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AIR UNIVERSITY

THE HISTORY OF THE AIR FORCE NURSE COPRS  
FROM 1984 TO 1998  
A RESEARCH PAPER

By

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A Research Report Submitted to the Faculty

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## *Preface*

This research project describes some of the major influences that have shaped the United States Air Force (USAF) Nurse Corps (NC). Part one reviewed the beginning of the Air Force Nurse Corps until 1968 and was completed in April 1998 by Colonel Jill V. Baker, USAF, NC, as her research project for Air War College. Lieutenant Colonel Melissa Rank, USAF, NC will complete part two in April 1999 as her Air War College project, examining 1969 through 1983. This project is part three and examines 1984 through 1998. A history of the Air Force NC has not been completed in the past and these three projects, when combined, will illustrate the progress the NC has made within the Air Force.

Thanks are in order for Dr. James Nanney, USAF Historian, and Lieutenant Colonel Linda Kisner, USAF, NC, both of Bolling Air Force Base, D.C, for their patience and assistance in answering my many calls for information. The Air University Historical Research Agency staff were extremely helpful in pulling needed documents from the archives, many times on a moments notice. With their assistance, this project was made possible. I also thank Dr. James Mowbray, my research advisor, for his patience in reading and rereading this project until its completion.

I hope Air Force nurses review all three parts of this historical documentation and reflect back on their personal contributions to the United States Air Force Nurse Corps.

Whatever the role, the contributions of all nurses have left a mark in the history of the Nurse Corps and are something we should all be proud of.

*Abstract*

The purpose of this research is to explore factors that influenced the development of the United States Air Force Nurse Corps from 1984 through 1998. The main research documents were the Annual and Semi-Annual Reports from the United States Air Force Surgeon General's office for the time period. A chronology of important Nurse Corps accomplishments has been delineated in Appendix A. From this chronology, four main influences were determined. They were the nursing shortage and retention challenge, participation in Operation DESERT SHIELD/DESERT STORM, participation in Military Operations Other Than War, and the transition to the Objective Medical Group. These four influences had a direct impact on the expansion of nursing opportunities in the Air Force. This chronology is the final part of a three part series conducted by fellow Air War College students. All three chronologies serve as a living document of United States Air Force Nurse Corps accomplishments upon which future accomplishments can be added.

## **Chapter 1**

### **Introduction**

The purpose of this research was to complete the chronology of historical events that influenced the United States Air Force Nurse Corps from 1984 through 1998. The historical chronology is delineated in Appendix A and is a living document to also capture the accomplishments of nurses in the future. These events cover the tenure of the last four and current United States Air Force Chief Nurses. The chronology delineates events leading to the expansion of the role of nurses in the United States Air Force.

The chronology was developed from a complete review of the Annual and Semi-Annual United States Air Force Surgeon General's Office reports. Throughout the research, issues and initiatives were discussed during the year of their inception. Unfortunately, on numerous occasions, there was no follow-up in subsequent years to provide a status update. For this reason, a conclusion could not be drawn on many of the issues and initiatives discussed in this research document or in Appendix A.

The main themes throughout the chronology were then expanded upon in chapters two through five. These themes were the nursing shortage and retention challenges, participation in Operation DESERT SHIELD/DESERT STORM, participation in Military Operations Other Than War, and the transition to the Objective Medical Group.

Throughout the chronology, it was obvious that the role the United States Air Force Nurse Corps had expanded immensely. Nurses were no longer limited to the clinical or administrative “nursing” career paths within the walls of a medical treatment facility. Changes in the United States Air Force, and more specifically, the Air Force Medical Service as a whole over the last fourteen years, yielded a broader scope of practice for nurses. This role expansion included serving as the commander of military treatment facilities of all sizes and participating in medical operations all over the world.

## Chapter 2

### The Nursing Shortage and Retention Challenge

During the late 1970s and throughout the 1980s there was a national nursing shortage. The decline in nursing school enrollments led to severe nursing shortfalls within the civilian and Veterans Administration hospitals. The decline in nursing school enrollments was believed to be a result of the expansion of women's roles in the workplace. "Nursing has been a predominantly 'female' profession...more avenues are open to women than in the past, and they're going into other fields."<sup>1</sup> A few reasons cited for looking elsewhere for careers was that nursing pay scales were far beneath salaries of other fields and nursing shift work tended to be counter productive to a stable home life.

Initially, the Air Force was only affected by the shortage in certain specialty areas. New nurse graduates continued to enter the Air Force during the national shortage and approximately seventy percent remained in the service after their initial four-year commitment.<sup>2</sup> The Air Force guaranteed nurses a salary that grew with time in service, whereas civilian nurse salaries were capped at approximately \$27,000, no matter how many years' experience one had.<sup>3</sup> Although initial military nurse salaries were lower than their civilian counterpart's starting pay, it was perceived that the military benefits of job security, housing, and medical care made up the difference.

Clinical nurses continued to enter the Air Force because of the ability to change jobs every two to four years without losing seniority. An Air Force nurse could hold a variety of positions from a clinical nurse, administrative nurse, instructor, flight nurse, and today, squadron or group commander. Air Force nursing offered opportunities not available in the civilian sector such as advanced education, travel, greater professional autonomy and responsibility, a transferable retirement plan, freedom from emotional and financial pressures of medical malpractice insurance, and the ability to change locations within the continental United States and overseas.<sup>4</sup>

Air Force Nurse Corps (NC) active duty clinical nurse authorizations remained in the high ninety percentiles during the nursing shortage as illustrated in Figure 1. In 1986, the



**Figure 1. Nurse Corps Authorization Percents by Fiscal Year**

Air Force Reserve and the Air National Guard had ninety percent of its authorized peacetime positions filled. However, it is important to understand that overall authorized strength does not always equate to NC filled positions<sup>5</sup>, especially if there are shortages in certain specialty areas. For example, the NC may be authorized 2000 nurses overall, with 100 authorized nurse anesthetists. If the NC has 2000 nurses in the corps, one may

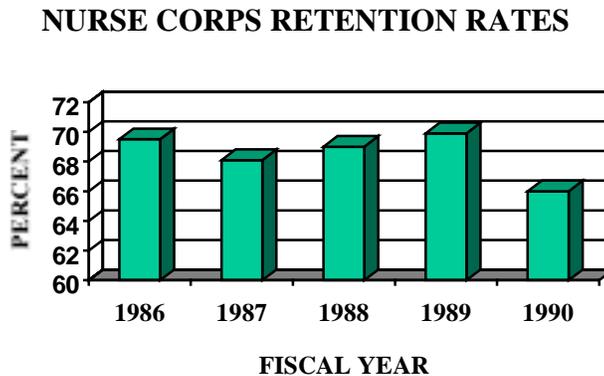
say it was fully manned. However, if the Nurse Corps (NC) only has 50 nurse anesthetists, there is an obvious shortage.

The active duty NC did indeed have a deficit of operating nurses, nurse anesthetists, nurse midwives, and Pediatric and Obstetrical/Gynecological Nurse Practitioners. However, the Air Force did not consider the problem serious enough to resort to special pay or bonuses in order to attract these specialty nurses into the Air Force NC during the early 1980s.<sup>6</sup>

Although military nursing accessions were down in 1984,<sup>7</sup> shortages were nowhere near those experienced in the civilian world.<sup>8</sup> Accessions were problematic in the specialty areas mentioned above, but clinical staff nurses remained stable. However, Brigadier General Carmelita Schimmenti, Chief, Air Force Nurse Corps, stated this shortage did affect the overall NC readiness status, and if the problem continued, the Air Force would be short 6,000 nurses if and when a war was to break out.<sup>9</sup> In 1986, the Federal Nursing Service Chiefs of both active duty and reserve components, the American Nurses Association, and the Office of the Assistant Secretary of Defense for Health Affairs discussed selective service registration of health care professionals to resolve identified wartime medical manpower deficiencies within the reserve components.<sup>10</sup> The research, however, did not indicate the outcome of these discussions.

The Air Force did not start feeling the nursing shortage until Fiscal Year 1988.<sup>11</sup> This was the first time a shortage was felt since the drawdown of the Vietnam War, during which time all military services experienced the same problem.<sup>12</sup> The military nursing shortage was not solely a result of decreased accessions. The nurse attrition rate upon completion of the initial commitment had increased. For this reason, in 1988

recruiters increased their goal to 700 nurses, the highest ever, to accommodate for the attrition rate. This goal was reached. Retention rates during the latter part of the 1980's are illustrated in Figure 2 below. As can be seen, the retention rate in 1990 dropped considerably. The research did not indicate a cause for this decrease in retention.



**Figure 2. Nurse Corps Retention Rates**

By 1988, the Air Force experienced low recruiting and higher attrition rates for reasons similar to those of the civilian sector; declining enrollment in nursing schools, the low starting salaries for civilian nurses, and expanded roles for women in the workforce which tended to offer higher salaries. An additional reason germane to the military was the reduction in join-spouse<sup>13</sup> assignments, where military husband and wife teams were moved to the same base within a reasonable time frame. This assignment process change was a result of budget constraints. Nurses did not want to be separated from their spouse for extended periods of time, especially with no guarantee they would be based together at the next assignment. As a result, nurses opted to separate.

The military nursing shortage led to the development of incentives to attract and retain quality nurses in hopes of defeating the wartime deficiency and the national

nursing shortage. Among the initial incentives were: 1) Continuing emphasis on a five-month nurse internship program for new nursing graduates in critical care and other specialties; 2) Increasing the number of Air Force Reserve Officer Training Candidate (ROTC) scholarships available to nursing students; 3) Upgrading specialty training for nurse anesthetists and nurse-midwives to the master's degree level; and 4) Developing programs which enabled enlisted medical technicians to earn nursing degrees.<sup>14</sup>

The Nurse Internship Program was established in 1978 to train new graduate nurses on the intricacies of being a nurse and to help them adapt to military life. The goal was to ease the transition from the theoretical classroom to real-life patient care responsibilities. Since it was harder to entice seasoned nurses into the Air Force, the nursing shortage led to an inexperienced Nurse Corps (NC), one not as experienced in the critical care areas as it was in the 1970s. The internship training program lessened the impact of this inexperience. Through the internship program, the Air Force was able to train its own nurses for numerous specialty areas. Studies also indicated that nurses who had gone through the Nurse Internship Program remained on active duty at higher rates than those who had not.<sup>15</sup>

The Nurse Internship Program was revamped in 1994 to increase the accession of new nurses. The Nurse Transition Program was a two and one half-month program, which assisted new nurses' transition into the Air Force. By decreasing the training time and keeping the nurses at the installation they trained at, the Air Force was able to double the number of nurses that were accessed without incurring the cost of permanent change of station moves.

Increasing Air Force ROTC scholarships from 50 to 65 was a positive incentive and all the Air Force ROTC nursing scholarships were filled.<sup>16</sup> Upgrading specialty courses to the master's level also was encouraging because the perception was that if nurses were able to obtain a masters degree subsequent to their specialty training, they would be more inclined to pursue specialty training. Certified Registered Nurse Anesthetists (CRNA) were the first group examined for the masters degree program with subsequent plans to look at midwives and nurse practitioners at a future date.

By June 1989, the Armed Forces Health Professionals Scholarship Program had been expanded to include fifteen CRNA scholarships.<sup>17</sup> September 1989 marked the beginning of the Masters in Nursing for Nurse Anesthesia at the University of Texas Health Science Center San Antonio School of Nursing. Another landmark accomplishment was the Congressional approval to implement a masters program for nurse practitioners at the Uniformed Services University of the Health Sciences, which began in November 1992.<sup>18</sup>

Enabling medical technicians to obtain an associate's degree in nursing and then selecting a few to go on for their bachelors degree and subsequent commissioning provided another pool from which to obtain nurses. A possible disadvantage of this option was that once the medical technicians obtained their associate's degree without officer status, they might be tempted to pursue a civilian career in nursing.<sup>19</sup>

Retention of CRNAs continued to be problematic throughout the entire time period examined. In late 1988, the retention problem was allegedly due to the perception that CRNAs were not getting a fair share of the promotions. Brigadier General Barbara A. Goodwin, then Chief, Air Force Nurse Corps, did not feel this was the problem.

Promotions were judged on a combination of job performance, professional education, a bachelor's degree to complement a registered nurse status, and professional military education. Brigadier General Goodwin felt nurse anesthetists were often not afforded the opportunity to go to classes due to work and on-call schedules. Couple this with the fact that in 1984, the bachelor's degree was waived for Certified Registered Nurse Anesthetists (CRNA) in hopes of attracting more into the Air Force. This made CRNAs less competitive for the field grade ranks when compared to peers. A remedy for this problem was to make the Air Force nurse anesthetist course a master's program. This program began in 1989.

A further deterrent to retaining nurses was the fact that in 1987, the Air Force allowed nurses with work experience and/or advanced degrees to enter the Air Force with more seniority than nurses who entered right out of nursing school.<sup>20</sup> The result was that militarily inexperienced, but clinically experienced, nurses outranked nurses with more time in the Air Force. In some cases, nurses dissatisfied with this policy chose to leave the Air Force, adding further to the nursing shortage.

Another option was implemented to combat the shortages across the board. This option increased the accession age of nurses to 48, adjusting rank and paygrades for education and experience. The previous age limit for nurses entering the Air Force was 35.<sup>21</sup> By raising the accession age, it was hoped that experienced nurses looking to further their careers after raising children would enter the Air Force, alleviating the shortage and thereby improving the Nurse Corps medical readiness stance. Today, the accession age is once again 35 due to the downsizing efforts that are in effect.

Although the age limit was raised, nurses over 40 who entered the Air Force were not eligible for retirement because they would be older than the mandatory 60-year-old retirement age prior to reaching their 20<sup>th</sup> year of service.<sup>22</sup> These nurses came on initial active duty as reserve officers and Regular status was initially not an option to them.

The National Defense Authorization Act of 1990 and 1991 allowed certain Reserve and Regular nurse officers, usually those in the shortage areas, to stay on active duty past the age of 67 if they received Secretary of the Air Force approval.<sup>23</sup> Opportunities for non-retirement eligible nurses were expanded in 1993 to include specialized training programs, Air Force Institute of Technology sponsored graduate education, and Professional Military Education in residence.<sup>24</sup> Flight School was opened to non-retirement eligible nurses in 1995.

Due to congressionally directed officer reductions, the Air Force Nurse Corps (NC) had to reduce its authorizations in the second half of the 1980's. These reductions were a result of the downsizing the Air Force was doing overall. The decision was made at this time to reduce the force through voluntary early release separations rather than through involuntary separations.<sup>25</sup> Because of this decision, the voluntary downsizing occurred at a gradual pace.

In the early 1990s, it appeared the accession problem had resolved on its own. The Air Force was able to recruit their quota of clinical nurses. That combined with the downsizing efforts underway left the Air Force NC in good standing with clinical nurses. However, the problem continued with the specialty areas of nurse anesthetists and Pediatric and Obstetrical/Gynecological Nurse Practitioners.

Several new incentives were established to combat the specialty nursing shortage and overall retention problems. These incentives were: 1) Field grade requirements were increased by 383 in September 1989; 2) Clinical career ladders were expanded for field grade nurses which ensured seasoned nurses were on duty for all shifts and which also increased promotion opportunities in the clinical arena; 3) An Incentive Special Pay was established for nurse anesthetists; 4) The masters programs for nurse midwifery and nurse anesthesia was implemented; 5) A streamlined charting system designed for manual and automated use was developed and implemented; 6) An automated system for patient care planning was approved for testing; 7) Work environments were evaluated and improved; and 8) The Workload Management System for Nursing, a patient classification tool which provided a standardized, valid, and reliable method for planning effective allocation and utilization of nurses on inpatient units, was developed.<sup>26</sup>

Another issue that effected retention was promotion rates for Nurse Corps (NC) officers. For many years, NC promotion rates lagged behind line-officer counterparts and officers within the Air Force Medical Service. The promotion rates for colonel and lieutenant colonel of the Medical Service Corps, the Biomedical Service Corps, and the Nurse Corps are illustrated in Figure 3 and Figure 4 respectively. Although nurses have increased their promotion potential over the last few years, it remains obvious that nurses continue to lag behind their medical peers.

### COLONEL PROMOTION RATES

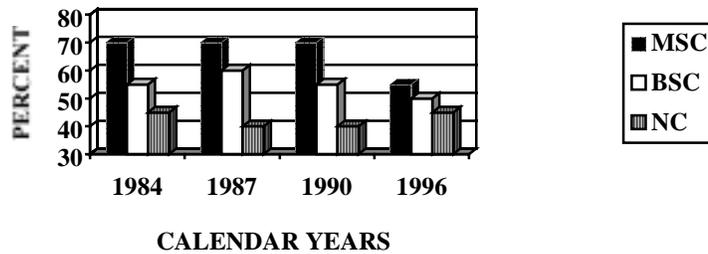


Figure 3. Colonel Promotion Rates

### LIEUTENANT COLONEL PROMOTION RATES

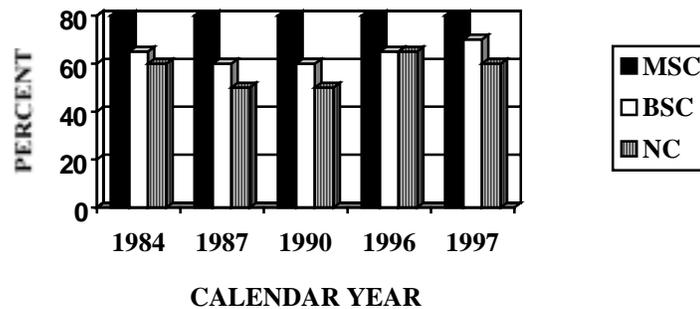


Figure 4. Lieutenant Colonel Promotion Rates

One rationale for the low percentages of field grade nurses getting promoted was that Nurse Corps (NC) major, lieutenant colonel and colonel ranks were considerably above NC requirements and authorizations for those grades resulting in the low promotion rates for all three ranks.<sup>27</sup> However, in 1988 when the Fiscal Year 1989-1990 Officer Grade Allocation Process was briefed, it was implied that non-line counterparts would receive increased grade allocations in the field grades.

In fact, in April 1988, the Colonel Requirements Review Board validated thirteen colonel positions for the Nurse Corps, Medical Service Corps, and Biomedical Service Corps. In December 1988, grade increases were approved by the Air Force Surgeon General for Chief Nurses, Newborn Nursery/Neonatal Intensive Care/Obstetric Nurses, and Operating Room Nurses/Nurse Anesthetists.<sup>28</sup> The Deputy Chief of Staff, Programs and Resources, in June 1989, validated and approved an increase in 188 nurse field grade requirements.<sup>29</sup> A review of medical/surgical and obstetrical units and Wilford Hall Medical Center requirements was also requested at this time.

A second study was completed in September 1989 and the Deputy Chief of Staff, Programs and Resources, approved another increase of 16 colonels, 82 lieutenant colonels, and 296 majors for the Nurse Corps (NC).<sup>30</sup> Although the increase in field grade ranks was a monumental accomplishment, it also indirectly supported the nursing shortage.<sup>31</sup> The NC now had additional positions to fill.

The effort to balance the appropriate authorizations of field grade officers continued throughout the 1990s. In 1995, a redistribution of grades increased NC authorizations by 83 majors and 56 lieutenant colonels.<sup>32</sup> A review of colonel requirements was to be completed in 1996. In 1997, a review of Defense Officer Personnel Management Act (DOPMA) constrained Nurse Corps (NC) colonel requirements was released. The review was initiated in response to low promotion rates and a low colonel inventory compared to fellow medical service officers. The team identified positions that were corps specific and corps neutral in order to balance the colonel distribution under the Objective Medical Group alignment. As a result of the study, nurses gained nine colonel billets. As can be seen, numerous reviews were completed to balance the need for field grade nurses against

authorizations and requirements, while simultaneously attempting to balance the playing field between fellow Air Force Medical Service officers and the Line of the Air Force.

A further incentive of the early 1990s to maintain nurses within the NC was to continue captains and majors who were non-selects for the next rank. This program allowed nurses who had been passed over to stay in the Air Force if they were within six years of retirement and if their records supported a continuation.<sup>33</sup> The selected continuation program was discontinued in 1994 when downsizing efforts contradicted the need for continuations.

Finally, although recruiting met its Fiscal Year 1989 goals, in 1989 the Air Force resorted to financial incentives to overcome the nursing shortage. The National Defense Authorization Act for Fiscal Year 1990-1991 created special pay for nurses. There was a 5,000 dollars accession bonus for nurses with a four-year obligation, and an Incentive Special Pay of 6,000 dollars for Certified Registered Nurse Anesthetists (CRNA) for a twelve-month period.<sup>34</sup> In 1994 the incentive pay for CRNAs was increased to 15,000 dollars to further enhance CRNA accessions and retention.<sup>35</sup>

In 1990, a recommendation was made to contract out CRNAs to help alleviate the chronic shortage problem.<sup>36</sup> In 1995, another incentive pay was passed by the Senate, which authorized privileged military nurses to receive special pay for being board certified. The constructive credit, increased accession age, accession bonuses, Incentive Special Pay, and certification pay initiatives appeared to decrease the impact of the nursing shortage, but a deficit remained.

Although the Nurse Corps (NC) received increases in its field grade ranks, it continued to be top heavy in these ranks. To alleviate this problem, a Voluntary

Separation Incentive and Special Separation Benefit was offered in 1992. Any once deferred or continued captain or major clinical nurse, with the exception of nurse practitioners, were eligible. A total of 40 nurses took advantage of these programs.

A Selective Early Retirement Board was held for nurses in 1993, the first time ever. The goal was to assist in “right sizing” the NC to attain Fiscal Year 1995 authorized end strengths. Colonels with two years time-in-grade who did not have an approved retirement date as of the board convening date were eligible. If selected, the colonel had to retire prior to 1 October 1993. A thirty-percent select rate was set and used by the board. A second Selective Early Retirement Board was held in May 1995 to facilitate Fiscal Year 1996 end strengths for colonels and lieutenant colonels with the exception of shortage specialties. Twenty-nine nurses were selected to retire early.<sup>37</sup>

As can be seen, initially the nursing shortage was due to decreased nursing school enrollments, an expansion of workplace opportunities for women, and a decrease in joint military member husband and wife team moves. The shortage continued throughout the time period examined due to increased Nurse Corps (NC) authorizations, decreased retention rates, unequal pay between the civilian sector and the military for specialty areas, and decreased promotion opportunities.

Today, the NC continues to drawdown to the Fiscal Year 2003 target. Shortages continue in a few specialty areas, but incentive pays, masters programs, increased autonomy, increased promotion opportunities, the redistribution of field grade billets, and the expanded roles for NC officers have had a direct impact on more seasoned nurses remaining in the Air Force. This, on occasion, was problematic spurring the need for Voluntary Separation Incentives, Special Separation Benefits, and Selective Early

Retirement Boards. Despite the challenges regarding the nursing shortage and retention issues, the Air Force Nurse Corps continues to strive for a highly trained and qualified force.

### Notes

<sup>1</sup> Grant Willis, "Shortage Bypasses the Air Force," *Air Force Times*, 13 April 1987, no. 47, 4.

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> David W. Givans, "Nurses: Opportunities Are Greater, More Varied in AF," *Air Force Times*, 7 March 1988, no. 48, 14.

<sup>5</sup> Don Winingham, "Nursing Chief Battles Shortages, Discontent," *Air Force Times*, 14 November 1988, no. 49, 14.

<sup>6</sup> Grant Willis, "Shortage Bypasses the Air Force," *Air Force Times*, 13 April 1987, no. 47, 4.

<sup>7</sup> USAF Office of the Surgeon General, A Semi-Annual History of the Medical Service, 1 Jan 84-30 Jun 84, 11.

<sup>8</sup> David W. Givans, "AF Feeling Nationwide Shortage of Nurses, Too," *Air Force Times*, 7 March 1988, no. 48, 14.

<sup>9</sup> Ibid.

<sup>10</sup> USAF Office of the Surgeon General, A Semi-Annual History of the Medical Service, 1 Jul 86-31 Dec 86, 108.

<sup>11</sup> David W. Givans, "AF Feeling Nationwide Shortage of Nurses, Too," *Air Force Times*, 7 March 1988, no. 48, 14.

<sup>12</sup> Ibid.

<sup>13</sup> The Joint-Spouse Assignment Program is outlined in AFI 36-2110. The phrase commonly used by military members is Joint-Spouse.

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid., p. 56.

<sup>17</sup> History, A Semi-Annual History of the Office of the Surgeon General, 1 Jul 89-31 Dec 89, p. 111.

<sup>18</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 92, Vol. 6, p. 4-111.

<sup>19</sup> Don Winingham, "Nurse Internship Program Eases Transition to AF," *Air Force Times*, 24 October 1988, no. 49, 21.

<sup>20</sup> Don Winingham, "Nursing Chief Battles Shortages, Discontent," *Air Force Times*, 14 November 1988, no. 49, 14.

<sup>21</sup> Sid Balman Jr, "Air Force Opens Slots to Older Nurses," *Air Force Times*, 18 September 1989, no. 50, 10.

<sup>22</sup> Ibid.

<sup>23</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 90, Vol. 7, p. SGH-B.

## Notes

<sup>24</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 93, Vol. 7, p. 4-129.

<sup>25</sup> History, A Semi-Annual History of the Office of the Surgeon General, 1 Jul 87-31 Dec 87, p. 28.

<sup>26</sup> History, A Semi-Annual History of the Office of the Surgeon General, 1 Jul 89-31 Dec 89, p. 111.

<sup>27</sup> History, A Semi-Annual History of the Office of the Surgeon General, 1 Jul 87-31 Dec 87, p. 39.

<sup>28</sup> USAF Office of the Surgeon General, A Semi-Annual History of the Medical Service, 1 Jul 88–31 Dec 88, p. 31.

<sup>29</sup> USAF Office of the Surgeon General, A Semi-Annual History of the Medical Service, 1 Jan 89–30 Jun 89, p. 34.

<sup>30</sup> USAF Office of the Surgeon General, A Semi-Annual History of the Medical Service, 1 Jul 89–31 Dec 89, p. 14.

<sup>31</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 90, Vol. 1, p. 3.

<sup>32</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 95, p. 123.

<sup>33</sup> History of the Office of the Surgeon General, Jan-Dec 90, Vol 6, p. SGH-A.

<sup>34</sup> USAF Office of the Surgeon General, A Semi-Annual History of the Medical Service, 1 Jul 89–31 Dec 89, p. 21.

<sup>35</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 94, Vol. 1.

<sup>36</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 90, Vol. 3, p. 1-66.

<sup>37</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 95.

## **Chapter 3**

### **Desert Shield/Desert Storm**

#### **Medical Readiness**

During the 1980's, Air Force Medical Service (AFMS) focused on improving its overall medical readiness status. Specifically, this included improving readiness training of medical personnel and establishing contingency hospitals in Europe that maintained a caretaker staff during peacetime and became fully operational during war. A third focus was the redesigning of Air Transportable Clinics and Air Transportable Hospitals.<sup>1</sup>

#### **Operation DESERT SHIELD**

The AFMS readiness stance was tested to the maximum during Operation DESERT SHIELD/DESERT STORM. It was the largest Air Force medical deployment since Vietnam, the size and speed of which is unparalleled.<sup>2</sup> The Air Force medical deployment in support of Operation DESERT SHIELD began in August 1990. Air Force medical teams were the first medical assets in the Gulf, arriving in the Arabian Peninsula just two days after combat units.<sup>3</sup>

To ensure the Air Force had sufficient nurses for Operation DESERT SHIELD and subsequently Operation DESERT STORM, the Air Force established the "STOP LOSS" program in the fall of 1990. This program froze separations, discharges, and retirements

for Certified Registered Nurse Anesthetists (CRNA), Operating Room Nurses, Nurse Administrators, Clinical Nurses, Flight Nurses, and Mental Health Nurses.

To lessen the pain of CRNAs having to remain on active duty during the war, The Persian Gulf Conflict Supplemental Authorization and Personnel Benefits Act was passed in 1991. This act allowed CRNAs to receive Incentive Special Pay (ISP) for a full year if they remained on active duty during the war. The ISP was guaranteed even if they separated once the war was over, before the full year was completed.

As would be expected, recruiting suffered during Operation DESERT SHIELD/DESERT STORM. Nursing applications were down 144 from the previous year during the same time period.<sup>4</sup> Retention and recruiting also suffered during Fiscal Year 1992, also a possible after-effect of the war. The “STOP LOSS” program was terminated in April 1991 and had affected 80 nurses who had desired to leave the Air Force during that time period.<sup>5</sup>

### **Medical Assets Utilized**

Many medical assets were employed and deployed during Operation DESERT SHIELD/DESERT STORM. The Central Command Surgeon commanded one 250 bed contingency hospital, 15 Air Transportable Hospitals, 31 Air Transportable Clinics, and numerous Aeromedical Staging Facilities in the Gulf area of responsibility. The European Command Surgeon commanded four contingency hospitals, three in England and one in Germany in preparation for the projected casualties. Denmark, a host nation, also established a contingency hospital in the event additional hospital beds were needed. Nursing personnel of the Reserve, Guard, and active duty were assigned to these facilities in support of Operation DESERT SHIELD/DESERT STORM.<sup>6</sup>

In order to fully appreciate the magnitude of this medical employment and deployment, it is necessary to understand the type of facilities available to medical personnel in the Gulf area of responsibility and Europe. An Air Transportable Clinic (ATC) provides minor first aid and emergency medical care. Squadron Medical Elements, composed of one physician and two medical technicians, usually staff an ATC. Squadron Medical Elements are typically assigned to fighter squadrons and, in this case, moved with the fighter squadrons when deployed to the Gulf. Thirty-one ATCs were deployed to the combat area.<sup>7</sup>

A larger medical facility is the Air Transportable Hospital (ATH), the backbone of the Air Force's deployable medical treatment system. Air Transportable Hospitals are hardened shelters and/or modular tents. They provide short-term, but more complex, medical care to a fighter wing of between 3,000 and 5,000 personnel. Squadron Medical Elements, ATCs, and Aeromedical Staging Facilities (ASF) transfer patients to the ATH if the medical problems are not readily treatable at the ATC or ASF. Fifteen ATHs were deployed in-theater to support projected casualties.<sup>8</sup>

The final asset utilized by the Air Force in Operation DESERT SHIELD/DESERT STORM was the contingency hospital. The contingency hospital consists of prepositioned medical supplies and equipment including ATHs and ambulances. They are called "Turn-Key" facilities because a caretaker staff maintains the facility and equipment during peacetime. During times of conflict, they become fully operational with the employment of personnel. Four contingency hospitals were fully functional by February 1991.<sup>9</sup> Contingency hospitals provided an intermediate stage of care prior to

aeromedical evacuation to a fixed military treatment facility elsewhere in Europe or the continental United States.

## Operation DESERT STORM

Active duty, Reserve, and Guard nursing personnel from all over the Air Force were deployed to one of the four contingency hospitals in Europe or to Air Transportable Clinics (ATC) or Air Transportable Hospitals (ATH) in the Gulf. The actual deployment occurred five times faster than during the Vietnam War.<sup>10</sup> Statistics of nursing personnel deployed during Operation DESERT SHIELD/DESERT STORM are depicted in Table 1.

**Table 1. DESERT SHIELD/DESERT STORM Medical Assets**

Nurses Deployed to Europe or Gulf AOR	Europe	Gulf AOR	CONUS
972 AD of which 19 were Flight Nurses	6892 Medics (3874 AD and 3018 ARC)	4868 Medics (2342 AD and 2526 ARC)	AD Medics and 1035 ARC nurses to backfill MTFs
872 ARC of which 613 were Flight Nurses	3740 Hospital Beds	1000 Hospital Beds 750 ASF Beds	2200 Hospital Beds

**Key:**

AOR-Area of Responsibility	ASF-Aeromedical Staging Facility
AD-Active Duty	CONUS-Continental United States
ARC-Air Reserve Component	MTF-Medical Treatment Facility

The majority of injuries treated by nursing personnel in the ATC were non-battle injuries such as lacerations and ankle sprains. Air Transportable Hospitals and contingency hospitals treated patients suffering from heat and fatigue casualties and foodborn illnesses. Throughout the war, there were 121,000 outpatients and 3,250 inpatients treated.<sup>11</sup>

Operation DESERT STORM identified nursing personnel training issues. The primary finding was that while reserve nurses were clinically astute, they lacked military supervisory and management experience necessary for military deployment situations. This included managing logistical and ancillary support and military discipline.<sup>12</sup> These issues were resolved following the war through the Total Nursing Force Strategic Plan deployment and implementation.

Operation DESERT STORM was the first time the Deployable Medical System was operationally tested and it was a resounding success. Following the war, flag officers of all services, Central Command, European Command, and the United States Air Force Surgeon General commended medical personnel for their efforts during the war. It was also the first deployment of the “Total Force”, where active duty, Reserve, and Guard nursing personnel worked side by side. Without a doubt, Operation DESERT SHIELD/DESERT STORM proved the “Total Force” concept was valid.

### Notes

<sup>1</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 90, Vol. 1, p.48.

<sup>2</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 90, Vol. 1, p. v.

<sup>3</sup> Dr. James S. Nanney, “Air Power and Medical Readiness—The Air Force Medical Service,” *The Journal of the US Army Medical Department*, PB8-92-1/2, (January/February 1992): 17.

<sup>4</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 91, Vol. 1, p 99.

<sup>5</sup> *Ibid*, p. 108.

<sup>6</sup> *Ibid*, p. 3-4.

<sup>7</sup> Dr. James S. Nanney, “Air Power and Medical Readiness—The Air Force Medical Service,” *The Journal of the US Army Medical Department*, PB8-92-1/2, (January/February 1992): 21.

<sup>8</sup> *Ibid*, p. 21.

<sup>9</sup> *Ibid*, p. 20.

<sup>10</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 90, Vol. 1, p.48.

<sup>11</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 91, Vol. 1, p. 51-52.

<sup>12</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 91, Vol. 4, p. 2-21.

## Chapter 4

### Military Operations Other Than War

The Air Force began decreasing in size following the collapse of communism and the Warsaw Pact in Eastern Europe in 1989. This decrease in manning requirements continued throughout the 1990s. Despite this decrease in Air Force numbers, Air Force responsibilities in Military Operations Other Than War (MOOTW) rose. Some MOOTW took place overseas in Third World countries, while some took place in our back yard, the United States.

Military Operations Other Than War, can be classified by: “deterrence (in the sense of prevention), prevention (in the sense of preemption), coercion, punishment (punitive), peacekeeping, war fighting, peacemaking, nation building, interdiction, humanitarian goals, and rescue missions.”<sup>1</sup> Whatever the basis of the MOOTW, they all test the Air Force’s medical readiness status and ability to deploy on a moment’s notice. Often with medical personnel arriving shortly after the military troops arrive.

This chapter discusses several MOOTWs that Air Force nurses have been involved in. The writer did not find statistics illustrating the exact number of nurses involved with each MOOTW. However, in all cases, Air Transportable Clinics (ATC) and/or Air Transportable Hospitals (ATH) were utilized. A valid assumption is that nurses are usually members of ATCs and ATHs. Nurses were also involved in numerous instances

through the Aeromedical Evacuation system, transporting patients from the area of engagement to medical treatment facilities in the overseas arena or within the continental United States.

It is important to note that several of these Military Operations Other Than War took place simultaneously. This strained nursing resources within the continental United States as well as medical treatment facilities located overseas. A few of the examples discussed below are low scale involvements while others illustrate large-scale medical deployments. The intent is to provide an idea of the scope of engagements nurses were involved in. When the term “medics” and the phrase “nursing personnel” are used, this infers a mix of nurses and medical technicians as deemed appropriate to the situation.

### **San Francisco Earthquake**

On October 17, 1989, Northern California experienced a devastating earthquake. It registered 7.1 on the Richter scale, killed 67 people, injured 2,000, and left 10,000 homeless.<sup>2</sup> Military medics provided medical care to the victims and their families.

### **Operation JUST CAUSE**

Operations JUST CAUSE was a military mission to neutralize the military structure of the Panamanian Defense Force and its tyrannical leader, General Manuel Noriega. The ultimate goal was to restore a democratic government in Panama. The United States launched a military attack against Panama on 20 December 1989. At that time, it was to be the largest military medical effort since Vietnam.<sup>3</sup>

The 24<sup>th</sup> Medical Group (24MDG), Howard Air Force Base, Panama, was the host military treatment facility (MTF) and simultaneously served as a forward deployed MTF

for the operation. The 24MDG provided medical and aeromedical personnel, ambulances, preventive health and environmental advice, and logistical support to the Unified Command, Joint Task Force-South, and the Joint Casualty Collection Point (JCCP).<sup>4</sup>

The JCCP was established at the end of the Howard Air Force Base runway. Medical personnel of two Army Forward Surgical Teams triaged, treated, and stabilized patients in the JCCP. The Army staff was supplemented by Air Force nurses, flight doctors, and medical technicians from the 24MDG and aeromedical components.

There were 275 casualties of which 257 were aeromedically evacuated to MTFs within the continental United States.<sup>5</sup> Wilford Hall Medical Center was the primary MTF while Brooke Army Medical Center served as a backup. A 100 bed Aeromedical Staging Facility was established at Kelly Air Force Base, Texas, to which patients were aeromedically evacuated. From there, the patients were then transferred to Wilford Hall Medical Center via ambulances, helicopters, and ambuses. The majority of the patients were treated for fractures, shrapnel, gunshot, trauma, lacerations, chemical burns, and heat related injuries.<sup>6</sup>

The JCCP received numerous accolades from the continental United States military treatment facilities. The exceptional patient survival and recovery rate was secondary to the superb triage, treatment, and stabilization provided at the JCCP. The overall joint Army and Air Force medical endeavor was exceptional and clearly indicated that medical readiness training had paid off.

## **Operation SAFE HARBOR**

Air Force nurses provided direct medical assistance, from October 1991 to August 1992, to Haitian refugees. The refugees had fled their country in boats while trying to find refuge in the United States. During this joint medical operation at Guantanamo Bay Naval Air Station, Cuba, more than 15,000 Haitian refugees were treated. Nursing personnel treated were 342 cases of malaria, 43 cases of tuberculosis, 35 cases of pneumonia, 35 cases of measles, 16 cases of chicken pox, and 16 cases of filariasis.<sup>7</sup> Many of these diseases are not found in the United States, which gave Air Force nursing personnel experience in treating diseases common to third world countries.

## **Hurricane Andrew**

Hurricane Andrew destroyed Homestead Air Force Base and southern Florida on 24 August 1992. Active duty, Reserve, and Guard nurses responded by providing medical care to the Homestead community and assisting in base clean up, working side by side with many other volunteer organizations. An Air Transportable Hospital (ATH) was established at Homestead Air Force Base with logistical support from McDill Air Force Base. In the month of September alone, 1,200 outpatients were treated, 17 patients were admitted to the ATH, and four patients were aeromedically evacuated to the nearest military treatment facility.<sup>8</sup>

## **Operation PROVIDE TRANSITION**

In August 1992, the Air Force assisted United Nations troops in moving demobilized Angolan troops back to their homes so they could participate in their national elections

that were to be held 28-30 September 1992. A flight doctor and 80 nursing personnel treated patients of three separate Soviet-built United Nations helicopter crashes.

### **Hurricane Iniki**

Members of the 15<sup>th</sup> Medical Group, Hickam Air Force Base, Hawaii, provided medical and aeromedical evacuation support to hurricane victims on Kauai during September 1992.

### **Operation RESTORE HOPE**

On 13 December 1992, the medical deployment to Somalia, a starving, war-torn country in Africa, began. It lasted until March 1994. The Navy and Air Force provided early on-site medical care. The first aeromedical evacuation was on 16 December 1992. Intratheater, Army helicopters and Air Force C-130s transported patients between conflict areas and second echelon medical units. The Second Aeromedical Evacuation Squadron was stationed in Cairo to begin the journey back to larger military treatment facilities in Europe and the continental United States. In all, there were 250 medics in Egypt, Ethiopia, Somalia, and Kenya in support of Operation RESTORE HOPE. The medics provided aeromedical evacuations out of the theater and medical support at transition points in the aeromedical evacuation route.<sup>9</sup>

In late December, an Army contingency hospital from a prepositioned ship was unable to off-load in Mogadishu harbor due to the shallow waters. As a result, an Air Force 100 bed Air Transportable Hospital, along with its complement of nursing personnel, replaced it. A big focus of medical care was anti-malarial precautions.

In October 1993, United States Army Rangers were caught in a firefight, which resulted in many casualties. Thanks to the efforts of Air Force medics, many lives were saved. Casualties were brought from the point of injury to a small staff at the Mobile Aeromedical Staging Facility located at the airport. Nurses worked the Casualty Collection Point triaging, resuscitating, and stabilizing patients so they could be helicoptered to the in-theater Air Transportable Hospital and then on to Germany. A similar attack occurred three days later, and the medics again worked to save lives. This effort in Somalia was a Total Force effort, with active duty members working side by side by Reserve and Guard personnel.<sup>10</sup> Operation RESTORE HOPE demonstrated, once again, the Air Force's ability to deploy rapidly and efficiently on a moment's notice.

### **Operation PROVIDE PROMISE**

In October 1993, 150 medics deployed to Zagreb, Croatia, to expand the Army hospital assigned to the United Nations Protection Force (UNPROFOR). Air Force medics used the facility and equipment already in place to provide third echelon and aeromedical evacuation support.<sup>11</sup>

Medics treated a wide spectrum of illnesses and injuries. The majority of the patients were treated for acute myocardial infarction, gasoline inhalations, typhus, rubella, malaria, pneumonia, and acute psychoses. Surgical teams treated patients with high velocity gunshot wounds, open and closed extremity fractures, and electrical and thermal burns.<sup>12</sup>

As an extension of Operation PROVIDE PROMISE, Air Force medics participated in the operation of a Triservice mobile hospital in support of UNPROFOR, from 10 February to 7 August 1995. UNPROFOR was attempting to pacify the warring factions

in the former Yugoslavia. Aeromedical units transported patients with orthopedic war injuries from Bosnia to Andrews Air Force Base, Maryland. The medical deployment in support of Operation PROVIDE PROMISE demonstrated the capabilities of Air Force medicine in a forward deployed environment.<sup>13</sup>

### **Operation SEA SIGNAL**

In 1994, over 350 Air Force medics were deployed to Guantanamo Bay Naval Station, Cuba, to treat 35,000 Cuban and Haitian migrants who fled their country by boat or ship. United States Navy and Coast Guard personnel had detained the migrants at the Guantanamo Bay complex. Medical care for the migrants was provided by the 6<sup>th</sup> and 59<sup>th</sup> Air Transportable Hospitals (ATH). Medical personnel primarily from Dyess and Nellis Air Force Bases manned the 6th ATH. Personnel from Wilford Hall Medical Center manned the 59th ATH.<sup>14</sup> Ten thousand Cubans were moved to Howard Air Force Base, Panama during Operation SAFE HAVEN. However, once at Howard Air Force Base, the Cubans, who were unhappy, rioted. As a result, Operation SAFE PASSAGE brought the Cubans back to Guantanamo Bay by February 1995.

### **Oklahoma City Bombing**

On April 19, 1995, a terrorist bomb exploded in the Murrah Federal Building, killing 168 people and injuring and wounding 500 more. A Total Force effort of active duty, Reserve, and Guard nursing personnel was put forth from bases in the surrounding area to care for the victims and their families.<sup>15</sup>

## **Operation PACIFIC HAVEN**

From September 1996 to April 1997, nursing personnel deployed in an Air Transportable Hospital provided health care and Immigration and Naturalization Service physicals to Kurds who had been relocated from Northern Iraq to Anderson Air Force Base, Guam. These services prepared the evacuees for relocation to the United States. Over 12,000 physical were completed and over 40 Kurd infants were delivered while on Guam.<sup>16</sup>

## **Operation SOUTHERN WATCH**

Two Air Transportable Clinics and several Squadron Medical Elements, a total of 60 Air Force medics<sup>17</sup> are currently stationed in Dhahran, Saudi Arabia. Their mission is to support Air Force units involved in the surveillance of Iraq following Operation DESERT STORM. Ten aeromedical personnel are also stationed in Dhahran in the event patients need to aeromedically evacuated out of the theater. The medics provide routine medical care to the flying squadrons and are in Saudi Arabia for 90-day tours after which they rotate back to their home base and another team is deployed.

As can be seen by the examples above, Air Force nursing personnel deployments to Military Operations Other Than War (MOOTW) have increased within the last ten years. The experiences nurses garnered from these deployments are numerous and irreplaceable. Through experience sharing, fellow nurses have learned the intricacies involved with MOOTWs, surely to be a large part of future Air Force nursing.

### **Notes**

<sup>1</sup> Richard N. Haass, *Managing Global Chaos* (Endowment of the United States Institute of Peace, 1996), pp.167-208.

## Notes

<sup>2</sup> Cynthia M. Stuhlmiller, "Studying the Rescuers," *Sigma Theta Tau International Reflections*, First Quarter 1996, 18.

<sup>3</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 90, Vol. 4, p. 2-1.

<sup>4</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 90, Vol. 1, p. 38.

<sup>5</sup> Ibid, p. 40.

<sup>6</sup> Ibid, p. 40.

<sup>7</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 92, Vol. 1, p. 34.

<sup>8</sup> Ibid, p. 27.

<sup>9</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 93, Vol. 4, p. 1-89.

<sup>10</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 93, Vol. 7, p. 4-129.

<sup>11</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 93, Vol. 1, p. 35.

<sup>12</sup> Lieutenant Colonel Linda Downing, "Operation Provide Promise." *Rhino Signs*, Volume 95-9, December 1995, n.p.; on-line, Internet, 5 December, 1998, available from <http://usafsg.satx.disa.mil/~sgn/decrs.htm>.

<sup>13</sup> Ibid.

<sup>14</sup> "GTMO After Action Report," n.p.; on-line, Internet, 5 December, 1998, available from <http://www.medsite.brooks.af.mil/deploy/gtmo/gtmorpt1.htm>.

<sup>15</sup> "The Many Graces of Oklahoma Nurses," *Sigma Theta Tau International Reflections*, First Quarter 1996, 11.

<sup>16</sup> Brig Gen Linda J. Stierle, Director, Medical Readiness Doctrine & Planning and Nursing Services, US Air Force, presentation to the Committee on Appropriations Subcommittee on Defense United States Senate, Washington D.C., April 1997, p. 15.

<sup>17</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 93, Vol. 1, p. 34.

## Chapter 5

### Operational Medical Group

In 1991, the Chief of Staff of the Air Force, General McPeak, established the Objective Wing,<sup>1</sup> and in 1992, he restructured the Air Force from top to bottom. His goal was to encourage decision-making at the lowest level. By placing all base and wing level functions under the wing or installation commander, the functional medical stovepipes lost their independence and autonomy. This restructuring prompted the Air Force Surgeon General's office to propose a new standard base-level medical hospital organization that was approved on 27 March 1992.<sup>2</sup>

The Surgeon General's proposal created a medical group subordinate to the wing commander for each base hospital. Clinics became medical squadrons. Medical Centers essentially remained unchanged, maintaining the title "center" and its senior rater status. Large clinics, such as Kadena Air Base and Ramstein Air Base, were approved as a medical group because of their size and complexity.

Internally, several squadrons staffed medical groups. A common core area such as outpatient care, inpatient care, and ancillary support aligned each squadron. The squadrons were: medical operations, aerospace medicine, health care support, and dental. The Medical Operations Squadron consisted of outpatient, inpatient, and ancillary flights. Aerospace Medicine consisted of flight and/or missile medicine, military public health,

and bioenvironmental engineering flights. Health Care Support consisted of readiness and training, resource management, patient administration, managed care, and medical materiel flights. Dental squadrons had dental services, dental lab, and dental support flights. Command positions of each squadron were corps neutral, meaning any Air Force Medical Service corps could be commander of any squadron.<sup>3</sup>

The squadron organizational structure aligned all resources under the control of a squadron commander and did away with corps-specific stovepipes.<sup>4</sup> An executive staff consisted of the Chief Nurse, Chief Professional/Clinical Services, Chief Biomedical Services, Chief Administrative Services, Chief Dental Services, Chief Aerospace Medicine, and Quality Assurance. This group was tasked with institution-wide strategic, three years out and beyond, planning, marketing, and resourcing.<sup>5</sup> They were also charged with ensuring group personnel supported professional standards and procedures, met accreditation requirements, and provided personnel management and career development to their respective corps.<sup>6</sup> A Medical Squadron Section provided administrative support to the entire group while another team provided quality assurance assistance to the commander and the administrator.

The Chief Nurse had oversight of all nursing issues and nursing licensure. Chief Nurses defined nursing standards of practice and policy as mandated by the Joint Commission on Accreditation of Healthcare Organizations. Other roles included coordinating services, overseeing resource requirements, promoting facility-wide partnerships and cooperation, maintaining external liaisons critical to the profession, and maintaining open communication lines.<sup>7</sup>

Initially, there were no prerequisites to being a squadron commander. Since the executive staff existed, anyone within the squadron could be selected as the commander. It was a “best qualified” process of selection, with the wing commander having the final approval authority.<sup>8</sup>

As the Objective Medical Group (OMG) developed, a Medical Service Screening Board was established to select eligible personnel to serve as squadron commanders. As mentioned earlier, squadron commander positions were corps neutral, the best qualified of any corps could hold the position for any squadron. When the executive staff was alleviated under the new OMG guidelines, members of the now extinct executive staff would hold the squadron commander or the deputy squadron commander positions.

Initially, the squadron commander could be “dual hatted” as a group staff member. However, this process was kept at a minimum due to the scope of responsibility of both positions, to allow for greater opportunity for leadership development, and to maximize capabilities of assigned personnel. Today, since the group staff as a separate entity has been alleviated, “dual-hatting” as a way of life.

Six military treatment facilities (MTF) were selected as test facilities for a one-year period. The six MTFs were Elmendorf, Yokota, Andersen, Charleston, Dover, and Tyndall. An evaluation of the test facilities’ reorganization was set for May 1993. The evaluation looked at areas of customer satisfaction, workload, cost, quality, access, and hospital efficiency and discipline. As Surgeon General, General Sloan’s policy was to test the reorganization, and if it did not work, the Air Force would not deploy it to other MTFs. As a part of the reorganization, General Sloan considered the training of new

squadron and group commanders as essential, as this was a new paradigm for medical personnel.<sup>9</sup> However, training was not instituted during the test period.

The Objective Medical Group (OMG) test period ended in December 1993 and rendered both positive and negative results. On the positive side, the OMG made the opportunity for command available for all corps. The Uniform Code of Military Justice authority was delegated at the lowest level, empowering squadron commanders with more command and control of their personnel. This allowed the Medical Group Commander to be more strategic in his or her thinking, because squadron commanders assumed the administrative duties for their respective squadrons. Squadron members had increased access to the squadron commander, as opposed to the group commander, and were also afforded more opportunity for recognition since the competition was now spread amongst four squadrons rather than one group.<sup>10</sup> The medical group and its squadrons were also more widely accepted by its Line of the Air Force counterparts.<sup>11</sup> Perhaps the most positive aspect of the OMG, from the writer's perspective, was that it allowed the future leaders of the Air Force Medical Services to be groomed as senior commanders.

As with all major change, there were disadvantages identified. Only one facility wanted the OMG as it was; two wanted it with modifications; and the other test facilities voted against it.<sup>12</sup> The OMG had not reduced costs nor did it provide better access or quality patient care. There was insufficient administrative support to handle the additional paperwork and communications that became more apparent with the extra squadron layer in the medical group. The "stovepipe" problem amongst corps was not totally alleviated. In some cases, the squadrons created rank inversions that led to

problems with opportunities to command, and which may or may not have been further complicated by the personalities involved. In regards to the squadron commanders, there was no formalized training and the commander selection process was not a balanced playing field. Finally, it was perceived that the Chief of Professional Services and the Nurse Executive had lost their stature.<sup>13</sup> It was perceived that the Objective Medical Group (OMG) blurred the professional accountability to the Joint Commission on Accreditation of Healthcare Organizations<sup>14</sup> because the Chief of Professional Services and the Nurse Executive were outside of the squadron process.

To rectify some of the problems identified, changes were made to the OMG, aligning it more into “product and service” lines. In a few facilities, deviations from the four squadrons were permitted. Health Care Support was renamed Medical Support Squadron. An orderly room replaced the Medical Squadron Section. The Chief of Professional Services, the Nurse Executive, and the Senior Biomedical Services Corps officers replaced the quality assurance team as consultants to the Medical Group Commander.

The Surgeon General also set a priority to examine ways in which to train OMG squadron commanders and group staff as they assumed new leadership roles. The various commands subsequently established training programs for both squadron and group level commanders. During this training, squadron and group commanders were exposed to command and wing services available to them to assist them in their new role.

All corps have had the opportunity to compete for medical group commander positions since 1987. However, prior to 1996, the Nurse Corps has never had more than three or four nurse group commanders: Fiscal Year 1994-4; Fiscal Year 1995-3; Fiscal

Year 1996-8; and Fiscal Year 1997-13. Nurses doubled their opportunity to command in 1996 with a 75% increase in 1997. Prior to the centralized group commander's selection process in 1996, medical group commanders were traditionally physicians. Nurses who were selected to command medical groups were often sent to the less desirable facilities, facilities that had historically been difficult to fill with physicians.<sup>15</sup>

The 1998 Colonel Command Screening Board met on 19 October 1998. Fifty eight percent of the eligible nurse colonels declined meeting this board. Of those selected to command medical treatment facilities by this board, seventeen were nurses, thirteen were physicians, eleven were Medical Service Corps officers, three were Biomedical Service Corps officers, and four were Dental Corps officers. Three nurses were selected eligible to command large and medium facilities respectively, while eleven were selected eligible to command small medical treatment facilities.<sup>16</sup> Assignments were announced 15 January 1999. Thirty one percent (12 of 39) of the available positions were filled with nurses. This clearly indicates the competitiveness of nursing personnel at the medical group command level.

At the squadron level, most nurses command Medical Operations Squadrons (MDOS), frequently the largest squadron in medical treatment facilities. In 1994, 44% of MDOS commanders were nurses; in 1995, 41% were nurses; and in 1996, 34% were nurses. In 1997, nurses commanded 47% of MDOS squadrons, 9% of Medical Support Squadrons (MDSS) squadrons; and 6% of the Aerospace Medicine Squadrons,<sup>17</sup> another clear indication of nursing competitiveness. Nurses commanded 43 of 267 (16%) squadrons in 1997. Fifteen nurses (20%) were selected to command MDOS or MDSS

squadrons during the Calendar Year 1999 Medical Squadron Screening Board assignment process, solidifying that nurses have left their mark in future command positions.

The Air Force Surgeon General fully supports equitable all-corps leadership positions, which, along with the dual-hatted corps specific duties, will develop medical service officers for General Officer billets in the future. As the Director, Medical Readiness Doctrine & Planning and Nursing Services, Brigadier General Stierle, stated, “This enduring support by our Surgeon General will uphold the broad opportunity for all corps to compete on a level playing field for equity in promotion and command positions.”<sup>18</sup>

#### Notes

- <sup>1</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 93, Vol.1, p. 1-56.
- <sup>2</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 92, Vol. 1, p. 16.
- <sup>3</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 93, Vol.1, p. 30.
- <sup>4</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 92, Vol. 2, p. 1-13.
- <sup>5</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 94, Vol. 1, p. 11.
- <sup>6</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 94, Vol. 2, p. 1-31.
- <sup>7</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 94, Vol. 3, p. 1-38.
- <sup>8</sup> Ibid.
- <sup>9</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 92, Vol. 1, p. 18.
- <sup>10</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 93, Vol. 3, p. 1-56.
- <sup>11</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 93, Vol. 1, p. 31.
- <sup>12</sup> Ibid.
- <sup>13</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 93, Vol. 3, p. 1-56.
- <sup>14</sup> History of the Office of the Air Force Surgeon General, Jan-Dec 94, Vol. 2, p. 1-31.
- <sup>15</sup> Brig Gen Linda J. Stierle, Director, Medical Readiness Doctrine & Planning and Nursing Services, US Air Force, presentation to the Committee on Appropriations Subcommittee on Defense United States Senate, Washington D.C., April 1997, p. 9.
- <sup>16</sup> Captain Russ Pinard, Directorate of Medical Force Management, Fellow, US Air Force, Presentation on the “Demographics of AFMS CY98 Command Screening Board Results,” Fall 1998.

## Notes

<sup>17</sup> Demographics of AFMS CY97 Group and Squadron Command Screening Boards.

<sup>18</sup> Brig Gen Linda J. Stierle, Director, Medical Readiness Doctrine & Planning and Nursing Services, US Air Force, presentation to the Committee on Appropriations Subcommittee on Defense United States Senate, Washington D.C., April 1997, p. 11.

## **Conclusions**

The United States Air Force Nurse Corps (NC) was not initially effected by the nursing shortage. However, certain specialty areas, such as the nurse anesthetists and nurse practitioners were chronically undermanned throughout the time period examined. The nursing shortage began as a result of decreased nursing school enrollments, an expansion of workplace opportunities for women, and a decrease in joint military member husband and wife team moves. Shortages continued due to increased NC authorizations, decreased retention rates, unequal pay between the civilian sector and the military for specialty areas, and decreased promotion opportunities to Lieutenant Colonel and Colonel.

The NC continues to drawdown to the Fiscal Year 2003 target. As it approaches its target, shortages may continue in a few specialty areas. Hopefully incentive pays, masters programs, increased autonomy, increased promotion opportunities, the redistribution of field grade billets, and the expanded roles for NC officers will encourage seasoned nurses to remain in the Air Force. Despite the nursing shortage and retention challenges it faces, the United States Air Force Nurse Corps continues to strive for a highly trained and qualified force.

Operation DESERT SHIELD/DESERT STORM demonstrated that nursing personnel, active duty, Reserve, and Guard, could successfully deploy to medical treatment facilities in the United States, Europe, and the Gulf Area of Responsibility for extended periods of time. Their superior efforts were lauded by all commands involved in Operation DESERT SHIELD/DESERT STORM. This was the first deployment of the

“Total Force”, where active duty, Reserve, and Guard nursing personnel worked side by side. Without a doubt, Operation DESERT SHIELD/DESERT STORM proved the “Total Force” concept was valid.

Since the late 1980’s, nursing personnel have deployed to numerous Military Operations Other Than War. These operations include providing medical care to survivors of natural disasters such as hurricanes or earthquakes, caring for survivors of civil wars or terrorist attacks, and supporting refugees fleeing their countries. With the end of the Cold War, it is conceivable that Military Operations Other Than War will be an important part of the Nurse Corps’ future.

The reorganization of the Air Force Medical Service was perhaps the biggest contributor to the expansion of nursing roles. Nurses are no longer limited to the clinical or administrative “nursing” career paths within the walls of a medical treatment facility. The Objective Medical Group has yielded a broader scope of practice for nurses, the ultimate of which is the opportunity to serve as the Medial Group Commander of all three sizes of medical treatment facilities.

This research had developed historical events that influenced the United States Air Force Nurse Corps from 1984 through 1998. It focuses on the main themes of the nursing shortage and retention challenges, participation in Operation DESERT SHIELD/DESERT STORM, participation in Military Operations Other Than War, and the transition to the Objective Medical Group. The historical chronology delineated in Appendix A discusses events leading to the expansion of the role of nurses in the United States Air Force. It is a living document that will serve as a foundation upon which to document historical events in the future.

Nurses of the United States Air Force Nurse Corps should be proud of the accomplishments the Nurse Corps has made over the past fourteen years. With the support of the senior leadership in the Air Force Medical Service, nurses will continue to forge ahead, competing equitably for top leadership and command positions.

## Appendix A

### A Chronology of American Air Force Nursing

#### 1984

Nurse accessions did not meet the recruiting goal. Lieutenant General Max B. Brallier, Surgeon General, approved a plan to increase NC accessions at the expense of other corps in FY84. The major commands and Surgeon Generals were encouraged to continue using Guard and Reserve supplementation, contracting, and civilian overhires to counter the nursing shortage. Nurse Anesthetists were at critical manning levels. Bachelor in Nursing requirement for entry into the Air Force was waived for nurse anesthetists in hopes of increasing accessions. (1:11) FY84 had the largest number of nurse anesthetists ever recruited in the history of Air Force NC. (1:7)

Second Annual Chief Nurse (CN) Selection Board selected 30 nurses for CN positions. Of the incumbents, 98% were recommended for future positions. (2:8)

Congress and the Defense Department proposed manpower reductions to decrease the FY85 defense budget through the FY84 Defense Authorization Act. The NC was to be reduced by 88. (1:20)

**3-4 April 1984** The 15<sup>th</sup> Air Force Nurse Corps Career Development Board revised Nurse Corps objectives to mesh more closely with Surgeon General goals. (1:10)

**12-14 June 1984** Colonel Beverly S. Lindsey attended the Air Force Reserve Objective Plan Council. She was the first nurse and first female to be represented on this council. (1:14)

**25 October 1984** Lieutenant General Bralliar approved the use of Army and Navy Workload Management System tool for Air Force nursing. The tool introduced acuity of nursing care into the manpower and management process in hopes of specifically validating nurses earned per specialty. The civilian nursing consultant had researched patient classification systems since 1981. (1:14)

#### 1985

Increased workload continued to be supported with Guard and Reserve augmentation, civilian overhires and creative staffing patterns. (4:88)

Third annual Chief Nurse (CN) selection board was held. Of 49 applicants, 32 were selected. Of the incumbents, 95% were recommended for follow-on CN positions. (4:91)

**6 January 1985** Colonel Beverly S. Lindsey was selected for Brigadier General with a date of promotion of 1 Jul 85. She was the first nurse general officer selected in the Reserve forces for any of the military services. (3:14)

**30 September 1985** Brigadier General Diann A. Hale retired. Colonel Carmelita Schmmmenti was promoted to Brigadier General and assumed the position of Chief, Air Force Nurse Corps on 1 Oct 85. (4:87)

**6 December 1985** The Air National Guard promoted its first female, Lt Col A. Marlene Ausen, to rank of Colonel. (4:93)

## **1986**

The outlook for NC field grade promotions was distressing for CY87-92. The potential existed for 0-5 promotion opportunities to be decreased to 45%. A working group of corps representatives was formed to develop a strategy to prevent the decrease. The major strategy was to alert major command surgeons at the Feb 87 Senior Medical Service Conference of the danger and their vital role in preventing any reduction in promotion opportunities. (5:34)

Congressional legislation proposed mandatory draft registration of health care professionals to resolve the identified wartime medical manpower deficiencies. Legislation focused on nurse shortfalls in the reserve components. General Schimmenti, Chief, Air Force Nurse Corps, and Colonel A. Marlene Ausen, USAF, NC, Air National Guard Nurse Advisor to Chief, Air Force NC, met with other Federal Nursing Service Chiefs, the American Nurses Association, and the Office of the Assistant Secretary of Defense for Health Affairs and discussed selective service registration. (5:108)

A potential resolution to the decreased nurse authorizations and inadequate use of medical technicians was the use of the Licensed Practical Nurse (LPN). The role of the LPN in the Air Force was under review. (5:108)

**1 November 1986** The Air National Guard celebrated its nurse's 30<sup>th</sup> anniversary. Colonel Norma Parsons Erb (retired), the first nurse commissioned in Guard, was the guest of honor. Colonel Erb had previously been commissioned in the Army Air Corps and Air Force Nurse Corps prior to her Guard commissioning. (5:107)

## **1987**

The FY87 congressionally directed officer reductions mandated the NC to decrease 21 officers. (7:32) The manpower reductions were to be 1% in Air Force officer strength for

FY87; 2% in FY88; and 3% in FY89. For FY87, medical officer reductions were to equal 58. The Air Force proposed reducing through early release separations, not through involuntary separations. For FY88, the plan was to continue the early release program and to decrease accessions. (6:28)

Licensed Practical Nurses (LPN) training was still being sought after. The Headquarters Air Training Command Command Nurse and the School of Health Care Sciences looked at the Community College of the Air Force to train medical technicians as LPNs. (6:99)

Nurse officers with special expertise were assigned to the nursing staff of the Chief, Air Force Nurse Corps. Four Reserve attorneys were tasked to examine nursing state disciplinary practices, review nursing malpractice cases, do a feasibility study of obtaining grants for NC history development, and to develop Air Force NC standards of practice. (7:139)

There was a focus on increasing readiness through exercises and training courses. War readiness training and exercises were added to the basic medical orientation course for all active duty and Reserve personnel for FY 87 (7:139) Air Force nurses were enrolled in civilian courses, schools, military specialty courses, and exercises with medical readiness content for peacetime terroristic scenarios or wartime scenarios. (8:145)

The Medical Readiness and Executive Management Nurse Fellowships were implemented in FY87. (8:144)

The Air Force NC worked on a Tri-service effort with the Department of Defense Health Affairs office, American Nurses Association, and other specialty nurse organizations focusing on war readiness. Efforts were directed at decreasing the nursing shortfall in Operating Room nurses, Flight Nurses, medical and surgical nurses, and nurse anesthetist specialties for Reserve forces. (7:139)

**March 1987** The National Nursing Executive Conference was sponsored by the Department of Defense (DoD). Its main focus was the national nursing shortage and the wartime nursing shortage. The result was a DoD publication of objectives to decrease the nursing shortfalls through recruiting incentives such as a loan repayment program and increasing the age limit for reserve duty. (6:98)

**July 1987** A Masters in Nursing for Nurse Anesthesia program was approved by the Surgeon General. The first class at the University of Texas Health Science Center at San Antonio School of Nursing was to be the fall of 1989. (7:139) Twenty students were to be in the first class. (9:150)

**19-29 July 1987** Captain James K. Nickerson conducted an Aeromedical Evacuation Training Course at Marka Air Base, Amman, Jordan. Thirty Royal Jordanian Medical Service Personnel were trained on C-130 aeromedical evacuation procedures. (8:144)

**3 November 1987** The Surgeon General approved a plan to consolidate all environmental health functions into the Biomedical Services Corps (BSC). Effective 1 Feb 88, environmental health was eliminated as a NC specialty. Future environmental health personnel were to be accessed through the BSCs. (8:36)

## **1988**

The Nurse Corps was briefed on the FY89-90 Officer Grade Allocation Process. The implication was that non-line components would receive increased grade allocations in the field grades. (8:36)

The three military nurse corps, the Public Health Service, and the Uniformed Services University of the Health Services began exploring the possibility of an uniformed service school of nursing. (9:148) (10:178)

The results of a NC survey examining the human dimensions of the NC were provided to the major commands. An identified area of improvement was dissatisfaction with nurse recognition and appreciation for hard work. Chief Nurses were encouraged to develop recognition programs for their deserving nurses. (9:149)

The national nursing shortage was a major challenge that subsequently affected FY89 recruiting goals. All nurses were encouraged to assist in recruiting efforts. (9:149)

Major Carl L. Anderson won the competition for an Air Force Nurse Corps song. The song was the unofficial NC song written about nursing services, a morale builder for nurses and medical technicians alike. (9:150)

**12 April 1988** The Colonel Requirements Review Board met to validate and prioritize NC, Medical Service Corps, and Biomedical Service Corps colonel grade requirements. Thirteen new positions were validated. (8:36)

**July 1988** Colonel Gloria Henandez became the first active duty nurse to be assigned as the commander of an aeromedical evacuation unit, the 9<sup>th</sup> Aeromedical Evacuation Squadron, Clark AB, Philippines. (9:149)

**6 July 1988** Brigadier General Schimmenti presented the first donation to the Air Force Sergeants Association's Medical Service Technician Scholarship Fund. The fund encouraged enlisted personnel to pursue a career in professional nursing. (9:149)

**August 1988** The Air Force Surgeon General's Retention Working Group (RWG) began meeting to discuss medical service retention. The RWG had members from Health Personnel Policy and Programs Division, corps chiefs, clinical consultants, public affairs, and the Health Affairs and Plans Division. The group's charter was to provide recommendations on how to improve retention for all corps. (9:39)

**1 August 1988** The new Officer Evaluation System took effect. Nurse Corps First Lieutenants were one of the first groups to meet a promotion board with the new form. (9:42)

**30 September 1988** Brigadier General Carmelita Schimmenti, Chief, Air Force Nurse Corps, retired after 30 years of military service. Brigadier General Barbara A. Goodwin succeeded her. (9:147)

The Air Force NC received affiliation with Georgetown University for a masters program in nurse midwifery. Clinical training was received at Malcolm Grow USAF Medical Center, Andrews AFB, Maryland. (9:150)

**October 1988** The Surgeon General convened an anesthesia working group to review anesthesia practice and policies. The group also addressed issues affecting recruitment and retention of Certified Registered Nurse Anesthetists.

**November 1988** The Armed Forces Health Professions Scholarship Program (AFHPSP) was requested to extend scholarships to nurse anesthetists. The request was under review by Department of Defense General Counsel to determine its legality under AFHPSP guidelines. (9:41)

**December 1988** The Surgeon General approved a selective continuation program for NC officers. Captains who were non-selects for major were to be considered for continuation on active duty if their records supported a continuation. (9:39)

The Surgeon General was briefed on the nurse grade review results. Grade increases were approved for Chief Nurses, Newborn Nursery/Neonatal Intensive Care/Obstetrics Nurses, and Operating Room Nurses/Nurse Anesthetists. The Air Force Medical Management Engineering Team conducted a nine-month follow-up study which began in Jan 89. (9:31)

## **1989**

Brigadier General Beverly S. Lindsey, USAFR, NC Mobilization Augmentee to the Chief, Air Force NC, retired. Colonel Marcia Clark assumed the position. (10:177)

Colonel Clara B. Wallace, Nurse Education Branch, Air Force Personnel Center, was appointed to American Nurses Association Board of Accreditation for a two year term. Her position assured Air Force inputs in national education and accreditation policies. (11:111)

The National Defense Authorization Act for FY90/91 created special pay for nurses. There was a \$5000 accession bonus for nurses with a four-year obligation and Incentive Specialty Pay of \$6000 for Certified Registered Nurse Anesthetists per 12-month window. (11:21)

Recruiting met FY89 goals. Nurse anesthesia remained a problem. Constructive credit and increased age for accessions appeared to have helped. The side benefit was that the NC gained increased experience levels. The increased age also afforded seasoned nurses a chance for career changes. Scholarships were increased for Air Force Reserve Officer Training Corps to include four, three, and two-year scholarships for qualified students interested in a military career in nursing. (11:110)

**16 March 1989** Chief Nurses of the Army, Navy, and Air Force testified before the Senate Committee on Appropriations regarding nursing issues, specifically the nursing shortage and special pay issues. This marked the first time military nurse corps chiefs were invited to present testimony in the Senate. (10:178)

**June 1989** The American Nurses Association (ANA) House of Delegates approved a courtesy seat on that professional body for a representative of the Federal Nursing Service Council. The House of Delegates also approved ANA organizations for overseas nurse participation. (10:178)

**1 June 1989** General McCarthy, Deputy Chief of Staff, Programs and Resources, approved a nurse grade review which increased field grade requirements in 5 work centers by a total of 188. The initial study done by the Air Force Medical Management Engineering Team looked at Chief Nurses, Medical/Surgical/Multiservice Nurses, Newborn Nursery/Neonatal Intensive Care Unit/Obstetrical Nurses, Emergency Medicine Nurses, and Operating Room Nurses/Nurse Anesthetists and discussed the increased nursing responsibilities caused by the change in patient acuity, Quality Assurance requirements, number of medical technicians supervised, and staff and patient education requirements. General McCarthy also directed a review of medical/surgical and obstetrical units, Wilford Hall Medical Center requirements, and Certified Registered Nurse Anesthetists requirements. The Air Force Surgeon General directed the development of a white paper to address the nurse grade requirement issue. (10:34)

**2 June 1989** The Armed Forces Health Professionals Scholarship Program expanded to include Nurse Anesthesia. Fifteen scholarships were available. Two scholarships were awarded. (11:111).

**September 1989** The first class of the Masters in Nursing for Nurse Anesthesia at the University of Texas Health Science Center San Antonio School of Nursing began. (10:179)

**21 September 1989** The Surgeon General was briefed on the second Air Force Medical Management Engineering Team study, which examined the NC grade structure. As a result, Air Force Programs and Resources approved an increase in the NC field grade requirements by: 16 Colonels, 82 Lieutenant Colonels, and 296 Majors. New manpower tables were distributed for all work centers affected. (11:14)

**1 October 1989** Nursing continuing education requirements changed from 30 per year to 20 per year for active duty nurses. Guard and Reserve nurses changed from 90 per three

years to 60 per three years. Thirty per year was initially established in 1981 in response to state licensing board license renewal requirements. The initial goal was to exceed the maximum requirements by most states. The new requirements were more in tune with state requirements. (11:109)

**4 October 1989** Department of Defense Directive 1312.2, Entry Grade Credit for Health Service Officers, afforded constructive credit to medical officers entering the Air Force. The Air Force Surgeon General was given the authority to determine which specialties were eligible. (19:SGH-B)

**17 October 1989** The San Francisco Earthquake occurred. Nurses from local bases, the Reserves and Guard performed triage on the multiple casualties. (11:111)

**4 December 1989** An interim progress report on the uniformed services school of nursing was presented to the Federal Nursing Chiefs. The task force evaluated various options for types and levels of program, curricula, and payback requirements for the nursing program. (11:110)

**20 December 1989** Operation Just Cause began. Nurses from the Reserves, Guard, and active duty participated in aeromedical evacuations from Panama to Wilford Hall Medical Center and Brooke Army Medical Center. (11:111)

## **1990**

FY90 recruitment goals were met with the exception, once again, of nurse anesthetists. Overall retention was 66%, down from 70% in FY89. (12:5) Ninety-eight percent of the Certified Registered Nurse Anesthetists (CRNA) recruited accepted the accession bonus. (18:SGH-B) There were 35 CRNA vacancies in the Air Force. Of the incumbents, 24 had 1990 separation dates, of which 17 had already indicated their plans of separating. (14:1-66)

The 1991 Department of Defense Authorization Act was established. Congress prohibited a decrease in medical manpower below the 30 Sep 89 level, in spite of several base closings. Many Air Force Medical Service leaders were concerned that Operation DESERT SHIELD/STORM may adversely affect retention and recruitment, especially in the Reserve and Guard. (12:6)

**20 March 1990** General Goodwin testified at the Subcommittee on Defense of the Senate Appropriations Committee hearing on nursing issues. (17:SGN-A)

**29-30 March 1990** Nursing report given at the Senior Medical Service Conference: The Associate Degree Nurse (ADN) Initiative was underway as a possible answer to the nursing shortage. Phase 1 included soliciting ADN-prepared medical technicians to work one year at McDill AFB and Homestead AFB hospitals to evaluate and refine the methodology and clinical roles of ADNs in the Air Force. Phase 2 was the actual training of medical technicians to the ADN level. The NC would also consider non-BSN nurse assessments if recruiting fell below 15% of accession goals with the understanding that

non-BSN nurses would work as technical nurses within a limited scope of practice. (13:1-7)

**27 April 1990** Colonel Judith Hunt became the first nurse to be a medical treatment facility (MTF) commander of the clinic at Pope AFB. This was the first time in the 43 year history of the NC that a nurse was a commander of a fixed MTF. Previously nurses were commanders of aeromedical evacuation facilities and units. (17:SGN-A)

**20 June 1990** American Nurses Association bylaws were revised. Guidelines were established for US nurse associations in overseas areas. A courtesy seat was established on the House of Delegates for a representative of the National Student Nurses Association. The House of Delegates also approved resolutions for: Recognizing and Supporting Aerospace Nursing; Endorsement of the National Disaster Medical Systems; and United States of America Nurses Overseas Association. (17:SGN-A)

**11 July 1990** Lieutenant Colonel Darlene Grubor, head of the Medical Wartime Hospital Integration Office, met with the Tri-Service nursing group to discuss the development of a training package for Deployable Medical Systems. Current training included basic tasks such as putting up tents and triage. The nursing group proposed including tasks to manage casualties in austere environments such as cardiopulmonary technical assistance, infection control, calculation of intravenous injections without mechanical infusion pumps, preparing casualties for aeromedical evacuation, and managing medications without the unit dose system. (12:27)

**9 August 1990** The build up of Air Force medical deployment for Operation DESERT SHIELD began. This deployment was to be the largest deployment since Vietnam. (12:v) Nurses were deployed to the four contingency hospitals in Europe and to the Gulf. (16:3-66)

**Fall 90** The “STOP LOSS” program went into effect, freezing separations, discharges, and retirements of nurses during Operation DESERT SHIELD/DESERT STORM. (18:SGN-B)

**18-19 September 1990** Nursing report given to the Senior Medial Service Conference: The NC requested extending the Incentive Specialty Pay to nurse midwives in hopes of resolving the midwife shortage. (13:1-9)

**16 October 1990** The Air Force Medical Service involuntarily called up medical personnel in support of Operation DESERT SHIELD. (12:72)

**November 1990** The first Clinical Nursing Service Excellence Award was awarded. The Association of Military Surgeons of the United States established the award in 1989. It honored accomplishments in clinical nursing, which had resulted in contributions of an outstanding nature by a nurse and had a substantial impact on the mission of a Federal Health Agency. (17:SGN-A)

**5-6 November 1990** The Civilian Nursing Consultant of the Air Force recommended replacing Air Force certification of Nurse Practitioners with a National Certification. (18:SGN-B)

**6 November 1990** The President authorized a substantial Air Reserve Component call-up in the 200,000 increment giving Tactical Air Command 266 Individual Mobilization Augmentees for 15 military treatment facilities. (12:72)

**10 December 1990** Air Force Reserve Personnel Center notified 1400 medical personnel of the “STOP LOSS” program in support of Operation DESERT SHIELD. (12:72)

**18 December 1990** 144 Individual Mobilization Augmentees were involuntarily called up to fill 12 continental US hospitals in support of Operation DESERT SHIELD. (12:72)

**December 1990** Operation JUST CAUSE began. Aeromedical units of the active duty, Reserve, and Guard transported casualties from Panama to US military treatment facilities. (15:2-1)

## **1991**

A total of 12,000 medical personnel from the Reserve and Guard were called to active duty during Operation DESERT SHIELD/STORM. (19:46)

This was the first year for a new flight nurse award from the Aerospace Medical Association. The Dr. Hans A. Krakauer Award honored the outstanding accomplishment of a junior flight nurse in areas of aerospace, clinical practice, education, management, or research. (18:SGN-B)

A comprehensive clinical career ladder was developed which gave nurses a choice of either maintaining a clinical career tract or adopting an administrative career tract. (19:108)

The Armed Forces Health Professionals Scholarship and Financial Assistance Program did not meet its goal. Only five of eleven opportunities were utilized for nurse anesthetists. (19:259)

The Pediatric Nurse Practitioner program at Sheppard AFB closed. The Air Force Institute of Technology now sponsored the program. (19:311)

**April 1991** The “STOP LOSS” program terminated subsequent to end of Operation DESERT SHIELD/DESERT STORM. The program had affected a total of 80 nurses. (19:108)

**8-9 April 1991** Nursing report given to the Senior Medical Service Conference: Pursuant to the newly established clinical career ladder, the Health Services Management Inspection focused on senior nurse functions on evening and night shifts. Actual placement of nurses was also discussed. It had been identified that nurses were

functioning outside of earned positions, such as in quality offices and other administrative positions. This process took nurses away from clinical areas where they were desperately needed, such as the wards. The Surgeon General urged executive nurses be placed back where they were earned, in clinical positions. Ten candidates were selected for the Associate Degree in Nursing program to begin Jun 91. (20:1-6)

**17-18 September 1991** Nursing report given to the Senior Medical Service Conference: The joint Air Force and University of Texas Health Sciences Center of San Antonio School of Nursing Graduate Nursing Program in Anesthesia was awarded full accreditation for four years by the Council on Accreditation of Nurse Anesthesia Education Programs. The Chief, Air Force Nurse Corps also stressed recognizing clinical excellence on senior nurses Officer Performance Reports and Promotion Recommendation Forms due to the new clinical career ladder. (20:1-6)

**30 September 1991** The “STOP LOSS” program ended for the Reserve and Guard. The program caused a substantial drop in retention but did not come close to predictions. The losses were apparently due to normal peacetime considerations, not a desire to avoid future deployments. (21:76)

**October 1991** FY92 National Defense Authorization Act renewed authorizations for nursing bonuses and Incentive Special Pays for Certified Registered Nurse Anesthetists (CRNA) and accession bonuses for new recruits. (21:78) Constructive credit was awarded for CRNAs, Obstetrical/Gynecological and Pediatric Nurse Practitioners, and midwives. (19:253-254) (23:2-50)

Operation SAFE HARBOR began in Guantanamo Bay Naval Air Station Cuba. It continued until Aug 92. (21:34)

## **1992**

The FY91 and FY92 Department of Defense Authorization Acts prohibited the Secretary of Defense from decreasing the number of medical personnel unless he certified there were excesses to current and projected needs and that a decrease would not result in increased costs to Civilian Health and Medical Programs of the Uniformed Services. (21:9)

General McPeak announced 1992 as the “Year of Training”. In order to determine future training needs of the Air Force Medical Service, all specialty codes and career paths were reviewed. The Surgeon General office revised career professional guidance for medical career fields. New career path pyramids were developed to enhance career counseling and decisions. (21:75)

Retention was down in all corps during FY92. (21:76)

Recruiting was strong for clinical nurses secondary to the nurse accession bonuses, but Certified Registered Nurse Anesthetists, Nurse Practitioners, and midwives continued to be problematic. (23:2-50)

A Voluntary Separation Incentive(VSI)/Special Separation Benefit (SSB) was offered in April and again in June. Any once deferred and continued Captain or Major clinical nurses, except nurse practitioners, were eligible. A total of 38 Captains and 2 Majors participated in the VSI/SSB. (23:2-50)

Colonel Gloria K. Lamoureux was assigned as hospital commander at Loring AFB, Maine. She was the first nurse officer to serve as a hospital commander. (25:4-109)

Air Force NC Executive Council approved the plan for active duty nurses to validate 30 continuing education units over a three-year period instead of 20 per year. (25:4-109)

The Associate Degree Nursing program was changed. The second class was to remain in place for two years and graduate with a Bachelor of Science in Nursing. Graduates of the first class were in the one-year clinical rotation at MacDill AFB and Maxwell AFB. The five graduates that were at Homestead AFB were moved to MacDill AFB following Hurricane Andrew. From this point further, enlisted desiring a bachelor degree in nursing and a commission had to apply through Airman Enlisted Commissioning Program. (25:4-110)

The NC participated in Corporate Information Management (CIM), a business practice improvement for nursing. CIM will be key to information management in the 21<sup>st</sup> century and beyond. (25:4-110)

The Health Services Management Inspection changed to the Health Services Inspection, changing the focus from compliance to a results orientation. The inspection guide decreased from 817 pages to 18 pages. Calendar Year 92 was the period of testing and evaluating the new inspection methods. (25:4-111)

**1 January 1992** Brigadier General Barbara A. Goodwin retired with thirty years of service in the Air Force. Brigadier General Sue Ellen Turner succeeded her. (25:4-110)

**March 1992** “Rhino Signs”, a NC information letter which updated nursing personnel on critical issues was established. “Rhino Signs” also served as a vehicle to obtain input on practice and policy concerns from nurses in the field. (25:4-109)

**27 March 1992** General McPeak approves the Surgeon General concept of the Objective Medical Group. (21:17)

**22 April 1992** Colonel Roberta V. Mills was promoted to the rank of Brigadier General. She was the first female in the 355-year history of the Air National Guard to be promoted to the rank of general officer. Brigadier General Mills served as the Air National Guard Assistant for Nursing to the Chief of the Air Force Nurse Corps. (24:4-17)

**13 May 1992** Ten medical technicians graduated from Lewis-Clark State College, Lewiston, Indiana, with an Associate Degree in Nursing. (25:4-109)

**June 1992** There was a revision of the medical profession evaluation board membership. The health professional board now comprised of one line officer board president, no more than two members from the competitive category under consideration, with the remaining two members normally from a medical professions competitive category not under consideration or line officers. (23:2-50)

**30 June 1992** Chiefs of the NC of the Army, Navy, and Air Force met at Arlington National Cemetery. They donated stocks and funds, which were jointly maintained by the three services for ceremonies honoring military nurses, to Women in Military Service for America Memorial Foundation. The memorial was to be built at the main gateway to Arlington National Cemetery and enshrine achievements of all service women, enlisted, officer, past, present, and future. (25:4-109)

**22 July 1992** The Nursing Career Path Review, which began in April 1992, was briefed to the Chief of Staff of the Air Force. Career paths were developed for all nursing personnel, both officer and enlisted. A formal review of all education, training, and manpower requirements was conducted in developing future career paths. (25:4-109)

**August 1992** Operation PROVIDE TRANSITION began in Angola. (21:33)

**24 August 1992** Hurricane Andrew devastated Homestead AFB. (21:27)

**September 1992** Hurricane Iniki destroyed Kauai in the Hawaiian Islands. (21:35)

**October 1992** A Colonel core requirements review process directed by the Chief of Staff of the Air Force (CSAF) was ongoing. Eleven of the 53 NC variances submitted were approved by the CSAF. These variances involved direct patient care areas. (23:2-50)

Two new fellowships for the NC were established for FY93: Managed Care and Medical Manpower. (25:4-110)

**November 1992** Fifty years of Flight Nursing was celebrated at Brooks AFB during the 75<sup>th</sup> Anniversary of both the USAF School of Aerospace Medicine and Brooks AFB. A total of 6,000 people attended, including flight nurses from seven nations. (25:4-110)

Manpower division at Headquarters, USAF used the Workload Management System for Nursing (WMSN) data for the manpower price-out. This was the first priceout using WMSN. All medical treatment facilities had at least one year worth of data. (25:4-110)

Congress approved one million dollars to plan and implement the masters nurse practitioner program at Uniformed Services University of the Health Sciences (USUHS).

(25:4-110) Air Force nurses and Public Health Service nurses joined USUHS to develop the graduate nurse practitioner program. (25:4-111)

**13 December 1992** Operation RESTORE HOPE began in Somalia. (21:30-33)

### **1993**

The active duty NC was manned at 99%. Retention in the Reserves and the Individual Mobilization Augmentee were problematic because of the financial losses incurred by Air Reserve Component medics during Operation DESERT SHIELD/DESERT STORM. (26:81)

The Joint Healthcare Manpower Standards (JHMS) were used during the manpower reapplication process. The Workload Management System for Nursing data on patient acuity provided the basis for inpatient nursing staff manning. JHMS established the need for increased nurses on inpatient and outpatient units, and for unit clerks on all inpatient units. (30:4-129)

“Rhino Signs” conducted a survey, analyzed the results, and reported the findings out to the field. The survey targeted the organizational climate throughout Nursing Services, using the six NC goals, which were founded upon the principles of Total Quality Management. Areas of improvement identified were communication flow throughout the organization; empowerment of junior officers; increasing opportunities for and willingness to do mentoring; and the nursing documentation process. (30:4-129)

Career opportunities were increased for non-retirement eligible nurses. They were now able to compete for specialized training programs, Air Force Institute of Technology sponsored graduate education, and Professional Military Education in residence. (30:4-129)

The Air Force NC was fully accredited as a continuing education approver through Feb 99 by the American Nurses Credentialing Center. (30:4-129)

Nursing Service developed a policy directive and metrics (Air Force Policy Directive 46-1, Nursing Services) and two major Air Force Instructions (AFI) related to nursing services throughout the Air Force. AFI 46-101, Nursing Operations, provided an organizational overview for Nursing Services in the military treatment facility. AFI 46-102, Nursing Care, outlined the delivery of nursing care in military treatment facilities. These new AFI's were part of the Air Force's Chief of Staff initiative to streamline all regulations. (30:4-129)

**January 1993** David Grant Medical Center began its in-house masters program in Medical/Surgical Nursing in conjunction with California State University Sacramento. The 20-month program was to be completed in 18 months. A master prepared nurse supervised clinical duties applying to the practicum. (25:4-110)

**20 January 1993** Selective Early Retirement Board was held in order to meet projected FY95 end strengths and grade requirements. Colonels with two years time-in-grade and who did not have an approved retirement date as of the board convening date were eligible. If selected, the colonel had to retire no later than 1 Oct 93. The maximum allowable select rate allowed by law was used which was 30%. (23:2-50)(30:4-129)

**February 1993** The Nurse Automation System Test (NAST) was expanded at David Grant Medical Center. NSAT supported patient care documentation, workload management, quality assurance, staffing, and scheduling. The patient classification module showed significant timesavings during the pilot test. (30:4-129)

A pilot program in aeromedical evacuation (AE) training was conducted to apply lessons learned from Operation JUST CAUSE, DESERT SHIELD, and DESERT STORM. Forty new AE crewmembers and 100 mission support personnel graduated from a two-week joint training program. Sixteen nurses graduated from a test five-week course, which included C-130 qualifications. They were the first class to combine training with the two week AE Contingency Operations Training Course for ground support personnel. The goal was to better prepare all participants through standardization and enhanced interoperability in contingency operations. Initiatives were underway to incorporate successful aspects of the course into Total Force AE training. (30:4-129)

Nurse Corps Chiefs of all three services implemented a nurse-technician staffing system specific for Labor and Delivery and Post Anesthesia Care Units. Twenty-one Air Force treatment facilities participated. The system classified patients based on direct nursing care time provided to patients. It also provided a staffing profile to assist with scheduling. Unlike the Workload Management System for Nurses, the new system required a retrospective analysis of data gathered concurrently or shortly after completing a task. For Labor and Delivery, the system also captured outpatient workloads accomplished by the inpatient staff. (30:4-129)

Lieutenant Colonel Constance M. Egan assumed command of the 14<sup>th</sup> Medical Squadron, Columbus, Mississippi. She was the sixth nurse to command a medical treatment facility. (30:4-129)

Major Terry L. Hammond, Obstetrical/Gynecological Nurse Practitioner (OGNP) at Kelly AFB, TX., was selected to serve on the National Certification Test Committee for the OGNP Certification Exam. Major Hammond was one of ten selected from a nationwide search and the only military member on the team. (30:4-129)

**2 March 1993** Air Staff notified the Surgeon General that medical personnel would not participate in the FY94/95 drawdown management plan. (26:5)

**October 1993** The Tri-Service nursing group's Functional Economic Analysis (FEA) resulted in a shift from nursing focused to patient focused care management and significant revisions of the cost/benefit analysis. Final approval by Health Affairs is awaiting completion and integration of a FEA on Special Care Units by the Tri-Service working group that began its tasking this month. (30:4-129)

The new Air Force specialty code (AFSC) system was implemented: Nursing Administration became 46A4/3/1 from 9716; Clinical Nursing became 46N4/3/1 from 9756; Mental Health Nurses became 46P4/3/1 from 9726; Operating Nurses became 46S4/3/1 from 9736; Nurse Anesthetists became 46M4/3/1 from 9746; Flight Nurses became 46F4/3/1 from 9766; and Nurse Midwives became 46G4/3/1. The 4 equated to staff level experience, the 3 equated to a qualified level, and the 1 denoted entry level. (30:4-129)

**1 October 1993** TRICARE, a managed care approach to control costs while maintaining high-quality care, was formalized and put into effect by the Office of the Assistant Secretary of Defense (Health Affairs). The fifty states were divided into twelve regions with a military medical center serving as the lead agent for all military medical treatment facilities in that region regardless of service. (26:17) Nursing had an expanded role under TRICARE. Nurses were involved with managed care, utilization management, case management, discharge planning, and health promotion. TRICARE expanded the use of Advanced Nurse Practitioners through cost containment and assisting physicians. Advanced Nurse Practitioners were involved with patient teaching, primary care, and referrals. (33:1-96)

**29 October 1993** Colonel Irene Trowell-Harris, New York Air National Guard (ANG), became the first Black female promoted to the rank of General in the Air National Guard. (28:8)

**December 1993** The Objective Medical Group test period ended. (25:29)

By the end of December 1993, 445 Air Force medics were deployed to numerous Military Operations Other Than War, with another 58 on call. (26:35)

The 733 Study final report was due. The study was tasked with evaluating and shaping the Air Force Medical Service; reviewing wartime requirements; and analyzing peace time care alternatives, clinical services marginal costs, patient response to cost sharing arrangements, and medical service utilization. (27:1-6)

## **1994**

Effective the CY94 promotion boards, majors twice passed over were no longer offered selected continuation. Those passed over were offered early retirement or continuation until retirement eligibility was obtained. (28:1-88)

Chief, Air Force Nurse Corps sought and received an increase in the incentive pay for Certified Registered Nurse Anesthetists (CRNA). The CRNA incentive pay increased from \$6,000 to \$15,000 while the accession pay remained at \$5,000. This program was extended through FY96. (31:84)

Nurse Corps job titles were standardized. Titles were developed that accurately reflected responsibilities under the new Objective Medical Group. These new titles also increased line officers understanding of NC functions and responsibilities since the terms flight, squadron, and others, were used in line “lingo” as well. The standardized titles also assisted in promotion and selection boards since the playing field was now balanced. (31:85)

The Air Force Nurse Transition Program went into effect in response to concern over the national nursing shortage. This program was a two and one half-month course to assist new active duty nurses’ transition into military nursing. It allowed the Air Force to double the number of new inexperienced nurses accessed by decreasing the current training time from five to two and one half months and saving costs associated with Permanent Change of Station moves. Under this new program, the majority of new accessions remained at one of six major medical centers where they trained, decreasing the need to move after training. (33:1-96) This program replaced the Nurse Internship Program. (34:4-45)

Nurse-managed clinics were initiated to improve care and increase patient satisfaction. Nurses ran the clinics with physician oversight. The nurses covered the wide spectrum of outpatient care of patient teaching, referrals, and interpretation of lab values. Nurse-managed clinics freed doctors to provide more intensive or specialized care. (33:1-96)

**10 January 1994** The Nurse Utilization and Training Policy went into effect. Nurses who received education and training in an acquired specialty were required to work in that specialty for a specific period of time as follows: Air Force Institute of Technology-five years in the specialty; courses greater than ten weeks-three years in that specialty (certificate Obstetrics and Gynecology Nurse Practitioners, Operating Room Nursing, Clinical Hyperbaric Nursing, and Nursing Executive Development); courses less than ten weeks had no requirements (Nursing Service Management, Staff Development Officer – Basic, Basic Infection Control and Surveillance, Accelerated Basic Obstetrical Nursing, Nursing Practice Requalification, Flight Nurse Course, and Operating Room Management). Although this last group had no requirements, having nurses work at least one tour in the specialty area was encouraged. (34:4-45)

**June 1994** The Chief, Air Force Nurse Corps empowered Chief Nurses to approve corps badges, conditional reserve status, and nurse attendees at Air Force Institute of Technology short courses, streamlining the process. (31:84)

**1 October 1994** The Air Force Medical Service adopted the Objective Medical Group structure effective this date. (31:iv)

## **1995**

Two expectation surveys were sent out. One to active duty and Reserve and Guard Chief Nurses and senior enlisted members. The second was sent to Chief Nurse Executives and Operating Room nurse supervisors. Results indicated the field wanted increased career

potential for nurses, mentorship, educational training, equity, and increased management training for middle managers. (35:114)

A request was submitted to develop a separate Air Force Specialty Code for Family Nurse Practitioners (FNP). The FNP had a broader scope of practice than the Primary Care/Adult Health Nurse Practitioners and covered the whole range of age groups. The request was honored. (35:2)

Medical support continued to US airman in Saudi Arabia and Bahrain. Over 100 medics were stationed in the Gulf area. (35:36)

The Senate added an amendment into the authorization bill adding privileged military nurses to the list of health care professionals who were eligible to receive special pay for being board certified. (35:2)

Flight School opened to non-retirement eligible nurses who met the same criteria as for Conditional Reserve Status or a Regular Commission. (35:2)

**January – March 1995** Medics participated in Operation UNITED SHIELD, the United Nations withdrawal from Somalia and Kenya. (35:36)

**January 1995** Operation SEA SIGNAL began in Guantanamo Bay Naval Station, Cuba. Operation SAFE HAVEN and subsequently Operation SAFE PASSAGE managed the movement of refugees from Cuba to Howard AFB, Panama, and then back to Cuba. (35:36)

**24-25 January 1995** Brigadier General Turner attended the 94<sup>th</sup> Air Force Uniform Board. Wear of the blue coat and hat with the white hospital uniform and the USAF Academy hospital white shoe test were approved. (35:3)

**10 February – 7 August 1995** Medical support provided to the United Nations Protection Force in the former Yugoslavia in Operation PROVIDE PROMISE. (35:36)

**16 February 1995** The standardized nurse job titles went into effect. Nurses in like jobs were now identified with the same titles. This initiative facilitated promotion and selection boards where a record review was performed. (34:4-25)

**24-27 April 1995** The Air Force Professional Executive Symposium, traditionally a nursing meeting, invited Command Medical Service Managers and other officer specialties to attend for the first time. (35:3)

**1 May 1995** Brigadier General Sue Turner retired this date with 30 years of service. Brigadier General Linda J. Stierle assumed the position of Director, Nursing Services, Office of the Surgeon General, as well as Director, Medical Readiness Doctrine and Planning. (35:1)

General Stierle shared her expectations of the NC with senior nurses: job knowledge, leadership, professional qualities, organization skills, decision making, and communication skills. These are areas nurses should strive to excel in and mentor in younger nurses. (35:113)

**May 1995** Request went out to all major commands requesting a list of nursing initiatives which resulted in cost savings for the medical treatment facility. Over 70 initiatives were collected. Thousands, and in some cases, millions of dollars were saved as a result of these initiatives. Data was utilized in General Stierle's testimony before Congress to illustrate how the NC was able to quantify how Nursing makes a difference financially. (35:2)

**15 May 1995** Selective Early Retirement Board held for FY96 end strengths. All colonels with 2 years Time-in-Grade and all lieutenant colonels with at least 20 years total active military service were eligible. Exceptions to the board were Certified Registered Nurse Anesthetists, Brigadier General selects, colonel selects, and officers with mandatory retirement dates. A 30% selection rate was utilized. Eleven colonels and 18 lieutenant colonels were selected. (35:121)

**October 1995** The NC grade structure was reexamined. A redistribution of grades increased NC additional authorizations for 83 majors and 56 lieutenant colonels. The colonel redistribution was not completed by the end of 95.(35:123)

The nursing newsletter, Rhino Signs, was established on the World Wide Web. (35)

**1 October 1995** A new section was published in Air Force Instruction 44-119, Medical Clinical Quality Management. This section covered registered, licensed, or certified non-privileged staff, i.e. nurses. The purpose of the new section was to protect patients, provide due process, speed resolution of issues, and allow proper reporting of negative nursing behaviors to professional regulatory agencies. It included peer reviews and recommendations for corrective actions, and due process rights and procedures. (35: 114)

Education with Industry fellowships were initiated for three nurse corps officers. The nurses worked in two Health Maintenance Organizations and the Joint Commission on Accreditation of Healthcare Organizations. (35:2)

**November 1995** The first NC strategic planning conference was held. Fifty active duty and reserve component nursing officers and enlisted personnel met to initiate the NC strategic plan. Six goals were identified: 1) Develop and Support Strong Leaders, 2) Champion Customer Driven Nursing Practice, 3) Be a Full Partner in Building Healthy Communities, 4) Champion an Integrated Ready Force, 5) Effectively Use Our Resources, and 6) Foster the Appropriate Employment of Technology. Two breakthrough areas were also identified: 1) Deploy the Nursing Strategic Plan, and 2) Define and Champion Opportunities for Reengineering the Healthcare Delivery System. The NC Strategic Plan will be the roadmap for the future, focusing on defining nursing service strengths and weaknesses and to forecast future opportunities and threats. The

elements of a nursing vision and an environmental assessment for Air Force nursing was also established. Members were tasked by General Stierle to report back to her by early 1996. (35:17, 113)

For the first time, active duty and reserve component nurses gathered to discuss readiness issues during Air Force Nursing Services Day at the Association of Military Surgeons of the United States annual meeting. (36:2)

**27 November 1995** The Objective Medical Group (OMG) was reexamined to clarify the role of the Group Staff. Sixteen senior medical service leaders discussed the OMG survey that was conducted during Jun and Jul 95, and decided improvements were needed. A working group was to start Jan 96. (35:8-9)

**5 December 1995** Air Command and Staff College increased its medical component from six to seven for the 96/97 class, with an increase of one each year for the next two years to a total of nine. Air War College was increased from two to six effective 96/97 class. (35:123)

## **1996**

Advanced Practice Nurses with current licenses and national certifications were awarded “regular” privileges and appointed to the medical staff, alleviating the need for direct supervision. (37:2)

Col Aleda J. Ahlgren championed a package that allowed USAF Academy cadets to attend a bachelor/masters in nursing bridge program at Vanderbilt University upon graduating from the Academy. Upon completion of the program, graduates were to enter the NC. Implementation was projected for FY97. (37:2)

**January 1996** “Rhino Signs” was changed to “Nightingale Express.” (37:1)

**April 1996** The second meeting of the strategic planning group met in conjunction with the Executive Leadership Symposium. Goal champions focused on developing objectives and metrics to meet the intent of the plan. Formal presentations were to be made at Association of Military Surgeons of the United States meeting in November 1996. (37:1)

**June 1996** The first class of ten Family Nurse Practitioners graduated from Uniformed Services University of the Health Sciences. (37:1)

**July 1996** Promotion opportunity to Colonel was set at 45%. (37:2)

**August/September 1996** Nurses who were health care providers, had a master’s degree in a nursing clinical specialty, and were board certified in their practicing specialty were eligible for board certification pay. The earliest effective date of eligibility was 10 February 1996. (37:2)

**October 1996** In response to an airplane crash in Ecuador, the Critical Care Air Transport Team and Mobile Forward Surgical Teams deployed on C-9 aircraft and subsequently transported 19 critically burned patients to burn units in the United States. (36:1)

**10-15 November 1996** Formal deployment of the Total Nursing Force Strategic Plan took place during the Association of Military Surgeons of the United States. Brigadier General Linda J. Stierle provided opening remarks. A member from each Goal and Breakthrough Area discussed objectives and provided progress thus far. Brigadier General Trowell-Harris from the Air National Guard and Brigadier General Mailey from the Reserves shared their vision and expectation from the Guard and Reserve perspective. (37:3)

## **1997**

The NC continued to achieve greater losses than accessions as it progressed toward the FY2003 drawdown target. The NC was expected to have the greatest reductions, with fewer cuts in the Biomedical Corps, and minor adjustments for the Medical Corps and the Medical Service Corps. (41:1)

Work continued on the Total Nursing Force Strategic Plan. Progress was shared at Executive Leadership Management and Association of Military Surgeons of the United States meetings. (38:1)

The Total Nursing Force Career Path Progression was revised using realistic career expectations and the new Objective Medical Group (OMG) duty titles. The new guidelines provided a realistic matrix of career progression and aligned NC and corps neutral positions with day-to-day medical operations, staff jobs, leadership, and OMG guidance. (38:2)

Battlefield Nursing (BFN) Course requirements were revised to allow state-side based nurses to attend. Traditionally, BFN was reserved for nurses going overseas for their first assignment. Nurses deployed to Military Operations Other than War felt the need to attend BFN to prepare them for this new mobility role. Five slots were reserved at BFN for nurses scheduled to deploy. (38:3)

A Distance Learning Guide listing and describing learning opportunities and financial assistance information was posted on the Nurse Corps Home Page. This provided a quick reference of distance learning websites, descriptions of degree-awarding programs, and listings of colleges and universities offering distance learning nursing courses. (40:5) There was an increased focus on using distance learning as an education and training modality due to decreasing budgets. (38:3)

The Nurse Transition Program was reengineered to ensure it met the needs of the students as well as the Chief Nurses and Nurse Managers. (38:1)

The Certified Registered Nurse Anesthesia Program at the Uniformed Services University of Health Sciences (USUHS) was underway. Nurses received academic training at USUHS with a clinical phase at a military treatment facility. (38:4)

Top Sustainment Training/Advanced Readiness (TopSTAR) was devised to solve competency problems created by declining training platforms. TopSTAR is a prototype simulation skills lab as an adjunct to hands-on clinical training for which active duty and reserve components partnered. Wilford Hall Medical Center was selected as the first TopSTAR site beginning early in 1998. West coast and east coast sites were to be added in the future. (38:4)

The results of the Surgeon General's office review of Defense Officer Personnel Management Act (DOPMA) constrained colonel requirements was released. The review was initiated in 1996 due to the unacceptably low promotion rates and colonel inventory for nurses. The team was to identify corps specific and corps neutral positions in order to balance the colonel distribution, identify management fixes needed, and ensure colonel promotion opportunities for DOPMA constrained corps were within plus or minus five percent of the Line of the Air Force. Criteria utilized to justify a colonel requirement were: 1) level of authority, 2) resources managed, 3) difficulty level of position, 4) management level, 5) judgement and decision making requirements, and 6) planning requirements. Of the 245 positions validated, 70 were identified as corps neutral. Overall, nursing earned an additional nine colonel billets. The Biomedical and Medical Service Corps validated their colonel requirements as well. Lieutenant Colonel and Major reviews were scheduled for 1998. (38:5)

The Air Force NC discontinued recruitment and accessions of non-retirement eligible nurses and nurses without Bachelors of Science in Nursing. The right-sizing efforts enabled the NC to be more selective in choosing candidates for careers in the Air Force. (38:5)

**January 1997** Eleven nurses were selected as Medical Group Commanders of which nine were new commanders. Two incumbent nurse commanders were selected for greater responsibility at a higher level of care military treatment facility. Of import was that one third of the new commanders were selected to command intermediate size facilities rather than a small size facility which was the traditional career path. (39:9)

**March 1997** The first Total Nursing Force Executive Leadership Symposium for both enlisted and officers of active duty, Reserve, and Guard personnel was held. (38:2)

The Chief, Health Care Integration (HCI) role was unveiled at the Worldwide Prevention Conference. The HCI was developed to support outpatient case management, disease management, demand management, and self care. (38:5)

**27-30 May 1997** The first Air Force Medical Service Integrated Forecast Board was held. The purpose of the board was to project personnel training requirements along

product lines. Nurse Corps Air Force Institute of Technology and Fellowship opportunities were projected. (41:3)

**June 1997** The first major “joint” aeromedical evacuation exercise, Patriot MEDSTAR was held. This was the first time all Aeromedical Evacuation Staging Squadrons and Air Transportable Hospital elements participated in a total force training exercise. (40:4) Over 550 participants were trained in trauma assessment and specific Air Force Specialty Code training. (38:2)

**Fall 1997** Two USAF Academy graduates entered the bridge program at Vanderbilt University to obtain a Bachelors/Masters in Nursing. This was a significant milestone as the NC attempts to grow a generation of nurses who will be serious competitors for Surgeon General of the Air Force. (38:2)

**October 1997** The NC opportunity to successfully compete for leadership and commander positions increased dramatically. Thirteen nurses were military treatment facility (MTF) commanders out of 76 positions this year. Of the four Aeromedical Evacuation (AE) Squadrons, three were commanded by nurses. All MTF and AE commander positions are corps neutral. At the Commanders Selection Board held this month, 18 of 58 commanders selected were nurses. (38:4)

**6 October 1997** The Centralized Colonel Command Screening Board screened 192 records to select candidates for 42 projected vacancies. (41:2)

**18 October 1997** The Women in Military Service in America Memorial dedication was held this date. Active duty, Reserve, and Guard personnel provided medical care and volunteer services during the four-day ceremony. Thirty thousand veteran women and their families attended this historic event. (38:2)

**November 1997** The first Total Nursing Force Day was held at the Association of Military Surgeons of the United States meeting. Active duty, Reserve, and Guard nursing leadership discussed the Total Nursing Force Strategic Plan, Medical Examination of the Value Jet Crash, Forensic Nursing, Enlisted Training Panel, and a historic modeling show of nursing uniforms, past and present. (38:5)

**10-14 November 1997** The Air Force Medical Service (AFMS) participated in the Central Professional Military Education Board. This was the first time the AFMS participated with the Line of the Air Force and other non-line categories in a central board format. Two nurses were selected to attend Air War College and Air Command and Staff out of eight selected for each school. (41:2)

**12 December 1997** The Air Force closed its Nurse Midwifery Education Program. With the changes under way in the Air Force medical services, and the outsourcing of obstetrical care, it was determined that midwifery was no longer an efficient and effective way to meet future Air Force requirements. (38:3)

**1998**

The Total Nursing Force Strategic Plan (TNFSP) marketing video and Implementation Guide was deployed to all military treatment facilities, Reserve, and Guard medical units. The TNFSP informational video reinforced the importance of the TNFSP and its linkage to operations. The Implementation Guide provided the field a detailed report of the TNFSP tasks and subtasks in support of goals and objectives. (40:1)

The Integrated Forecast Board was established to forecast fellowship requirements. Approval was gained for fellowships in Executive Nursing, Risk Management, and Medical Readiness Planning. The Total Nurse Force competed for these nurse-specific and other corps-neutral fellowships. (40:1)

The Department of Defense (DoD) Executive Skills Catalog was distributed to Command Nurse Administrators and medical treatment facility Chief Nurses. This catalog provided a listing of leadership courses offered by DoD to facilitate training in executive skills. (40:1)

The Air Force Medical Services empowerment course was deployed at the medical treatment facility level. Twenty-eight lesson plans provided facilities the opportunity to incorporate leadership training into local training programs. (40:1)

The revised NC Career Progression Path was deployed. This product integrated operational, staff, and executive leadership tracks under the Objective Medical Group reorganization, aligning it with a format utilized by the Line of the Air Force. It facilitated realistic career planning for NC officers. (40:1)

A Total Nursing Force Awards Guide was posted on the Nurse Corps Home Page to facilitate the nomination of well-deserved nurses for recognition. (40:2)

The need for a nurse to be on staff at the Office of Preventive Health Services Assessment (OPHSA) was established. This position provided on-site nursing input and expertise on Building Healthy Communities and provided a point of contact within the OPHSA. (40:2)

Attempts were made to have the Department of Defense extend the eligibility period for Reserve and Guard Diploma and Associate Degree nurses to enroll in financial incentives to pursue baccalaureate studies. This initiative will positively influence the retention and contribution of Air Reserve Component nurses to the Air Force Medical Service. (40:3)

Aeromedical Evacuation (AE) Unit Type Code from the total force inventory were integrated into the Joint Readiness Training Center (JRTC) schedule. This ensured AE and Air Transportable Clinic participation in all JRTC activities and training exercises, increasing the efficiency of the AE nursing force. (40:3)

A FY98/99 Nurse Transition Program (NTP) Strategic Plan was developed. This plan provided objectives and tasks to improve the NTP using a pilot test of a simulated

inpatient unit to evaluate the potential cost savings and effectiveness of alternate training platforms. (40:5)

**January 1998** The Accelerated Basic Obstetrical Nursing Course site was moved from Keesler AFB, MS, to Travis AFB, CA. This decision was made based on the fact that Travis provided the most experience in an allotted training time. (40:4)

**Spring 1998** An Air Force Institute of Technology Student Assignment Input questionnaire was developed for non-provider majors. It assisted in follow-on assignments by determining information on academic major, special projects, thesis topic, research accomplishments, and specialized skill training, and then meshing the information with assignments that were available. Two Doctoral level graduates had assignments coordinated with this tool. (40:4)

**September 1998** The first integrated Air Reserve Component (ARC) Aeromedical Evacuation (AE) Unit Type Code (UTC) course was held at Sheppard AFB, Texas. The initiate was a result of integrating the ARC AE UTCs into the AE Contingency Operations Training schedule. The course fulfilled a major training deficit identified during Operation DESERT STORM. (40:3)

## **Appendix B**

### **List of References for Appendix A**

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## *Glossary*

AAC	Army Air Corps
ADN	Associate Degree Nurse
AF	Air Force
AFIT	Air Force Institute of Technology
AFHPS	Air Force Health Professionals Scholarship
AFMEDNET	Air Force Medical Management Engineering Team
AFMS	Air Force Medical Services
AFNC	Air Force Nurse Corps
AFPC	Air Force Personnel Center
AFR	Air Force Reserve
ANA	American Nurses Association
ANG	Air National Guard
ARC	Air Reserve Component
ASF	Aeromedical Staging Facility
ATH	Air Transportable Hospital
ATC	Air Transportable Clinic
ATC pre 1990s	Air Training Command
BG	Brigadier General
CENTCOM	Central Command
CN	Chief Nurse
CNE	Chief Nurse Executive
Col	Colonel
CONUS	Continental United States
CRNA	Certified Registered Nurse Anesthetists
CSAF	Chief of Staff of the Air Force
DEPMEDS	Deployable Medical Systems
DOD	Department of Defense
DS/DS	Desert Shield/Desert Storm
EUCOM	European Command
FAP	Financial Assistance Program
FY	Fiscal Year
HSMI	Health Services Management Inspection

HQ	Headquarters
IMA	Individual Mobilization Augmentee
JCCP	Joint Casualty Collection Point
LG	Lieutenant General
LPN	Licensed Practical Nurse
MAJCOM	Major Command
MDG	Medical Group
MTF	Military Treatment Facility
NC	Nurse Corps
NP	Nurse Practitioner
OB/GYN	Obstetrical and Gynecological
OPR	Officer Performance Report
OR	Operating Room
PRF	Promotion Recommendation Form
ROTC	Reserve Officer Training Corps
SG	Surgeon General
SGB	Directorate of Biomedical Services
SGN	Directorate of Nursing
SME	Squadron Medical Element
SSB	Special Separation Benefit
TAC	Tactical Air Command
TIG	Time-in-Grade
UN	United Nations
US	United States
USUHS	Uniformed Services University of the Health Sciences
VSI	Voluntary Separation Incentive
WHMC	Wilford Hall Medical Center

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