During the Vietnam era, it also provided care for many of that war's casualties. Early in the 1990s, the Army incrementally reduced the medical center into the 100-bed Letterman U.S. Army Hospital and later in June 1993 into clinic status. Letterman closed permanently on 31 July 1994, with all equipment and personnel departed by 30 September 1994. The hospital's mission, many of its specialty staff, and other personnel transferred to Madigan Army Medical Center in Tacoma, Washington, where a new facility had recently opened.

Throughout the dismantling process initiated by the BRAC Commission, the Letterman staff and patients faced enormous stress and uncertainties. Major problems were a seemingly perpetual dearth of information from higher authorities, reduced ability to provide a diverse range of required patient services, and the need to carry on daily operations and maintain quality of care vis-à-vis a steadily diminishing level of administrative and logistical support. Another challenge was the accelerated departure of civilian employees. Once closure became a certainty, the civil service staff—as could be expected—sought other jobs, promptly leaving the organization as soon as alternative positions became available in the civilian community. In normal situations, the civilian force exerted a stabilizing effect. But these were unusual times and the military staff of Letterman quickly discovered that in a BRAC situation, the exodus of the civilian workforce further undermined already declining operations and contributed to the sense of anxiety and confusion. To cope with the evolving organizational change, the hospital contracted with a group of management consultants who worked with the staff on a regular basis.[82]

Faced with the pending dissolution at Letterman, nursing staff also conducted strategic planning to facilitate transition and ease the pain of shutting down the institution and terminating its services. Most of the beneficiaries who received their care at Letterman were retired personnel and their families, over 65 years of age,

and eligible for Medicare. Many had multiple health problems. To complicate matters, a significant number of beneficiaries had failed to sign up for Medicare Part B, which generally compensated for outpatient care, when they were first eligible. The Letterman staff exerted significant efforts to negotiate inclusion in Medicare Part B for these beneficiaries, allowing them to enroll without incurring a financial penalty for their late applications. In addition, the staff devoted much time and energy in referring these beneficiaries to suitable civilian health care providers.[83]

The 1995 BRAC Commission recommendations also directed that Fitzsimons Army Medical Center in Aurora, Colorado, close its doors primarily because there was no longer a major Army presence in the area. Significant pain resulted. The pre-World War I facility, designated for many years as a tuberculosis treatment center in the first half of the 20th century, downgraded into a clinic in June 1996 and closed entirely soon thereafter. The 14 tenant units on the grounds realigned to other existing locations. The only remaining Army elements were 11 reserve units housed in the McWethy Reserve Center. The 50,000 to 70,000 military retirees who formerly received health care at the hospital felt bitter, disillusioned, and abandoned by the military that had promised retirees free medical benefits for life.[84] After the AMEDD's almost total departure from the Fitzsimons grounds, the University of Colorado Health Science Center created a bioscience research park in its place.[85] In 2004, the educational institution opened the Anschutz Inpatient Pavilion, a state-of-the-art hospital facility, on the former Fitzsimons Army Medical Center site.[86]

Other facilities faced inactivation as a result of the BRAC process. Noble Army Community Hospital at Fort McClellan, Alabama, closed. Additionally, Kimbrough Army Community Hospital at Fort Meade, Maryland, and Kenner Army Community Hospital at Fort Lee, Virginia, downgraded to clinic status.[87] Cutler Army Community Hospital at Fort Devens, Massachusetts, claiming 75 years of service to the nation, also closed.[88] Furthermore, TO&E hospitals within CONUS were not exempt from the downsizing. In September 1993, the Army inactivated the 8th Evacuation Hospital at Fort Ord, California.[89] The 93rd Evacuation Hospital at Fort Leonard Wood, Missouri, the 42nd Field Hospital at Fort Knox, Kentucky, and the 46th Combat Support Hospital at Fort Devens, Massachusetts, also closed in FY 1994.[90] During the summer of 1995, the 16th MASH at Fort Riley, Kansas, and the 2nd MASH at Fort Benning, Georgia, cased their colors.[91]

In 1998, the surgeon general noted that of 168 field hospitals existing in 1990—both active and reserve—only 52 remained. He expected that number to drop even further in the future.[92] The numbers of fixed TDA facilities—both overseas and within the United States—fell from 49 in 1988, 14 outside of CONUS and 35 within CONUS, to 27 by 1999, with five overseas and 22 within CONUS.[93]

The long-term effects of the drawdown of the 1990s remain unclear. Nonetheless, several of the readiness concerns articulated in May 1994 by Brigadier General Dorothy Pocklington, the first female and nurse to be promoted to brigadier general in the U.S. Army Reserve (USAR), seemed prophetic. When discuss-

ing readiness, she observed that "a lot of things may not be in place before the next major conflict begins" and optimistically hoped that the situation would not adversely impact on recruitment and retention. Pocklington added that with the downsizing of the active component and the increased dependence on the reserves and National Guard, retention would be adversely affected if the USAR and Army National Guard units were repeatedly mobilized.[94]

In the time frame that commenced in the aftermath of the Cold War, serious challenges, critical issues, and thorny dilemmas proliferated. Chief among these were the draconian cuts levied on the Army Nurse Corps, making it difficult—if not virtually impossible—to provide safe, quality care. Fortunately, the three chiefs of the Corps who sequentially served in these troubled times were equal to the task.

Brigadier General Nancy R. Adams became the 19th chief of the Army Nurse Corps in November 1991 and led the Corps for four challenging years until December 1995. Before this most senior leadership role, she served as Army Nurse Corps consultant and previously was chief nurse of the Frankfurt Regional Army Medical Center in Germany. Colonel Terris E. Kennedy served as Adams' assistant chief of the Corps.

During her tenure, Adams assumed various roles and responsibilities. In the first months of her administration, she held three positions, serving as chief of the Corps, the assistant surgeon general for nursing, and director of AMEDD Personnel. In the summer of 1994 she assumed command of the U.S. Army Center for Health Promotion and Preventive Medicine at Edgewood Arsenal, Maryland.

Adams' contributions were many and diverse. She developed a conceptual model of Army nursing practice that optimized the role of the advanced practice nurse in clinical case management and managed care. She encouraged individual Army nurses to design and implement innovative programs and processes that resulted in significant cost avoidance, better access to care, and improved quality of care. She took the lead with Kennedy's assistance to revamp the face of nursing research in the Army, supporting the TriService Nursing Research program, restructuring the organization of nursing research into local regions with imbedded consultants, assigning officers to the Medical Research and Materiel Command to manage the multimillion-dollar Breast Cancer Research Program, creating the Persian Gulf War Illness Task Force to add clinical input and media coordination, and instituting research fellowships at the Walter Reed Army Institute of Research. She furnished nursing informatics experts to work on the development of clinical information systems within DoD. Adams adopted a proactive approach to the USAR and Army National Guard components. She assigned regional training coordinators who integrated and scheduled unit training that improved care in military treatment facilities, enhanced readiness, and led to the establishment of recognized Active, Guard, Reserve positions within the Health Service Support Areas. Adams also worked tirelessly to minimize and mitigate the loss of Army Nurse Corps authorizations within the context of a massive Army drawdown. In 1995, she assumed command of the Southwest Health Service Sup-

Pictured is Brigadier General Nancy R. Adams, who served as the 19th Chief of the Army Nurse Corps from 1991 to 1995.
Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

port Area and later command of the William Beaumont Army Medical Center. In 1998, the president of the United States nominated Adams for promotion to major general, a first for an Army Nurse Corps officer. She then assumed command of Tripler Army Medical Center and the Pacific Regional Medical Command. She also served as command surgeon of the U.S. Army, Pacific. Adams retired from active duty in 2002.

Following her retirement, she served in the Senior Executive Service in Aurora, Colorado, as senior advisor to the director of TRICARE management activity. She subsequently accepted an appointment as regional director for the TRICARE North Regional Office in Falls Church, Virginia.

The 20th chief of the Army Nurse Corps was Brigadier General Bettye H. Simmons. She served in this most senior leadership position from December 1995 to January 2000. Before her selection as chief of the Corps, Simmons discharged the responsibilities of chief nurse, U.S. Army Medical Command, and filled the role of consultant to the Army surgeon general for nursing administration. Previous to these assignments, she was chief nurse at the U.S. Army MEDDAC, Fort Polk, Louisiana. Colonel Susan C. McCall was Simmons' assistant chief of the Corps from November 1995 to September 1998. Following McCall's retirement, the assistant chief's position remained vacant for more than a year.

When Simmons assumed her duties as chief of the Army Nurse Corps, the surgeon general simultaneously directed her to fill the position of deputy commandant of the AMEDD Center and School at Fort Sam Houston, Texas, with San Antonio, Texas, being the location of her principal office. McCall's office, however, remained within the National Capital Region at Fort Belvoir, Virginia. Some 18 months later, Simmons departed from Fort Sam Houston and reported in to Fort McPherson, Georgia, to become the command surgeon of FORSCOM. Two years later, she completed her tour of duty as FORSCOM command surgeon and assumed command of the U.S. Army Center for Health Promotion and Preventive Medicine.

As chief of the Army Nurse Corps, Simmons left a significant legacy. She created a managed loss plan designed to reduce corps strength to mandated numbers with the least possible adverse influence on mission accomplishment. Simmons also used a variety of strategies to enhance relationships and build a cohesive team of enlisted medics, licensed military practical nurses, and professional nurses in the Army. She presided over a revamp of the Army Nurse Corps specialty mix, implementing an Emergency Nurse Course to improve combat nursing skills, and combined the four specialties of nurse practitioner roles into one generalist nurse practitioner, the family nurse practitioner, thereby providing a flexible health care provider for virtually every patient population in almost any contingency. Simmons collaborated with the reserve components to craft a postdeployment medical care package that employed nurse case managers with physician support to triage injured soldiers to the proper level of care before demobilization. She also sponsored an Active Component/Reserve Component Chief Nurse Strategic Planning Summit that convened to develop a long-range plan to drive future Active

Pictured is Brigadier General Bettye H. Simmons, who served as the 20th Chief of the Army Nurse Corps from 1995 to 2000.
Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

Pictured is Brigadier General William T. Bester, who served as the 21st Chief of the Army Nurse Corps from 2000 to 2004.
Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

Component/Reserve Component initiatives. Simmons retired from active duty in January 2000 and became the director of the Leadership Institute at Hampton University in Norfolk, Virginia.

Brigadier General William T. Bester succeeded Simmons as the 21st chief of the Army Nurse Corps, serving in this role from 2000 to 2004. Bester was the first male Army Nurse Corps officer to hold this position in the century-long history of the Army Nurse Corps. Colonel Deborah Gustke served as the assistant chief of the Army Nurse Corps and simultaneously as the Corps-specific branch proponency officer at the AMEDD Center and School at Fort Sam Houston, Texas, at this time. Before becoming chief of the Army Nurse Corps, Bester served as advance party commander when deploying to Taszar, Hungary, in support of Operation Joint Endeavor. For the 60 days before his departure from that theater of operations, he functioned as the Medical Task Force commander, shouldering responsibility for all medical assets in Hungary and Croatia. Immediately before his selection as chief of the Corps, he commanded Moncrief Army Community Hospital at Fort Jackson, South Carolina.

Upon selecting Bester to be chief, Army Nurse Corps, the surgeon general simultaneously assigned him as the assistant surgeon general for force projection and deputy chief of staff for operations, health policy, and services, with an office in the Pentagon. In the spring of 2002, he left these positions and assumed command of the U.S. Army Center for Health Promotion and Preventive Medicine.

While chief of the Army Nurse Corps, Bester faced the challenge of recruiting and retaining adequate numbers of Army nurses while the nation was undergoing a severe nursing shortage. He marshaled an array of initiatives such as the critical skills retention bonus for nurse anesthetists and operating room nurses and the $18 million Health Loan Repayment Program for the accession and retention of Army nurses with six to 96 months of active duty service. He championed expanding Reserve Officers' Training Corps scholarships for nurses to almost 200 colleges and universities nationwide and enlarged the Army Enlisted Commissioning Program for Nursing from 55 to 75 slots. Bester sought and obtained congressional approval for direct hire authority for civilian registered nurses, reducing the length of the hiring process from an average of 101 to 21 days.

Bester retired from active duty in March 2004. Following his retirement, he accepted a faculty position at the University of Texas at Austin, teaching both undergraduate and graduate students. Still later he joined the staff of the Graduate School of Nursing at USUHS.

Notes

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3. Jerry Harben, "Commander Draws Up Blue Print for '97," The Mercury 24 (January 1997): 3.

4. "Statement by Brigadier General Nancy R. Adams, Chief of the Army Nurse Corps, before the Subcommittee on Defense, Committee on Appropriations, United States Senate, 2nd Session, 103rd Congress, Health Services and Infrastructure," 2, 14 April 1994; and "Statement by Brigadier General Bettye H. Simmons, Chief, Army Nurse Corps, Army Medical Department, before the Subcommittee on Defense, Committee on Appropriations, United States Senate, 2nd Session, 104th Congress, DoD Health Care Programs," 2, 5 June 1996 (both in ANCC, OMH).

5. Gordon R. Sullivan, "Total Army, Total Victory," Typewritten Address presented to Eisenhower Luncheon, Annual Meeting of AUSA, Washington, D.C., 15 October 1991. Gordon R. Sullivan, "The Return to History," Typewritten Address presented to National Security Seminar, U.S. Army War College, Carlisle Barracks, PA, 1 June 1992. Gordon R. Sullivan, Untitled Typewritten Address presented to Army Session Luncheon, ROA Mid-Winter Conference, Washington, D.C., 21 January 1992. Gordon R. Sullivan, *America's Army, Into the Twenty-First Century* (Cambridge, MA: Fletcher School of Law and Diplomacy, Tufts University, 1993). Army Initiatives Group, Office of the Deputy Chief of Staff for Operations and Plans, "State of America's Army on its 218th Birthday," Printed Report, 1993. Laurence Jolidon, "Military, Clinton at Odds," *USA Today* (8 February 1993): 4. Stephen Conley, "Downsizing the U.S. Military," *USA Today* (8 February 1993): 4. Gordon R. Sullivan, America's Army (Cambridge, MA: Institute for Foreign Policy Analysis, 1993). Edward D. Martin, "Danger, Opportunity Challenge for DoD," *U.S. Medicine* 30 (January 1994): 7–8. "Military Operations, Force XXI Operations, A Concept for the Evolution of Full-Dimensional Operations for the Strategic Army of the Early Twenty-First Century," TRADDOC Pam 525-5, 1 August 1994. Mark Newell, "Force XXI, A Revolution

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14. Enrique Mendez, "Implementation of the Coordinated Care Program," Memorandum, 8 January 1992; Assistant Secretary of Defense (Health Affairs), "Coordinated Care Program," Printed Document, 8 January 1992; Frank F. Ledford, "Implementation of the Coordinated Care Program," Action Memorandum, 8 April 1992; and "Outlook for Coordinated Care," n.d., Enclosure 5, in Memo from the Chief, Army Nurse Corps (January 1993) (all in ANCC, OMH). Bonnie M. Jennings, "Nursing Implications of the Department of Defense Coordinated Care Program," *Military Medicine* 158 (December 1993): 823–27. Dwight D. Oland and David W. Hogan, *Department of Army Historical Summary Fiscal Year 1992* (Washington, DC: Center of Military History, United States Army, 2001), 170–71.

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and attended an AMA-sponsored session at the Drake Hotel. Hudock wrote, "We effectively distanced ourselves from this proposal and supported the ANA position." Hudock added that he and the USAF chief "articulated that 'medics' were trained, supervised, and evaluated by Professional Nurses, not physicians (or others). Medics practiced under our license—end of case." John Hudock to Author, Handwritten Notes, 1, 5 July 2005, ANCC, OMH.

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22. In a decreasing order of reductions, the Medical Corps and Medical Service Corps sustained losses of 19 percent each. The Veterinary Corps and Physician Assistants each decreased by 10 percent. "AMEDD Manpower/Personnel Drawdown," 7, Briefing Slides presented to MSC Commanders, 12 February 1998, Box 455, OTSG/Medical Command, OMH.

23. Lowering the selection rate resulted in more pass-overs. A pass-over occurred when a board failed to select an officer for promotion. Officers who had two successive pass-overs were mandated to separate from the service with some severance pay. Usually an

officer had to serve in grade for three years in order to retire in that grade. For instance, if a lieutenant colonel wanted to retire and receive lieutenant colonel retirement pay, she would had to have been promoted to lieutenant colonel three years prior to her retirement date. Tom Wilson, "Officer Force Reductions in the Future," Officers' Call (January–February 1990): 19–21. "Personnel Boss Foresees Force Outs," *HSC Mercury* 19 (October 1991): 1. LTC Kitsopoulos, "AMEDD Selective Early Retirement Boards, FY94," Information Paper, 4 May 1993, ANCC, OMH. Jim Tice, "Medical Dept. Begins Its Officer Drawdown," *Army Times* 58 (2 March 1998): 5. Dwight D. Oland and David W. Hogan, *Department of Army Historical Summary Fiscal Year 1992* (Washington, DC: Center of Military History, United States Army, 2001), 117–19.

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26. "Army Nurse Corps Branch Briefing," Briefing Slides, October 1997, ANCC, OMH.

27. "Statement by Brigadier General Nancy R. Adams, Chief of the Army Nurse Corps, Army Medical Department, before the Subcommittee on Defense, Committee on Appropriations, United States Senate, 1st Session, 103rd Congress, DOD Medical Programs," 1, 5 May 1993; Theresa M. Tominey for Sharon I. Richie, "Congressional Testimony," Memorandum for PAE, 1, 22 April 1993; and "Army Nurse Corps Branch Briefing," Briefing Slides, October 1997 (all in ANCC, OMH).

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29. Theresa M. Tominey for Sharon I. Richie, "Congressional Testimony," Memorandum for PAE, 2, 22 April 1993, ANCC, OMH.

30. "Statement of Brigadier General Sue E. Turner, Director, Nursing Services, Air Force Nurse Corps," Draft Copy of Testimony, n.d., ANCC, OMH.

31. Draft copy of testimony presented by RADM Stratton to Congress, n.d., ANCC, OMH.

32. Jan K. Herman to Author, 6 September 2005; and Jan K. Herman to Author, 7 September 2005 (both E-mail Correspondence, ANCC, OMH).

33. VI was a level of officer career status that followed an obligated tour but preceded Regular Army status. Several years after VI became available, Conditional Voluntary Indefinite (CVI) became a preliminary option conferred before VI status. A board selected Army nurses for VI, and the number chosen was "dependent upon how many vacancies recruiting would not be able to fill." CVI evolved into being the Army Nurse Corps' "way of hedging [its] bets about candidates who were not the most stellar performers." It also was a bolt hole for officers who "were only staying in to see if they could get a certain assignment or if they were applying for specialty training/school." Darlene McLeod to Author, E-mail Correspondence, 12 June 2003, Army Nurse Corps Archives, OMH. For a while, an officer had to be in CVI status before applying for VI. Later, however, certain officers could apply directly for VI. Gail Croy to Author, E-mail Correspondence, 29 July 2003, Army Nurse

Corps Archives, OMH.

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35. Carolyn Bulliner, "PERSCOM Update," *The Army Nursing Newsletter* (January 1998): 2, ANCC, OMH

36. Carolyn Bulliner, "PERSCOM Update," *The Army Nursing Newsletter* (December 1998): 2, ANCC, OMH.

37. Michael J. Foster, "Minutes of the Army Nurse Corps Staff Meeting on 6 October 1993," Memorandum for Record, 5, 14 October 1993; "SERB History, AN," and "SERB History, AMEDD," n.d., Presentation Slides attached to "Statement by Brigadier General Nancy R. Adams, Chief of the Army Nurse Corps, before the Subcommittee on Defense, Committee on Appropriations, United States Senate, 2nd Session, 103rd Congress, Health Services and Infrastructure," 14 April 1994; and Michele Kohl, "PERSCOM Update," Memo from the Chief, Army Nurse Corps (1 September 1997): 2 (all in ANCC, OMH). Deborah Funk, "Medical Dept. Under Drawdown Fire," *Army Times* 58 (1 September 1997): 3. Jim Tice, "Medical Dept. Begins Its Officer Drawdown," *Army Times* 58 (2 March 1998): 5. Dwight D. Oland and David W. Hogan, *Department of Army Historical Summary Fiscal Year 1992* (Washington, DC: Center of Military History, United States Army, 2001), 129.

38. Jerry Harben, "Some MC, NC, MSC Officers Face SERB," *The Mercury* 24 (September 1996): 1. Tranette Ledford, "Medical Officer Drawdown Gets Reprieve," *Army Times* 58 (12 January 1998): 3.

39. The lieutenant colonels and majors considered by the SERB had been passed over or nonselected for promotion to the next grade.

40. A year group was a collection of due course officers whose entry date on active duty occurred within the same fiscal year. The officers were sorted into year groups as a way of managing promotions and other board actions. Jennifer L. Petersen to Author, E-mail Correspondence, 30 January 2004, ANCC, OMH.

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