

U.S. NAVY MEDICAL DEPARTMENT ORAL HISTORY PROGRAM

ORAL HISTORY WITH RADM (ret.) TODD FISHER, MSC, USN

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**Interview with RADM S. Todd Fisher, 2 March 2000. RADM Fisher was the Deputy Surgeon General of the Navy.**

**Take me back to your childhood, about growing up in New York.**

Sure. I was born on the 7th of April in 1941, in a small town in upstate New York called Little Falls, New York. Which is about 10,000 people, the whole town size. It's known for, it's right on the Erie Canal, so it used waterpower for manufacturing and things like that. I lived up on the side of the hill overlooking the town with a dairy farm right behind us, which was the testing farm for Cherrybrook Corporation, which made milk machinery and pasteurizes, and separators and things like that.

So as a kid, I had the woods and the farm and the fields, and all that at my doorstep to play with. And I was pretty much an outdoors kid. Went through the typical kid stuff, very active in Boys Scouts. I belonged to the YMCA Boy Scout troop. I became an Eagle Scout there, was a member of the Order of the Arrow and was very active.

I was a camp counselor in a Boy Scout camp in the Adirondacks for a good number of years. I was brought up with the ethic of work from my father. My father ran a small steel fabrication plant in Utica, New York, which was about 25 miles away.

At that time, it was the Utica Steam Engine and Boiler Works, which is no longer in existence. But originally they did steam engines for the railroad, and special metals. I worked there one summer to earn money. On the hill there was a metal rail fence. I think there were probably four miles of metal rail fence, which I earned money at 15 cents a section, scraping it, wire brushing it, and painting it. So that's where I got my spending money and things like that.

There was no free lunch, very strong Protestant ethic. My father was a product of the depression, so those values were very strong and what I was brought up with. I didn't graduate from Little Falls High School. I wound up going to prep school for my senior year, which was in Vermont, Vermont Academy. And did one year of Vermont Academy, graduated from there in 1959, and then went on the college. Went to Washington and Jefferson College, outside of Pittsburgh, Pennsylvania, where I double majored in economics and biology, primarily economics.

In those days, you couldn't show a double major, so it was shown as economics, but I had a major in biology too. My grandfather was alive, I knew him, my mother's father. And he had Parkinson's disease, with the shakes and all. Originally I thought that I'd like to be a surgeon, but numbness occurred to my hands when they got cold in the wintertime.

So I convinced myself that I was early Parkinson's, and therefore my career would be cut short if I wanted to be a physician. So Little Falls has a small hospital, 123-bed hospital, which is unique in the United States in that its Board of Directors are all women. And my mother was on the Board at that time.

**Is that still true?**

Yeah, still all women. And they were in the process of looking for the first hospital administrator and they hired a guy by the name of Bill Milgriest. And this was while I was still at Washington Jefferson College. And I didn't know anything about the profession, didn't know anything that it even existed but it was in the environment that I was interested in being. So I shadowed him one summer.

I didn't work; at least I wasn't gainfully employed. But worked in the hospital one summer and decided, gee I sort of like this stuff, hospital administration. So, that's what I decided I wanted to do. And I gave up the idea, because of bad logic quite honestly, of being a physician.

And I graduated from W&J and then went to Cornell University for my Masters Degree in Business, certified in hospital administration. Cornell's program was two years of academic in the summertime, in between is an internship. And I did that internship at West Penn Hospital in Pittsburgh, Pennsylvania, which was another wonderful experience.

**Was it West?**

West Penn, Western Pennsylvania Hospital. So I graduated from Cornell in 1965. And as you remember, that's the start of the build up of Vietnam. So as a young male in this country, the draft was very interested in me. So I, you know, I knew I needed to do something. So interviewed with or looked at the Army, the Navy, and the Air Force, and the Public Health Service, all those commissioned corps.

The Army would make no guarantees that I wouldn't go to Vietnam and no real guarantee I'd work in hospital administration, even though I had my Masters Degree. The Air Force was a four-year obligation, but it would be working in a hospital. And the Navy was a three-year obligation in a (unintelligible) hospital with, in essence, no chance to go to Vietnam.

Public Health Service was the other option, but I was told that you could not get into the commissioned corps of the Public Health Service. So, I gave up on that idea. And came into the Navy for primarily selfish reasons of no chance of Vietnam, and one year less than the Air Force. When I came in, well, I applied and did all the

paperwork and all that, they sent it to Washington and didn't hear anything, didn't hear anything. I graduated from Cornell, still didn't hear anything.

So, I went back to West Penn Hospital and started employment there. And then in came a Navy message saying report like two days from now to Bethesda for orientation. Actually, it wasn't a message, it was a letter. And the recruiting had all be done out of Buffalo, in the recruiting district there. The date on the letter was way back in April, and this is July. So, obviously recruiting had really screwed up on the deal.

So I, to say the least, I was perturbed because I kept making telephone calls to recruiting saying, what do you want me to do, and gee, we don't know, and being jerked around. So, here I am now, gainfully employed, doing stuff for a hospital, and they say come immediately.

So, being very perturbed, the letter was signed by a person by the name of Herman, and that meant nothing to me other than the name Herman. And so I got a telephone number for him and called him and told him what I thought of his organization. And then when I reported to Bethesda, I discovered that Herman just happened to be the head of the Medical Services Corps.

#### **That Herman.**

That Herman. But in those days, we were called, what we call 30 day wonders, in that the orientation for direct procurement, MSEs for everything, was done at Bethesda, in what was then the Naval School of Hospital Administration, which was also the home of the old Mat School in all of Bethesda. And they did the orientation program there and they had some other programs going on there.

So I did the orientation program there, which was 30 days. And that was my first taste of the Navy. And we learned how to wear a uniform, how to put it on, how to salute, how to march. In fact, they used patients from the hospital to help teach us marching. And we got a one eyed DI from the Marine Corps to teach us marching. So we were really very good by the time it was all done.

But the other aspects of orientation at Bethesda, was we had the opportunity also to learn customs and traditions. And one of the customs and traditions is the change of command. So we went to watch the (unintelligible) change of command ceremony, which was just down the street from NASH Bethesda as it's called now, which is the same building way back then in 1965.

And I'll never forget it because I believe it was Captain Sutcliff who was one the participants in the change of command. I don't know whether he was incoming or outgoing commanding officer. But there was an MSC Commander as I remember that was the Officer

of the Troops. And they all had swords. And he drew the sword and did a sword salute. And with the incoming commanding officer, when he brought the sword up, he nicked the incoming COs nose enough to make it bleed and flipped his hat off.

And so when we went back to the classroom and discussed the finer points of the ceremony, the point was very well made that normally medical department people do not draw swords, and you know why now.

### **Memorable.**

Yeah, it was. The other was sort of the traditions of the Medical Service Corps. Because the orientation was either just before or right at the time, I think it was just before, the August time frame, 7th I think is when the Ball was that year. And as being, you know, completed it, we had an XO at the school, T. G. "Mack" Mahone, who we were all scared to death of. I think he was a commander at the time. We were all talked about, encouraged to go to the Medical Service Corps Ball.

Well, I didn't know any women down here, you know, and certainly was not dating anyone from back home or any place. So, I went and check in Bethesda and I was summoned to Commander Mack Mahone's office. And he said, Todd, come in and sit down. Do you have a date for the Ball; are you going to the Ball?

I said, well no I don't know, you know, I don't have a date. He says you do now, I'll see you at the Ball, and oh by the way, her name is. And it wound up that the fix up date was one of the summer secretaries, at NASH there, in Bethesda, that I guess wanted to go the Medical Service Corps Ball. So that was my first Medical Service Corps Ball in 1965.

But going back, my first duty station was at the National Legal Medical Center in Bethesda. And the National Legal Medical Center was in those days, it was the Center Command. It was sort of like a regional kind of set up. The boss of Center Command was the admiral, and basically did all the support things for the Bethesda complex.

My job was the head of military personnel for Center Command and the assistant head of civilian personnel for Center Command. Military personnel did all of the commands with the exception of the Medical School and the Hospital.

So I had the Navy Toxicology Unit, Navy Evaluation, Radiation Evaluation, Exposure Lab, Armed Forces Radiological Research Institute. All those kinds of places were my responsibility. I guess NMRI had their own personnel office at that time. So, I'd been interested in personnel. I'd spent a lot of time in personnel at Western Hospital.

So I was very comfortable and very pleased with that assignment.

I didn't know about civilian personnel, the rules of engagement, regulations for civil service personnel. So that was my first exposure to that. My boss was a commander by the name of John Reid, who probably wrote the book on military personnel and civilian personnel. For years and years and years he wrote the MSC exam questions in that area. MSCs then coming up through the ranks, would take a professional examination written by Medical Service Corps officers.

And it would cover personnel, labor relations, patient record administration, laundry, supply, all of the different functional areas that a Medical Service Corps officer would have responsibility of doing in the hospital. And it would be a compilation of a whole bunch of questions, coming from rules and regulations and things like that. So it was a test of knowledge of a foundation level knowledge, to be able to be functional in that area.

**A real cross section of everything.**

Yeah, it really was. I think one of the most humbling experiences that I had was I had the opportunity to proctor the exam within the first two years that I was on active duty. And, you know, I thought I was pretty cocky and pretty smart coming from Cornell and all that sort of stuff. And then I looked at the questions on the exam, and they were really tough. It was a tough exam.

And so, all of a sudden I had an instant awareness and respect for those that came up through the ranks in the Medical Service Corps. Well, at Bethesda I had a great time. The times and all were very different then they are now. I would go over with a whole bunch of folks after work, and we'd sit in the club and drink and carry on, after work almost every night.

There was a game room in the club at Bethesda where on Fridays, there were poker games. And I saw \$10,000 change hands on the turn of one card. And, you know, that was way out of my league but I didn't mind watching. So the camaraderie in all that, the closeness of it, while I was different, I was a 30-day wonder, had not come up through the ranks, so I had to earn my way and prove myself.

And, you know, I was constantly challenged that way, but really that was a lot of fun. I was used to doing that since I was a kid anyway. But there was a certain amount of bias in the Corps at that stage of the game about people with formal education being recruited directly in.

**So these were Mustangs, most of them?**

Yeah, Mustangs, it was sort of Mustang versus a 30-day wonder kind of thing. Some of the Mustangs were a little nasty, others were not at all. They were very, very professional.

**I would imagine even at that time, there were probably some people left over from the Hospital Corps.**

Yeah, there were. There were some of the original commissioned members were still in the Navy at that time. I think the average education in the Medical Service Corps was high school education. It certainly was not a bachelorette degree. One of the goals was a bachelorette degree for the Medical Service Corps. That's why they developed a program at NAHS, NAHCA, NAHA, it changed its name but the building stayed the same.

They had a bachelorette program with George Washington University, on the bachelorette level, where students would come and take three semesters really of credit. And then would have to pick up English and some other things. And they'd get their bachelorette degree from GW, in hospital administration and it was accredited by ACHE and all the rest of the stuff.

**Did you find a lot of those Mustangs doing that or?**

Yeah, in fact that was the standard flow. That the Mustangs would then make up the class of 40. Every year they had 40 students, and they would all be Mustangs that would come to the school. Faculty members would usually have a Masters degree, most of them were Mustangs.

In fact, the vast majority were Mustangs that had gone on with their education, gotten a Masters degree, or were absolutely the leaders of their field in their technical specialty. And they would teach on the faculty there. Well anyway, at Bethesda on that first tour, I really enjoyed the Navy.

You know, I had a lot responsibility and authority. It was fun. I loved the people that I worked with. I liked the pomp and circumstance of the military. So I got gung ho and I volunteered for Vietnam.

**So it would be '66 then?**

It was in 1968.

**Oh, really, '68.**

So I was there from '65 to '68.

**That's a long tour.**

Yeah, it was a two and a half, three-year tour. And again, I was very, very fortunate in that I was watched over by the detailing process, which would happen to be, in those days, it was here at BUMED, were the detailers. And I was assigned to the hospital ship, Repose, off of Vietnam. And got on board in March of '68, right after Tet,

and came off, I guess it was February of '68 I got on board, and came off February, March of '69.

**What was the procedure now at that time. The war was going full blast even at that time, '68. Did they announce that there was a position open on the Repose or they just?**

No, I just got gung ho and communicated in the dream sheet, which you filled out every year. And I just asked to volunteer for Vietnam, whatever was available. And Bob, I'm blocking on the individuals name, but the person who was doing assignments, Russ Hunter, was doing the assignments then. And he assigned me to the hospital ship, Repose.

So obviously he knew what the vacancies were and all. But I was lucky I wasn't assigned in country, in a unit where really field experience and the rest of it would have been necessary. So I got hospital ship duty.

**What was the orientation to go aboard the ship? Once you got your orders, report to and that was it?**

None report to, yeah.

**And where did you report to then?**

Well I flew into Saigon. Flew from, I took some leave in conjunction, so I went home, not knowing what I was in for. And leaving I'm sure a teary Mom and Dad, I flew to Treasure Island in California. And got on another flight there, which was a military contract flight. And flew from TI into Okinawa, then Okinawa on into, well actually, TI to Hawaii, Hawaii to Okinawa. Then Okinawa into Da Nang, the airfield in Da Nang, the airfield in Da Nang is where we flew in to.

**Do you remember that flight?**

I do, vividly. The flight was really upbeat and bubbly, into Hawaii. Got to Hawaii and the bars weren't open yet so we convinced a lady to open up the bar so we all had drinks in the airport bar in Hawaii. And that was the first time I had been in Hawaii. Then we flew on into Okinawa. Some of the members got off there and there was some change of people there.

And then, as the closer you got to Vietnam, the quieter the plane got. And when we flew into Da Nang, it was right after or during a rocket attack. Because you could look out the windows. We darkened the plane and you could see though the rockets and the incoming towards the airfield and stuff. So we bailed out of the plane, it hit the ground and pulled up to a quick stop.

We took off running out of the plane and went in to a secured

area that was pretty well sandbagged and pretty well protected. And then we checked in. And they had a big bus there. I think I was the only person going to the hospital ship *Repose*. So then they took us into *White Elephant Landing* and there was a *BOQ* there on the street corner. And there was a big sandbag area where a guy with a rifle all over, around the building.

It was pretty well guarded. Went up and had a cot, I think it was a sleeping bag, it wasn't a whole lot. But crashed there, and with the game plan that I would catch a boat out to the hospital ship the next day.

**Was it off shore?**

Yeah, it was off shore.

**Within sight?**

Yeah, the main harbor's a large harbor but the ship wouldn't tie up, but it would anchor in the harbor. And then it would run ship boats, barges back and forth to pick up patients and bring them to the ship and other kinds of things. The two methods of getting on the ship were by barge or boat, or by helicopter out of the flight deck. So got out to the ship.

**Was this just a matter of days now, one day when you arrived?**

Yeah, if I remember correctly, it was only day in *Da Nang*. I got in at dusk, dark, got up the next morning and I think I caught the boat two o'clock, three o'clock in the afternoon. There was someone that told me that the boat would be in the harbor. Then I don't remember the communications but it was something like that. And then we went out on the shuttle boat.

**Any first impressions coming up on that big white ship?**

Yeah, I thought it was gorgeous, absolutely gorgeous. You know, I was still scared to death because, you know, the war zone mentality, it wasn't *Washington, D.C.*, it was very different. But the ship was absolutely beautiful. Then the boat came along the gangway to it, and with the motion of the waves and all, you had to time your jump to get on the bottom rung of the ladder to go up. And with a sea bag and all that sort of stuff, it was a little bit of a challenge, but made it.

The other thing is I remember vividly is that I was going up the gangway. The person I was relieving was going down the gangway. And that was the turnover. It was, welcome aboard, I'm glad you're here I'll see you. So, I guess I went into the personnel office on board the ship. And they said okay, this is where you're bunking and it was down in officer's country in double-decker bunks, which

are all steel and stuff. Relatively comfortable and it was in essence a stateroom, with a couple of desks and two bunks and about two chairs.

**You shared it with other officer?**

You shared it with another officer.

**Both lieutenants, JG's.**

No, I shared it with a Chief Warrant Officer aboard the ship that, he was the mechanic for keeping all the different, electrician, keeping all the electrical kinds of systems of the ship going. We first had two crews. We had the ships company crew, which was under the command of a line captain. And he was the captain of the ship. And then you had the hospital company, which was again under a commanding officer, which was a physician, with a physician XO and a MSC director for administration.

So you had two organizations functioning in really fairly tight spaces. Hospital ship wasn't huge. We carried a lot of patients, but length and width of it, it wasn't really huge.

**What would have been the patient census at that time. It was supposedly a 250 to 500?**

Oh no, it was a 1,000 bed hospital.

**Oh, it was up to 1,000 bed by then.**

Yeah, yeah. We had 500 basically self-care beds and they were way down in the hold, stacked either three or four high. I think it must have been four or five high. And, you know, typical little room in between them, with lockers over on the side where you could stow your gear. And those were people that were in the final stages of recovery. They might be Pting (?) they might be doing things like that to get ready to go back in country. And then the rest of the 250, I think 250 were more acute kind of care beds and, I'm sorry, it must have 750 beds, not 1,000 beds.

It was about 500 beds down below and I think 250 beds or so that were pretty active. I'd have to go back and pull the data on it, but I think that's about what it was. And when I was on board, the census, you know, I got on right after Tet, and so it was full. So, I would guess that the census was probably 500, maybe a little bit more than that.

**Yeah, because I think those Haven class, that was a Haven class, anywhere from 250 to 500 was generally what they ran. But if you were up to 750, that was really.**

I think it was 750.

**Yeah, that was a tight.**

Yeah, but most of those were way down in the bowels of the ship.

**They could maneuver themselves, they could be more ambulatory.**

They were totally ambulatory, most of them. But, you know, on cardiology unit, for instance, they were stacked two and three high. And it was nothing to have chest tubes running out of the bunk up on the top, and all the rest of the stuff. So you know the quality of care and the way they managed to provide the care and all was really something to behold. The teams were very, very tight.

The camaraderie on the boat, on the ship as you can imagine, the war room, we ate in two sittings. The junior officers in the, I guess it was the first sitting, and the more senior officers in the second sitting. And you sat by rank, so as you went up in rank or new junior officers came in, you moved up. So I think by the time I left the ship, I was in the second sitting as a lieutenant.

**So you were JG when you got aboard?**

JG when I got aboard, and was promoted to lieutenant on board.

**Who was the skipper, the medical skipper there?**

The skipper was Holloway and Markowitz. Markowitz was the first one, Herb Markowitz; he was a survivor of the Bataan Death March. And actually, it might be just the other way, but the other one was a guy by the name Holloway. I don't know what his specialty was. John Wolf was the Senior MSC, Director for Administration. And I don't remember who the XO was quite honestly. Ship wise, the CO of the ship was a guy by the name of Campbell and he was super, you know, a real gentleman.

And then he was relieved by a guy by the name of Drew, and Drew didn't like being on board a white ship. He was a gray ship guy. And decided that gee, with all these women, I can be sort of the bell of the ball here in the Pacific and I'll take my nurses in country and we'll entertain the troops. So Campbell was.

**He was a line or the physician?**

Line.

**He was a line.**

Campbell was the line physician, you know, was the line first skipper, a real gentleman, a real professional and conservative. Drew was the line captain but he was not conservative. And looked for opportunities to go in country and encouraged his troops to go in country, and visit the marines and visit the navy, and the rest

of those kinds of things. So he was, I guess you could probably call him to a certain extent, a social butterfly because he had all the women in country.

**What would a, say a typical day for you on the ship? What would that have been like?**

I had two different jobs on board. The first job I had, and we split it roughly six months was operating services and security. That job, a typical morning, I'd be up having breakfast by 6:00, 6:30. And then out moving around, looking at from the operation services piece of it, were the patient getting their food, was that system working okay, how was the laundry system working? How about painting and maintenance of the equipment in the showers.

So I had the responsibility for all of the stuff in the hospital spaces. The ships company counterpart had responsibility for all the ships systems, but I had the responsibility for all the medical spaces. So for painting and maintaining, and chipping, and all that stuff in the medical spaces, was my responsibility. Hauling trash, holding trash on station until it was appropriate time to dump it over the fantail and all that stuff. I was responsible for the flight deck.

So my job was to meet and organize the litter bearers and have them ready to go to meet the helicopters when it came on board the plane. Take the patient off the helicopter, bring it down into the triage area, was responsible for taking armament off of them when they came in. It was not unusual at all for them to have taped to themselves, grenades with the pins pulled and the rest of it in weapons, of various asunder kinds for self booby trapping, if they thought they were going to get captured by the enemy, and things like that.

So it was clearing weapons and stuff. And then I was responsible for the flow of coming out of triage. Normally the individual went down to x-ray or lab, actually the bloods and all were drawn in triage, x-ray or wherever into the ER. So to make sure all that flow worked well. We also took care of Vietnamese. We had a Vietnamese ward on it where we took care of women and children primarily, but also on occasion, we would take on board, the enemy.

So it was my job to make sure the enemy was protected. Particularly if you had an ARV and Viet Cong on board. The ARV would know it and he may well be dying, but he was going to kill the Viet Cong before he died. So there were some really tense situations from time to time on that. So then you'd break for lunch and then you'd go back, you know, doing all those same kinds of things.

I was responsible for the, when we went into port, in Subic Bay in the Philippines, for the certification for doing all of the

epidemiology reports on syphilis, for both the patients as well as the staff. And doing the surveys in country of what's going on, and where the problems are. And coaching the troops on where not to go and where to go. So it was a whole smorgasbord of stuff that I did.

**The rotation schedule, you had two ships on station, you had the Sanctuary and the Repose. And how did they operate? How do you decide where they would operate off a ship?**

Yeah. When I first got on board, the rotation schedule was really pretty loose in that one of the hospital ships would be on station maybe 30 days. And they would be off to Subic or Hong Kong, or some place like that. And you really had it pretty neat when I first got on board. During my one-year tour, it looked like we'd go to Hong Kong, Singapore, obviously several times Subic Bay, because that was our main supply place. But very quickly that changed so that either we or Sanctuary had to be on station all the time.

So we were on station basically for 90 days, 120 days at a time. And then would go off line and go to Subic. So getting our supplies, that was another function that I had was, you know, the supplies and making sure the high line operation worked and the rest of that. Taking underway replenishments or vet reps, where vertical replenishments, where they dropped the cargo and that sort stuff on flight deck. And controlling all that sort of stuff.

**We have a photograph of you at that time. I think it was aboard the Repose. Captain Buckley is in that picture I think.**

Yeah, he relieved Captain Wolf as the Director for Administration.

**Yeah, and you look like everyone's little brother. You look like you're about 18. I know you're older than that in there, but you look, you know what picture I'm talking about?**

Yeah, I do.

**You look like you're about 18 years old in there.**

Yeah, I've always had a baby face. I look a lot younger than I am and always have. I like it now, as I'm older. As a kid, I hated it because I never could get into a bar that required an age of 21.

**So you were on there for a year, and do you remember any of the big operations that were going on?**

Yeah, there were some phenomenal ones. When I was in the security operational area, Khe Sanh went down. And one of the things that I'll never forget, we took on board 95, well a couple things

of that. A couple of times in one, they call it flight quarters, flight quarters, and they call it away, and all the medical would man their stations and I'd go work the flight deck. In one of those, we took on 95 I think casualties, injured and working the flow of getting them in, and the rest of the time to think.

At the same time, you know, during this one, I can't remember which operation it was and I can't remember if I was manning the flight deck responsibilities or if I'd moved on and was in supply, fiscal and supply at that time. But right in the middle of the medevac operation, taking all these on, I think it was CINCPAC Fleet Medical Flag came on board. And it was right about the time they changed the operational schedule to leave us on line for 90 days to 120 days which, that amount of time dealing with the patients and all that we were getting, and the stresses of war injuries, was tough. You needed a mental break.

Well, someone asked him a question and he apparently just, I wasn't there, just lit into him and chewed him out for being selfish for not carrying their weight for, et cetera, et cetera, et cetera. And then interrupted flight quarters and left. And he had absolutely no concept at all, of the work that was going on board the ship. He chewed people out for not having enough people there for his admiral's call in the wardroom. And it was just total insensitivity and lack of knowledge.

He was doing his own agenda item and was totally oblivious to the almost 100 casualties we were taking on board while he was there. And serious wounded, you know, you were taking on board some really serious stuff. The other thing I remember was, and it was the aftermath of Khe Sanh. And I can't remember how many body bags we got on board but we got a whole bunch of body bags on board; again up in the 90 range. And positive identifications had not been made on the remains yet.

And they sent out a young corporal to do the identification. And he couldn't do it. So, I in essence held his hand as we went up and unzipped bag by bag so he could look at the faces and identify his comrades that were killed in the battle.

#### **This was at Khe Sanh?**

Yeah, it was in Khe Sanh. And he did I think, just about 100 percent of the identification of the casualties. But that was probably the toughest thing I ever had to do on board. And then we made arrangements for getting them on down to the mortuary in Da Nang, and on back stateside. But, you know, they'd been in the jungle, they didn't smell good, they didn't look good. It was to support a kid that hey, some of these are friends and buddies, you know. It had to have been devastating on that young marine.

**Is that why they brought them out there because he could identify them?**

Yeah, why they brought him out. They brought him out there to get them out of theater, out of the battle.

**Was he injured himself?**

I don't remember him being injured, but he certainly psychologically was injured.

**Sure.**

But it was really devastating. The other thing I remember on board is that the second job that I had was on doing fiscal and supply. And you had one fiscal, it was a combined operation, you didn't have a supply operation and a fiscal, you did it all. So I had to cook the books. The supply line was basically Alameda, California. And you had to figure out what would be on board the boilers, and what would be on board the ammunition ship because you can get oxygen tanks from one and you could get nitrogen from this other. And then you had an auxiliary supply ship and it could have other medical supplies.

So you did the calculation of who you would get from whom. And be able to work your catalogues so that, you know, on when you reorder, where do you need to reorder from. And your time of shipment and getting the stuff, varied by item and where it was coming from. But the other piece of it was that we were using sulamylnacetate cream, otherwise known as Ludsick Butter for treating burns. We had.

**Ludsick Butter, like the city of German (unintelligible)?**

Yeah, apparently, and it was an experimental. It was not approved, but we had a plastic surgeon come on board. And we had a fair number of burn cases when Amtrak would blow up and catch on fire and burn people and stuff like that, napalm and things like that. And I can't remember what we were using; we were using some sort of a sulfur compound before that I remember. And this plastic surgeon had worked with Ludsick Butter before.

And so I was tasked to find that and get it cleared by FDA, and get it on board so it could be used. And we switched to Ludsick Butter. And had very, very good results with it with the patients on board. That was an unusual supply item that I had to do.

**Is there a separate burn ward?**

No. Jan, I don't remember. It was up on the O-2 level, but I don't remember. You had isolation obviously working on it, but I don't remember if it was separate. I want to say it wasn't, but I don't remember. I can remember some Koreans that were on board for

a very long time that were very badly burned. And they were up near the flight quarters area, up on that level.

**So you really had the capability to do the whole range of products?**

We did. We did all sorts of things. Captain Russ Brown now, whose down in Roosevelt Roads, he was the cardiopulmonary tech on board, and he ran the heart lung machine. So we did some, you know, sort of cutting edge kind of stuff with heart lung machine, recirculating blood and stuff so you could do heart surgery and stuff. We had superb talents on board.

**Was there every a stage where you had a patient you just couldn't deal with your capability and had to evacuate off the ship?**

Yeah. Well part of the triage process also was that when they came in, you did an assessment and you took care of those that you could make a difference with. If you couldn't make a difference with, they were the expected, and they were put over on the side. And then you got to them when you could. But to the best of my knowledge I don't believe we saw anything we "just couldn't handle". We'd try anything.

It was before I got there, but there was a guy who was sucked in the intake of a jet, and was really chewed up. He came to Repose, was stabilized and all, and then went into a medevac process. So, you know, you had neurosurgeons, you had cardiothoracic surgeons, you had general surgeons, and you had the whole spectrum.

**Probably the best nursing too.**

Yeah, had really good people.

**I think I'm trying to remember, years ago; we did a story in the magazine. I think Admiral Shea was aboard.**

She was. In fact, she was there when I was there. And she was the OR nurse on board. And she and I would lock horns on more than one occasion. Her guys in the OR were special case kids. And their hair could be longer than others. And seeing as I was security and responsible for good order and discipline and military appearance and all, I was constantly hassling her to shape her troops up. And she was constantly telling me to get off her case.

**She wrote a piece for the magazine and talked about the emotional toll, just the nature of the causalities, and the number of causalities. And the fact that there was no respite sometimes. It just kept coming and coming.**

Oh yeah, there was no respite. It was not unusual, you get a

guy into the OR, and you'd have three, maybe four specialties working on him at exactly the same time. So the neurosurgeon would be up working on the head, and the arthropod would be working on the arm or the leg, and the cardiothoracic surgeon would be working on the trunk. And they'd all be there at the same time working and just making room for each other. And doing what they could to save lives and put bodies back together again.

And, you know, we had a guy by the name of Jim Meredith, who was a neurosurgeon. Our neurosurgeons were absolutely superb, I don't know how they did it, with the stressors and all that they had. But Jim Meredith if I remember correctly, was operating something like 36 hours straight without a break with cases. And finally, you know, just decompensated. We had difficulty getting another neurosurgeon in but we got one in from Da Nang, from the hospital there.

What Repose did was they basically just drilled holes in the sea. Got off station wherever the battle was going on. Campbell was further off the coast than Drew. Drew would keep the ship probably within a mile of the beach, just as close as he dared to get it to the beach. And we wouldn't drop the hook, but we'd just sort of go up and down, just drill holes in the water. And so we would be there for the planes when they needed us and they'd bring casualties out, the little Vietnamese boats, the little fishing boats.

And one day, there was, we called them LBGBs, but they set up a mortar on the back end of this LBGB, and tried to get us with the mortar. And a helicopter then came in and blew them out of the water. So, you know, Drew was very aggressive, and wanted to be as close to where the action was as he could possibly could be.

**That was consistent with his personality as you mentioned.**

Yeah. And you know, we'd see, New Jersey came over while we were there and so we'd see her firing broadsides. And my gosh, what a sight that was. And, you know, it would move two or three ship widths out after, you know, full broadside, it would just slide in the water. And it was just absolutely phenomenal. We could see gun fights with the tracers. Some of the hills around Da Nang were not safe. And we'd anchor in the main harbor. We wouldn't circle in Da Nang Harbor. And you see gun fights with the tracers and all, going on the beach and the hills on route one, which was going north.

We'd have Seals come around the boat on a regular basis and drop concussion grenades in the water, just in case there were swimmers. And, you know, if you were in your bunk at night, it sounded like someone with a sledgehammer came and just winged the side of the metal side of the ship. You know, just everything just sort of vibrated.

But that was in case there were swimmers in the water that would wipe them out, with the concussion stuff.

**You were definitely in a war zone, no question about it.**

Well, the others that I flew into country with, a guy by the name of Matt McCauldey (sp), MSC, Epidemiologist.

**I remember him.**

He's retired now. And I went into Da Nang to visit him one day and, you know, really had to talk my way into doing it because it wasn't really recognized that that was a good thing to do. And had a great visit with him in Da Nang, and seeing how the hospital worked there. Made some good contacts with the hospital in regards to sharing resources and that stuff. And then coming back to the ship, we had to go along an area, and the jeep couldn't get out of first gear.

And I was in khakis and he was in cammies, and we took sniper fire from the woods in this jeep that he couldn't get it out of first gear, and that was a little tense. And then when they got me back to the boat to go back out to Repose in the harbor, the guy that was my driver, 2nd Class corpsman, said, sir, next time you come in wear cammies. There's a bounty on officers and your in khaki, they know you're an officer.

**You were probably unarmed too.**

Yeah, totally unarmed.

**No way to protect yourself.**

But, you know, .45 wouldn't shoot that far anyway.

**You'd throw it at the enemy rather than shoot at them.**

I sure wish that jeep had gotten out of first gear, I'll tell you that.

**Engine racing at full tilt, and you're cruising along at three miles an hour.**

Yeah.

**So you left there when?**

Left there in March of 1969. And my next duty station was in Newport.

**Do you remember the leaving?**

Yeah, very much so. The leaving is sort of a neat story in itself. We were under a typhoon, quasi typhoon conditions. And I

had my plane booked out of Da Nang. And no one when you got to that stage of the game, no one wanted to have that bird leave.

### **Freedom Bird.**

That's the Freedom Bird and you didn't want it to leave without you on it. And we were up north, off of Quang Tri, Dong Ha, up in that area. Up near the northern border. And in this pouring rain and stuff, the conditions were terrible. And the Jolly Green Giant came and landed on the deck. And doing practice, touch and go, so I didn't know it was practice touch and go. And I got on the communication with them and I said hey, are you going to go back to Da Nang tonight, can I get a ride? And he said, sure you can ride with us, but do you know how to shoot a machine gun? So I lied and I said, sure, no sweat. And so I threw myself on the plane.

And then he proceeded to do two or three more touch and goes. And that was a terrifying experience too because the Jolly Green's got a big old nose cone that sticks out for refueling. And when you brought the Jolly Green down on the flight deck for Repose, you had to angle the cone beside the stack. You couldn't come in like other helicopters. You had to angle it to make sure you didn't hit anything, and also that then your wheels would touch the deck and wouldn't be in the safety netting around the side.

But when you're sitting in one of those things, actually sitting, you're harnessed in the machine gunners seat, watching the tiny little deck come up at you, and knowing, you know, that the margin of error wasn't great. And doing two or three of that, that was sort of fun. Well, I did some practice rounds with the machine gun and so I was comfortable with that.

And then I asked the dumb question, by the way, you know, when are we going to head back to Da Nang. He said, well as soon as our mission's over. I said, what's your mission? Our mission is to go into North Vietnam and rescue downed pilots if there are any up there. So the good Lord was watching after me again and we had no missions. So went on down to Da Nang and spent the night in a hooch and then made it to the airport the next day, and came back home on a Freedom Flight.

**No problem, right. They may have been doing that to see what kind of reaction they'd get out of it.**

The other sort of fun thing is that, you know, coming into, we flew into I guess Travis Island again, San Francisco. No, it was a commercial flight; we went into the International Airport in San Francisco. And when I left Bethesda and the United States, the hemline level was down below the knee. And when I got back, it was the ultra mini skirt. And walking through the airport in San

Francisco with all these mini skirts around me, it was quite a culture change.

**I imagine so. I imagine it probably took you a while to get used to.**

It did and the other thing it took, the camaraderie and the closeness of all the people was absolutely phenomenal. And went to then to Newport, Rhode Island. You know, *Repose*, we were our social networks, we were our support systems, we were in each and everybody's pocket. You couldn't afford to have adverse working relationships because you had no place to get away from any of that stuff. So people as a general rule, got along fairly well. Went to Newport, Rhode Island, and there the social network was away from the place.

So getting MSCs together for social things, getting the command to have a sense of camaraderie was very different. I'd had some of that at Bethesda in the first tour. I had, you know, a phenomenal experience with that on board *Repose*, and then it was very different at Newport. So that was another adjustment kind of period.

**Did you have some leave between the time you got back from Vietnam?**

Yes, I took some leave but not very much. I think that in the orientation program, you were told that, you know, leave is very precious. You want to use it when you want to use it. And don't get forced into using it. And it's always good to have the maximum amount on the books, because when you retire or you quit, you'll get all that in money, so you won't lose it--the 60-day limit.

So, what I did was I built up very early, 60 days on the books. And then just sort of maintained the 60-day level on the books. So I don't think I took a whole lot of time. Took a few days in San Francisco to get acclimated as I said before and had an old girlfriend that was in San Francisco. I saw her and then went home for a while. I had a car that I'd put up on blocks at home. So I got it back down off the cinder blocks and made sure the tires were okay, and got it tuned and got it working, and then drove on to Newport. I got there right after a snow storm in March.

**Well there's a culture shock right there, coming from that tropical climate back to New York state.**

Yes, New York state and then to Newport, which wasn't a whole lot better.

**So you reported in to Newport. What was your duties there?**

Well, I thought that I was going in, again, I wanted to be sort of a generalist and do a lot of different things. So the Bethesda

tour was personnel. The *Repose* tour was fiscal and supply, which I enjoyed. And the operating services, security stuff, which was okay but I didn't really enjoy it all that much. But it was a good learning experience. So I thought that I was going into Newport, Rhode Island as a Patient Affairs Officer, which was an area that I wanted to learn about.

When I got there, John Pruitt was the Director for Administration, and he had a habit of looking at people in their background and giving them a test. And the test de jour in Newport was do a Xerox study for me. And I think that every MSC officer that ever went to Newport in the year before I got there, while John Pruitt was there, all had to study the same need, do we need a Xerox machine here? And I was sort of a smart ass on that, and I read the last reports and I told him which one I concurred with and turned it in.

And he said, well with that, you know, I think really you're in personnel, your backgrounds in personnel. So I was assigned personnel. So there I was head of military and civilian personnel, which turned out to be a really good deal.

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**You got to learn about systems then?**

Yes. And, I learned that Newport, Rhode Island was unionized. And their union contract was about ready to expire. So I came to Washington, DC, to learn how to negotiate union contracts. And, in fact, my wife Myra was on board *Repose*. We never dated or anything like that, going back to the sort of the close knit of *Repose* people, I knew she was in Washington, D.C. at the time.

So, called her up and said, hey do you want to go out for dinner? And her roommate said, you might as well, it's your birthday, and you're not doing anything else. So I took her out for dinner and then commuted from Newport, Rhode Island. But that's how I learned the principles of negotiating union contracts. And then went back and was on the negotiating team for the union contract at Newport.

**So you became a labor relations person also. You really got a little smattering of everything didn't you?**

Right. And that's what brought me the tour after Newport, what brought me to, then it was called the Naval School of Health Care Administration, I think at that stage of the game. That's when they had the bachelorette program for GW. To be on the faculty, you needed a Masters Degree.

And now I had good expertise in both personnel, labor relations, because of the Masters in Hospital Administration, general hospital administration. And with the expertise or the experience in fiscal

and supply, operating management services, personnel, I was selected to come on the faculty there. And I was selected by Captain Dan Van Landingham, who then became head of the Corps right after that. And came on board to do that job, and wound up staying there for a long time.

**So you were there for two year (unintelligible)?**

The tour in Newport was a three-year tour. So I got there in '69 and left in '72. Myra and I got married in '71. So when I went there, I got a little house, rented a little house out in Portsmouth, Rhode Island, which was a delightful, just a little cul-de-sac, off one of the main drives. And I had the house all by myself and just really enjoyed that. I love to cook and that stuff, so I'm very comfortable with that.

And when we got married, Myra came up and that was our first house in married life. And we had a great time there, with very, very good people. You know, a lot of good mentoring. Charlie Hosteller now, who's a Pharmacists Captain, he was a 2nd Class Corpsman, 3rd Class Corpsman, working in pharmacy there. We mentored him to go on and come back in as a pharmacists. We had a bunch of really good people up there, that did very, very well in other places.

**So you left with a bunch of new skills.**

Did, and again, a bunch of new experiences in, you know, standing the watch and all. Around the personnel area, you know, I've already talked about labor relations stuff. They had a lot of issues in labor relations that I needed to work. But then in a small hospital you stand the watch and it's the functioning of the hospital. So, you learn a lot about patient affairs too. So I had the duty when a couple of Filipino stewards stabbed each other, and one was killed so I began working the decedent affairs issues for that.

I had another interesting decedent affairs case where a reservist came to the War College and was riding, on an ADT training kind of deal, was riding in a helicopter and the helicopter crashed. He was killed. His page two said his wife was such. Well lo and behold, he'd gotten divorced from that woman, and was married to another woman. However, the Navy records were such that, you know, you had to listen to the ex-wife in regards to what the burial plans were which was a little exciting when you had a very strong conflict. And her, if I remember correctly, her desire was burn that guy. And the other one wanted a full nice military ceremony with proper burial and the rest of the stuff. And sorting that out so that you could get to some sort of a win-win situation.

There were a bunch of interesting things like that that happened

in the tour. Newport was a great job and a great place. The hospital I guess was probably about 120 beds, someplace in there and we were probably running.

**Very manageable.**

Yeah.

**It must have seen a small time operation compared to the Repose.**

Yeah, it did. And it was nice. And you didn't have the high stress stuff. The ships piers, and you had oiler piers, and I think you had about three or four oilers in there at that time. And you had the Tin Can Fleet in there, plus all the schools. So Newport was a pretty busy place. But you didn't have the high trauma, high stress kinds of patients that would come in. You had some excitement every now and then, but nothing like the intensity of the care and all that we experienced on board Repose.

And as administrator, you know, in that security job, going back to Repose, you were involved in patient care. You know, you were on the wards all the time, checking to make sure they were okay with supplies and all that sort of stuff. So, you learned a lot about patient care and what was going on.

**That was kind of a university education right there. You could probably pretty much handle anything after that.**

Yeah, it was. I got so I was pretty decent at reading x-rays with shrapnel wounds and all that sort of stuff. The physicians were always very open. The nurses were all very open. If you showed the least bit of interest, they'd be delighted to teach. So it was a great learning milieu also.

**Kind of a family, really a family.**

It really was, it really was.

**You took care of each other.**

That's why the network still is pretty strong. You know, where is who, and what are they doing and those kinds of things.

**Do you still keep up with them?**

Some of them. (Unintelligible), Buckley, Rosemary Cox here in town, and some others.

**So you left Newport and you went on.**

Left Newport and came down to NSHS where the first year I taught hospital administration and personnel. And that was a very traumatic year. I'd never taught before. And I learned a lot that

first year. And some of my students probably would have gladly killed me. In fact I know they would have but I think that over time I got a whole lot better.

I did some really stupid things like; I didn't like short answer tests. I liked essay tests because I felt I could understand better what's going on in the persons mind by seeing their thought processes if they wrote an answer. Well, the students liked short answer tests. They didn't like essays. And I think it was one of the first tests that I gave, I basically made a list of the kinds of things that I was looking for in the answers and graded it. And they didn't do well at all. In fact, I maybe had two or three out of 40 that passed the whole thing.

So I went in and I told them, gee, you know, you guys really bombed this one, it was terrible. And I'm going to give you another chance. And I passed out another test right then, making the assumption that they felt really bad about what they had done the first time and had gone back to the books and learned some more. Well, I about had a mutiny on my hands but we all survived that and I decided that that, gee, if I'm going to do this education stuff, I'd better get smart myself.

So then I enrolled in Catholic University and took a course in measurement and evaluation to try and understand how to write tests and do things better.

**And it helped you?**

It helped a lot, helped out a lot.

**That was a Masters?**

Yeah.

**Masters Program?**

Yeah. It started out just to make myself better and then bit-by-bit, more courses and so it grew into a Masters.

**Well, you were in a good location. That was one of the great advantages from being around here because you had access to all these educational opportunities.**

Right, and particularly, it was in the School of Education. And their Masters program or a lot of their programs were at night, because obviously they were for teachers already that were teaching. And this was their upward mobility so they couldn't have the classes in the daytime, they were evening classes.

So it worked out very, very well. Some of the other, University of Maryland wasn't really all that much into evening courses in some of the things that I wanted to take, nor GW. That all developed very

shortly thereafter as I remember.

**So with all those new skills, you found the teaching really improved considerably?**

I think so. I think some of my later students might say that I was okay. But I really enjoyed it and wound up staying on the faculty there for quite a while. And teaching personnel and labor relations. And one of the fun things I did in labor relations, I gave the class, I divided them into labor teams and union teams. And wrote a manual on how to negotiate a contract. It had body language skills, reading in it, and other things.

I wrote up a synopsis, what the situation was in the hospital and, you know, therefore, what are the issues. And then gave it to the two teams so that management would figure out their strategy and what they wanted to protect or recoup. And union would figure out what they wanted to go after.

And that was in essence the final exam of the course. And we had several days of union negotiation where we set them up like negotiating teams. And had at it and I wandered around and watched them. And had other people doing mentoring and coaching and evaluating.

**What was the length of that course?**

Yeah, it was a ten-month course. So in ten months, you crammed in three full semesters with a minimum of 15 credit hours a semester. So it was tough.

**Really concentrated too.**

And the quality of the education was very good. It was probably closer to Masters level than it was bachelorette level. People that left NASH that went to Baylor for their Masters program, I think Chuck Roseum if I remember, was one of the very first students that graduated from the bachelorette program at Little Red School House, that went to Baylor. I understand had no problem at all with the Baylor curriculum with the foundation he had at NASH. In fact, almost coasted through it. So it was a good program.

**Where did you go from there?**

Well from there, I went to, I got one year at full time officer training.

**Was that the CU program?**

Catholic University and that was to complete my Doctorate. And I screwed up and I didn't get it. I was given one year off to do it. And so I did comps and I had a draft of the dissertation but

couldn't get it through committee. Got a telephone call from then the CO of the school, Captain Bill Delawton, who asked me to come back and be his XO. The years that I was at NASH, I started as an instructor and then became head of the Management Education Department and Director of the Academic Affairs for the School House.

And then I went to Catholic University. And then I came back and became the XO of the School House. And there was for Captain Delawton and then he was relieved by Captain Ray Christian. And from there then I went downtown and became the Enlisted Community Manager for all the hospital corpsmen and dental techs.

**So you were here for the Bureau?**

Not here at BUMED. It was then over at Arlington Annex, in the 8th Wing. It was an OPNAV, they had OP-13 code. It was relatively new. Ron Turco was my predecessor on the job and I relieved Ron. And the job was, well, you were the only medical department person in OP-13. So you had all the responsibility for the health and welfare of the hospital corpsmen, dental technician community which meant you did recruiting plans, you did bonus plans, you did promotion plans.

Everything and anything that's an OPNAV policy affecting corpsmen, dental techs, I did. Did in-strength planning. I did the management of all the C schools to insure that the end strength that I was driving towards as close to 100 percent manning in each of any C community as I could. I wound up buying a computer, an old Dec Rainbow at that time and using peach kelk, developed a model to be able to model the end strength.

So that I knew what I'd have to put in for all those 36 NECs to be able to drive as close to the 100 percent manning as I could, which was a lot of fun. And then convinced OP-13 to computerize. Before that, all the stuff was on the back of an envelope.

**What year was that?**

Nineteen eighty-one to nineteen eighty-three.

**So you bought that computer in '81 then?**

I think I bought it, I think maybe in '82.

**Talk about a plank owner. You were probably one of the first ones.**

It was one of the earlier ones and boy, the capabilities weren't great and it was expensive. I think it was \$1,500, \$2,000.

**Wow, then that was a lot of money.**

That was a lot of money then. But Myra and I decided that, you

know, it was the thing to do. And then what I'd do is I'd pull all the data there, then I'd bring it home and I load it in the computer at night. And work the models and stuff like that. I never took the computer there. I always did the computer work at home. So then she could use it also.

The other aspects you did, because you're the only medical rep, you were the CHAMPUS expert for the OP-13. Any medical question for the legislation or any medical issue legislation that related to personnel, would come to me for the (unintelligible) and advising, going up to Admiral Herberger at that time, who was OP-13. And on up to BUPERS, Admiral Zeck, as I remember was BUPERS at the time. So you did a whole ton of things. It was a lot larger then just that.

That was the time that the Medical Department was under the gun in regards to selecting qualified people for command. I don't know if you remember the early days, we created a major command list. Then you had a major command screening list.

**Oh yeah, '83. I think it was '83.**

Yeah, I think it was. I created the list. I tried to get support from BUMED and I got no support from BUMED. So I said, okay and submitted the list and that was the original list. And then the first board, I was one of the recorders on the board. And Admiral Custis was the first Chairman of the Board. So they took the command authority away from Navy Medicine to do the picking. And they put it under line leadership because there was tremendous distrust of Navy Medicine at that time.

And by being Navy Medicine over there, I was trusted and it made a very awkward situation in being able to carry on Navy Medicine's message, and what they wanted to do. Maintain the support and credibility in the line organization was a fine line. So I was back and forth working. Admiral Diserp was 931 at that time.

We did an awful lot of work together in Jim Radcliff's office over here, 01 and other areas over here. Tried to be as plugged in as I could to carry the message back, and support what Navy Medicine wanted to do. But very, very awkward.

**That was the, as I recall, the very tail end of Admiral Cox's administration and the beginning of Admiral Seaton's.**

It was.

**And it was a very rough time over here, I remember.**

Yeah, Admiral McDermott was, as I remember (unintelligible) or BUMED, or whatever it was.

**And Captain Quinn, (unintelligible) at his height at that time.**

He was, right. And what was happening here, as I remember at BUMED, they had a Saturday morning meeting. And what they would do in the Saturday morning, was only select invitees would go to the meeting. And they'd plot out what they'd do the next week. And they'd make the strategy and all the decisions on what would happen at BUMED for the next week. I was never included in the meeting so I don't know what all went on.

**Yeah, those Saturday meetings actually started, Admiral Arentzen used to throw those meetings when he was here. In fact, that's when he had his run in (I can turn this off just for a second.) And then of course we had the Billig affair, which followed shortly thereafter. And we were probably at the low point.**

Yeah, and I was lucky I was out of town then. At the end of the OPNAV, OP-13 job, which was a wonderful job, I was selected for captain out of it. And transferred to Hawaii. And that's an interesting story too. Joe Castles was the Medical Officer of the Marine Corps. And I can't remember where I was, but he summoned me to his office. I was in the same building with him. And he said, Todd, you know, I'd like to send you to Hawaii, to FMF PAC, what do you think about that?

I said, well I don't know anything about it, let me go talk with my wife. Well, can I call you back? Sure. So went home and talked it over with my wife. We had just gotten a baby Great Dane and I knew there was a four month quarantine period over in Hawaii. We had another, we had a Weimaraner, a female that was getting old, and didn't think she'd survive through the quarantine.

We had been in Washington, D.C. since 1972, so here we are 12 years in Washington, D.C. And we were getting to think that, you know, we'd died and gone to hell, we had a pretty good lifestyle here. We're pretty well settled in. And, you know, four young daughters, one that would start kindergarten, and we lived in a neighborhood with a great kindergarten.

So I went back to Admiral Castles and said, well, you know, we talked about it, we really don't want to do it. And he said, you don't understand, you're going to Hawaii. And that was interesting too because, you know, I've had a whole bunch of firsts in my career. But that was another first in that Admiral Castles picked me to go because he liked what I did in the, he was at a level where he could see what I was doing in OPNAV. He had known what I did in the teaching in the School House. And he liked apparently, the way I thought.

My supposition, the incumbents of that billet in Hawaii had all been Mustangs, had all been years and years and years experience with the Marine Corp. So he sent me over there with no experience with the Marine Corp whatsoever and, you know, to do the job. Well, you

know, I was scared to death. My Lord, here I am, the water levels way over my head again. But that turned out to probably be the highlight of my career, that tour with the Marines (unintelligible). It was absolutely fantastic.

From a professional perspective, lots of things to do. I knew personnel cold. So, obviously the thing that I know cold is the thing I gravitated to first. And discovered, the Marine Corps works on table of organization, and the Navy works on manpower authorizations. Well, you have to translate the table of organization into the Navy manpower document because Navy won't man the Marine Corps based on the Marine Corp Table of Organization. It's not in their system.

So that shows up in the M plus 1 category and stuff. And I discovered, you know, that my predecessor was constantly beating up on the detailers in fights with Navy Medicine and all, because you're not giving me the skills that I need, my table of organization says. And I discovered that it was because they weren't in the Navy manpower documents. So I started out, that was as FFM PAC, you had all the Marines in the Pacific, you had the Marines in (unintelligible) and the Marines in Camp Pendleton. So you had 1st and 3rd divisions, wings, the FFSGs, plus then the group, the (unintelligible) which was there in Kunai.

To start off with, I worked with Kunai and we cleaned up their manpower system, and lo and behold it worked. So then I worked on fixing the manpower systems for the other. The other part of it was the augmentation system, and that was all run out of BUMED. But again, they were running off of the M plus 1 numbers to supply what I needed.

So I totally revamped and readjusted the M plus 1 numbers to match the table of organization for the Marine Corps. So that then when the need for augmentation came for any kind of operation kind of thing, it came off of those numbers. And so, I did a lot of things rewicking it. And the neat thing is that I got to see the fruits of my labor in that when Desert Storm went down, the augmentation process for the Pacific went pretty much without a hitch. Their major problems were the (unintelligible) because of the.

**The difference in the terminology.**

Yeah.

**But you would match the two right?**

I'd match the two so the Navy documents now reflected what the Marine Corps TO called for.

**So you got to see that work.**

The other fun thing, I worked with a really great flight surgeon.

A guy by the name of Clyde McAllister. And he and I are still good close friends. But Clyde was into computers also and he had an Osborne. And we didn't have computers in the offices as I remember at that time. So we worked off of Clyde's Osborne and then we got another computer for the office. But one of the problems we have is how much medical supplies should the MEDLOG companies maintain because we were going through, you know, the doctrine of the Marine Corps was they needed to carry 30 days worth of supplies for a (unintelligible).

So what we did, the concerning point was how much money we were wasting every year by throwing away drugs or having to re-supply because of outdated drugs and material. So he got the list of all the material that we carried and the volumes of it and their expiration dates. And loaded all this stuff on his Osborne and we started analyzing it. And lo and behold, ten items accounted for over 60 percent of the cost. Ten items, most of them the same items, accounted for over 70 percent of the weight and the cube which was also a problem in packaging and getting it there.

So we decided that, gee if that's the case, you don't have to manage all 600 of them, let's go where the money is. So we concentrated on the only ten items to see what we could do to make a difference in changing the system. And we saved millions of dollars in the first year for the Marine Corps, by managing the high volume, high cost items that were the supplies. And what we did was we did a directed buy with EPSC, the supply system, so that we could code into the system to get the maximum shelf life on a product, rather than the normal system where they'd send out the one with the least shelf life.

So we did all sorts of things, changing the system. And in fact, one of the things we got at loggerheads with DLA. And my three star general allowed me to put DLA on report for not being responsive to the Marine Corps needs. And he didn't know what I was doing, and he totally backed me. And I presented, you know, the data and what I did and why I was doing it, and the rest of it. And he said, go for it. And I'd never experienced any of that kind of backing and absolutely total unmitigated support, in my whole career in the Navy before that.

**Never asked questions, he just trusted you to do it.**

I had to show him what I was doing. Convince him enough that I'd done my homework.

**But he didn't have to micro-manage you?**

He didn't micro-manage me. He said do it, it'll go out under my signature and we'll see what happens. And we won.

**Well, you had great experience with Marines then.**

Oh, it was absolutely fantastic. Personally too, you know, I had good, warm personal relationships. In Hawaii, I did not wear the Marine Corps uniform. I was not a Marine. I am not a Marine, I'm a Navy officer. So I wore whites everyday. I could wear khaki's but I wore whites everyday. And I went out and I made myself a Marine Corps globe and anchor belt buckle.

So I wore my globe and anchor belt buckle and my whites everyday. And made sure that my shoes were shined and that I looked AJ squared away in my whites. And I wore that every single day that I was with the Marines and never got a hassle from it.

You know, I think they respected me because, you know, the flip side of it is the Marines don't wear Navy uniform when they're with the Navy. Why does the Navy have to wear a Marine Corps uniform when they're with Marines? You should have pride in your service. And I did, and had a great, great tour. Another small world story, all of our careers are full of small world stories.

When I was at Bethesda, way back, I guess it was in 1966, I was a swimmer in college and did the backstroke. And I had a dislocating shoulder, chronically, so it was pretty bad. So I had surgery, they did (unintelligible) and took a spur off and all that sort of good stuff. And while I was a patient in the hospital, there was a guy by the name of Tony Tokars, who was a Marine Lieutenant, 2nd Lieutenant, 1st Lieutenant that had been wounded in Vietnam.

He had gotten shot with a AK- 47 round that went through his hip and then caught the rib cage and just sort of spiraled up his body. But, you know, did a number on his hip and a number on internal things and all. Well, he was a patient on the ward. And he and I just sort of click it, hit it off together. So when I was able to have liberty and go back to my apartment, I lived alone again out in Greenbelt, I'd bring him home on weekends anytime that he could get away. And we'd go do bachelor things and have a good time.

One of the first things, and I was in his wedding when he married a Navy nurse, Joanie. Well, we lost track of each other, you know, and then I went to Vietnam and, you know, we just totally lost track of each other. And I went over to Kunai for one of the parades, evening parades. I can't remember what the celebration was, it may well have been Navy birthday, and the Marines at Kunai were holding a parade for us.

So we all went over there and I was in the stands for the parade. And I looked up and said, that face is familiar, it was Tony Tokars, who is now a Colonel, JAG Officer in the Marine Corps. He had gone on to law school and came back as a JAG. And then we had just a great relationship, reunion again and saw each other socially quite a bit.

**So your Hawaii tour was very successful. You found that to be.**

Very, very much so. And we were talking last time about the small world of running into a lawyer with the Marines over in Kunai, Tony Tokars, who had been a patient on the ward with me in Bethesda, years and years before. And then we had a wonderful time getting re-acquainted, his family and our family, during the tour. I think the, in retrospect, the tour in Hawaii was probably very instrumental, probably in my becoming Flag.

The Marines are wonderful in that if you do your homework, and they're comfortable that you do your homework, they'll back you. And some of the things that I think, did I talk about on the last tape doing the analysis of the dated and (unintelligible) items within the Marine Corps and how Clyde MacAllister, Captain MacAllister did the analysis and then we did focus things.

But in doing that, put DLA on report for not meeting the Marine Corps needs, totally supported by the three star FMF PAC, General. No problems with that. Matching up also the Marine Corps to the Navy Manpower document because Navy thinks in manpower documents and that's how we do assignments. The Marine Corps thinks in TOs. It's not translated into the Navy system. But by translating it into the Navy system, and cleaning up the 3rd and the 1st Division Wing in FFSG's manpower documents, when it came time for Desert Storm, they got the proper augmentation from Navy Medicine.

So we really worked that issue too. But again, total backing from the Marine Corps. They wanted to rush ahead on some things. I said, no, let me work it, they did. And I think the proof was in the pudding when it came time for augmentation for Desert Storm. The Pacific Marine System worked fine. The Atlantic Marine System did not. And it's just one of those issues.

**But you'd established a reputation for yourself having done that with the Marines?**

Yeah, and also self-confidence that, you know, quite honestly, you know, growing up you usually had people looking over your shoulder. So there's almost always a failsafe there, am I doing the right thing or not. There's someone there that will guide you and control you. With the Marine Corps, they gave you proceed until apprehended. By gosh you'd better be right, but I don't enough about it to tell you whether you're right or wrong. That's why I hired you. So make sure you do your homework, make sure you know what you're doing, and then go for it. And so it was a tremendous self-confidence booster also.

And I think the other part of it is, no one has pomp and circumstance like the Marine Corps. There's nothing like an evening

parade with the Marine Corps. So Myra and I did those at every opportunity that we had, and thoroughly them. And participation really in the military life, both Navy and Marine Corps, on the island of Hawaii. And just had a wonderful tour.

The girls were all growing up at that time also. They were in the public schools. The youngest was in kindergarten and the oldest was in fifth grade when we got there. And they did fine. You know, girls for birthday parties go to other girls' houses and they do girl things, cooking, dolls but usually cultural kind of things. And in the school system, they were minority, which was a new experience for them.

And then, you know, with their friends being Japanese, Chinese, Samoan, local Hawaiian, learning the different kinds of traditional family things, and customs and courtesies that go on, really broaden their social skills a lot. The school systems were not as good as we would have liked. But at that age, it really didn't hurt them when they came back here to Fairfax County.

**Yeah, that's what I've heard about (unintelligible) school. The education system is really quite poor.**

But the social development was absolutely fantastic.

**Where did you go from there?**

Well, from there came back to Washington, D.C. I was selected to be the CO of all the clinics in Washington, D.C. So I was headquartered at Washington Navy Yard. I relieved Captain John Turner, who was the CO there at that time. And had 11 clinics in Washington, D.C., metropolitan area. The Navy Yard, Arlington Annex, Carter Rock, Nebraska Avenue, White Oak, Indian Head, Dahlgren, Naval Air Station at Andrews Air Force Base, Sugar Grove, West Virginia, and I've forgotten I guess two more. But it was a neat tour working all the different typical issues of a clinics command.

That was back in the days where you had, in both California, Tidewater, and here, you had the clinics separated from the hospitals, and run by a separate commanding officer. So I sat on the GO Com Board at Bethesda, and had the pleasure of being commanding officer for all the clinics. About half way through that tour, was time to look at reorganizing Navy Medicine again. It was the time that decided that we'd do away with the GO Commands.

**Eighty-eight, Eighty-nine?**

Yeah, it was '88. I became CO in '87 and left command in '88. But right at the time I left command, in fact I have a, in the shadow box behind me, I have an inside joke in that it's got the invitation

for the change of command when I took over. And it's got the invitation for the change of command for Dave Kemp, who was the CO at Bethesda, was to relieve me as the commanding officer.

Well that change of command never happened. They reorganized the whole structure. Admiral Hagan was put in as Commander of Bethesda, relieved Dave Kemp. Then because of the planned restructuring, all of the clinics and the clinic command would be abandoned and it would fall under Bethesda as a clinic section of the command. Admiral West in BUPERS, was the leader of the group that did the analysis and did the recommendations for the, I guess this was probably one of the blue ribbon panels also looking at making Navy Medicine better.

So at Bethesda then I went back to a flight officer in charge. It's almost like a full cycle. When I first came in the Navy, the Flag was at the GO Command, even though it was called NAMC. And then you had the hospital command, with a captain in charge of it. Then it evolved to the Flag there and then it went back to a captain there, and now it's back to a Flag as commander of the large treatment facilities. So it's sort of history repeats itself, recycle.

**Well, it was the return of New Med, if you remember also, was the cycle.**

It was.

**And I recall Admiral Zimble came over here and he said, I understand, he said to me, I understand you have a sign that you've kept in the basement. I said, Admiral, I never throw anything away. He says, go get the sign. I brought the sign up from downstairs.**

And they still had stationery as I remember also.

**I still have some, I can share those. (Unintelligible) put it in the drawer somewhere. Because you just never know around here, coming back and repeating itself.**

No, no. So, and with the organization or the reorganization then, Admiral Sears was over here and he was interviewing for an EA. And I interviewed for the job, and Ed Phillips also interviewed for the job. Ed was selected, I was not, which was fine with me. But during the interview with him, I told him my interests and strengths really were in manpower personnel, and education and training because of the years I spent at NAHS.

So in the reorganization here, all of the single digit codes then got deputies. Because the Flag codes or Flags in those single digit codes, were gone so much of the time. Meadow 5 in particular, because Admiral Hall, who was Meadow 5 then, was also one of the two Flags, female Flags in the Navy. So all of the female issues in the

Navy, she was on the Board with the other line female Flag.

So she was gone all the time, with the selection boards, and being the women Flag rep for the Navy doing (unintelligible) and all that sort of stuff. Basically, I was left home alone, doing Meadow 5, which was wonderful. Admiral Hall again, gave me the backing and the support that I needed to do that. So, in that reorganization, Admiral Sears said, no not to be my EA, I want you to be the Deputy to Admiral Hall. And so I left the Clinics Command in November of 1988, came to BUMED at that time.

**That's when I met you, when you were O-5.**

The change of command was in such turmoil that we didn't know who was going to be in charge ultimately. So the change of command was done in a very quiet ceremony, really in my office, in front of the troops, where I turned over command to the XO, Captain Billy Joseph, who became the interim CO of Clinics Command until it was ultimately absorbed into Bethesda. And then Admiral Hagen then became the Commander of it all.

And in fact, it went through another change as I remember before it ever got to Admiral Hagen as the Commanding Officer. So I came over to BUMED and was the Deputy. And the culture here at BUMED was interesting at the time. It was welcome aboard, here's your office. And it was a nice office. In fact, it's got Maury's initials scratched in the glass in that office also. But it was an empty office. There was no furniture. So I came without per se, a job description, with an office but no furniture, no telephone, no nothing. So, my first job was to find furniture.

**I remember you came around. You were looking for historic pieces.**

I was. I came to you to get what would have been in the room. It was a sitting room and I remember that there was a peer table. And I knew what a peer table was because I had one at home, in fact, have one at home. It had a horsehair couch.

**That's right.**

And when I was a kid growing up, we had a horsehair couch. So a lot of things that were on the inventory list for that room at that time, I could picture. But it would be very expensive, very difficult to procure them all. So, I got some things and not a whole lot else.

**I remember we dragged out the inventories. I remember that now very well.**

Which is fascinating. And I think that that's when I started

to really get a perspective and appreciation for the history and traditions here at BUMED. It was in those early days, which are really fun. Well, got the gear and got things set up. And Meadow 5 at that time had civilian personnel and we had a small staff of experts there. And our basic function was do civilian personnel policy for Claimency 18, but also give guidance.

For example, there were a lot of areas that we could give guidance in. One would be negotiating a contract. What should a commanding office look at in regards to uniform allowance? Do you want to do uniforms in kind, or an allowance for uniforms, and guidance like that.

Quite honestly, I don't think that the capabilities of the civilian personnel the side of the house in Meadow Five, really panned out or lived up to the capabilities that we really had. We just seemed to have a great deal of difficulty getting ideas down to paper, translated into policy and getting them out to the field. The other functions were the whole accession area and then the career development.

So Meadow 5 folks would go to Newport and do the briefings on the different corps for OIS that was taking place in Newport. We worked enlisted issues and there were some huge issues working in Meadow 5 when I first got there. The manpower numbers were really out of sync. In the enlisted ratings, there were big gaps in manning of any C communities. Admiral Border at that time was head of BUPERS, and he took a personal interest in Navy Medicine. And wanted to see how things were working on correcting shortages, in both the officers side of the house, and the enlisted.

So as the Deputy in O-5, I spent lots of time in meetings over in the BUPERS arena. Actually it was the OPNAV, OP-13 arena at that time, working enlisted staffing issues and those kinds of things, in driving toward better manning. Did the same thing in the officer communities. Physicians were way short. Nurses were a critical shortage.

And we developed a whole bunch of programs at that time. One of which was the Technical Nurse Warrant Program, which was really Admiral Border's brainchild. And it sort of forced on us to do it in Navy Medicine because the associate degree nurse was a ready pool of people that were not eligible to come in the Nurse Corps because they needed to be bachelorette degree or diploma nurses.

So we created Technical Nurse Warrant to capitalize on nursing manpower out there, that we could bring in. With the intent that we'd help them get their bachelorette degree, and then convert out of the Warrant Officer area into the commissioned corps or the Nurse Corps. Lots of things in the physician community also to drive inventory. So those were really busy times at that time in Meadow

5.

Another issue that was working in Meadow 5 was the, BUPERS was concerned about the number of ratings there were. And the number of NECs that there were. So there were a lot of consolidation and reorganization. And it came time for the annual survey, called the NOTAP Survey, of the hospital corpsmen rating. And Master Chief Burke, who was Meadow 5 at that time, and I became aware that they had an unspoken game plan that they were going to drive service ratings into the hospital corps where they'd cluster all the operational independent duty corpsmen, service under C, et cetera, into a sub-rating.

They would cluster laboratory into another one. X-ray into another one. The OR community into another one. And basically, divide up the hospital corpsmen rating into probably six or seven sub-clusters. That way they could allow then direct recruiting from people in the civilian sector, into that specialty field. The promotion examinations would be written that way, and all the rest of it. Well, we took great umbrage in the lack of forthrightness of the people.

So Pat Burke and I sat out to absolutely destroy the study and argue against their findings, but using their data to do it. And we were very successful at it. A good number of other places went into service ratings, but the hospital corpsmen rating did not because of the work that we did here at BUMED to try and maintain the power and the integrity of the corpsmen rating's we've got.

Quite honestly, as times gone on, I think, and I've told this to the force each time we've had a new force, that I really think they need to look at the service rating concept for hospital corpsmen. I think that it's got a lot to offer and could solve some problems with the corpsmen rating. But I think that's an idea that's before its time.

**It's still before its time.**

I think it still is before its time. But I would guess.

**Why do you think that is?**

Well, there's tremendous traditions in the hospital corpsmen rating. And we're still operating to a great extent, on the old mentality of World War II, Korea, where any corpsman is a corpsman. If you're lab tech, you're really a basic hospital corpsman first. Because in those days, if you're in the field, you're a corpsman first. And you'd get pulled out of a hospital or anything else, to go be a line corpsman.

Well, I'm not so sure that we'll ever see that day again. The way our platforms and the sophistication of medicine has been, we've

really grown, I think, beyond our ability to do that. Because no corpsman can be a general lab tech, or can be an x-ray tech with the other kinds of things.

**You've got to specialize them. You can't really survive without specialization.**

And I don't see how you can, to keep up within your specialty, I don't see how you can keep up also as a general duty corpsman, in the level of sophistication that's also happening in that area. So I think that someday, the service-rating concept could be a good deal for the hospital corpsmen rating. If it were structured properly. I think you could structure them in large enough quantities so that you would not adversely affect promotion planning and the rest of the kinds of things.

**Are the Army and the Air Force doing it?**

I really don't know Jan. They have a different MOS system, but I don't know how the clustering works with them, or if it even does. But they, you know, for example, you can be an optical tech in the Army, and never go to basic Hospital Corps School. Whereas we all go to the Hospital Corps School before we go specializing in anything. So they're using some of the logic of what a service rating could give you, but I don't know how much of it they're using.

So in the Meadow 5 things, Admiral Hall left and Admiral Stratton came in. And again, we enjoyed a super working relationship with her. And was selected for Flag from her. And was the Flag Officer, Director of Medical Service Corps following Charlie Lore, which was a wonderful experience.

**I wanted to really hear your thoughts on that because that's a very unique position to be in obviously. Started your career as a JG.**

Well, actually I started as an Ensign.

**Rather an Ensign, and worked your way up to Admiral. That must have been a tremendous experience to arrive at that day.**

And I was the first direct procurement to be head of the Medical Service Corps. So a lot of unique feelings. Quite honestly, I didn't expect to be selected as head of the Corps. In fact, my life had been sort of planned that I was going to go out and be CO of HSETC, and relieve Dave Kemp, who was out at HSETC at that time.

And I think he was going to come down to MED-05. I think we were going to flip flop, if I remember correctly. And then that would give me enough time, and I'd retire out of HSETC and go into academia

in some sort of a job was what I was thinking.

So, it was out of the blue that Admiral Hagen called me into his office and said, I didn't know what was going on but I was expecting the worst, and went in and he could have knocked me over with a feather when he congratulated me on being selected for Flag. And it was quite a thrill.

The great thing about the Medical Service Corps, is that I've been very active. They've been in strategic planning for quite a while. And as by being one of the senior members of the Medical Service Corps, I was involved in the strategic planning. And was very active with that for Admiral Lore and for the years of his tenure.

**So you got a good background. You didn't go in cold really.**  
Right. And knew a lot of the issues and.

**What were some of those issues?**

One was professionalization. How do you build a sense of us, when you've got 36, I think it's 36 sub-specialties in the Medical Service Corps. If you look at the other corps, you know, you've got one commonality in the Medical Corps, you're a physician. A commonality in the Nurse Corps, you're a nurse. Commonality in the Dental Corps, you're a dentist. You've all gone through that same, same, special professional school.

In the Medical Service Corps, there is no same professional orientation on life. You've got administrators next to optometrists, next to podiatrists, next to clean site, next to industrial hygiene, and so you go. So how do you create a sense of family and sense of community. So when I was head of the Corps that was basically my drive. The drive of building cohesion and sense of oneness within the Medical Service Corps.

And the other was I was very much worried about what the long-term viability of the three medical services would be. There was talk about purple suits back in that time. And how do you provide long-term career viability for the superb people we had, when you go into a purple suit kind of arrangement. Well the only answer that I could think of was the characteristics of a profession because we, all of us, no matter what profession we're in, we supposedly expose those views and it's a common line, lifelong learning, contributes to the profession.

In other words, as you learn, contribute back to the profession, mentoring, teaching, living by a code of ethics. All of those are primary dictates of professionalism. Well, my mental set was that, okay, we have one job and there's an Army guy, a Navy guy, and Air Force guy all competing for it. They all have a Masters degree. Okay, there's no difference now between those three candidates.

What are going to be the things that you'll separate out, the one that you want from them, the two that you don't want. Well, it probably lies in professionalism.

If you're keeping up with the literature, you're probably, or you should be on the cutting edge of what's going on in your field. If you're living by a code of ethics, probably you should not have any problems at all in regards to personal behavior, or your work ethic in your work behavior. So, if I could get the people in the Medical Service Corps, to hold tight to the characteristics of being a professional, I thought that that would give us the edge in being selected.

And we came up with then a model, Leaders of Choice, with a power term probably in there, choice. That's leader not by divine right. And a good number of times we fall in the trap, I'm an O-6 Medical Service Corps Officer, I've been in 26 years, I deserve being allowed to be a commanding officer. Well, no, you don't deserve it, but you deserve to be able to compete for it. And if you have the characteristics of a true professional, you'll probably get selected. If you don't, you might not.

So the kinds of things in professionalism we also stressed and worked, was that it's not the issue of a ticket punch, it's the issue of making yourself better. So if you want to join AAMA, ACHE, any of, for example, I didn't belong to either of those professional organizations as I was growing up. My professional organizations were in the personnel arena. And I was very active in those organizations. That's the key point, being active, not I'm joining the politically correct organization and punching a ticket.

But whatever the organization it is, the purpose of joining is life long learning, making better that gray matter that's between your two ears. And those kinds of things, rather than punching a ticket. The same thing with college education. The purpose of a bachelorette degree should be a symbol on your wall that says you have the ability to do discriminate thinking.

So you want to go to the educational program that will push you, so that you grow. Not the educational program that will be a cakewalk to you and you get a ticket on the wall because then you've sold your self-short and you haven't grown. The whole name of the game is growth and continual self-development, self-improvement, self-growth. And then sharing that with a mutual support group. So my two themes were family and professionalism. And that was the logic behind it.

**As head of the Medical Service Corps, its got such a wide range of professions. It's, I don't want to call it the catch all, but in essence you've got your administrators, your hospital**

**administrators, and you've got your allied scientists. It's just such a wide range. Did you find dealing with that range of professions, that you had any particular problems?**

No, I didn't. I had a team of specialty advisors, the Medical Service Corps had specialty advisors all along. I had a superb group of specialty advisors that met with me just about on a quarterly basis. Between quarterly and six month basis, where we went over the issues of that specialty. What were their manning concerns, what were their professional concerns, what was going well, what wasn't going well, what are the kinds of things that I could do to help them.

I would go to as many professional meetings within the breakup of the Corps, or the sub-sections of the Corps as I could. I would go to recruiting sessions with them at professional meetings, and stuff like that. So, I was pretty comfortable with each and every one of the sub-specialties of the Medical Service Corps. And had a pretty good feel for what its issues were and trials and tribulations within it.

Along that line, I was particularly concerned about the Selection Board process. In that, how does a person sitting on a Selection Board, it's fine for me and I would sit on every other Selection Board basically, it's fine for me to have that understanding. When I'm on the Board, I can share that knowledge and share that understanding with the other members of the Board. But what happens if I wasn't there? Who would carry that knowledge?

So we wrote two books. One, a senior level book and the other a junior level book. Which was a paragraph, paragraph and a half, of each and every one of the specialties of the Medical Service Corps, and some of the key aspects of it. Including characteristics that you needed to look for the growth and development. Holding on to the professional development of individuals within the Medical Service Corps.

And that book is still at use at Selection Boards in Millington. And it's used a lot, believe me, by members of the Board, gaining knowledge of okay, what is this specialty do, and what are the different kinds of things. What should I expect educationally, what should I expect professionally, professional affiliation wise. What should I expect certification wise, or not certification wise, and those kinds of things. And a very valuable document.

So, from that, it was always a challenge and it still is a challenge to build family. But that overall, I think it was a wonderful experience. Probably the toughest thing that I had to do was, and I'll have to digress but, the toughest thing I had to do was give up being head of the Medical Service Corps.

When I made two star, and came in to be the Deputy Surgeon General, I felt that the nature of the decisions I was faced with

making here, I couldn't afford to be also the head of the Medical Service Corps. So I gave up being head of the Medical Service Corps early, to Ed Phillips, who did a wonderful job, so that I would be in essence, corps less in the Deputy Surgeon General position.

**Because that was a first too.**

That was a first also.

**(Unintelligible)**

While I was head of the Corps, Senator Inoue was instrumental in changing the law allowing nurses and Medical Service Corps officers, to compete for their second star. And I was the first in DOD to be selected for the second star of nurses or Medical Service Corp officers. Then Admiral Engel was the second. She was the first nurse, I was the first MSC.

**That had to be a thrill that had to be an incredible thrill.**

Oh it was, absolutely was. And Admiral Koenig brought me in to be the Deputy and then again, another thrill has been that I'm the first Deputy, probably this is certifiable by a psychiatrist, but I've been the first, I've held the job the longest, but the first deputy to serve two Surgeons General. And when I retire this year, I will have been in the job just a few days shy of five years.

**I can certify that. You don't need a psychiatrist to do that for you. You have been the first to serve in two administrations. Of course in doing that, of course you have different management styles to deal with, certainly with two SGs who have obviously separate ways of doing business. Did you find an adjustment in that?**

Oh yes, yeah, very much. The styles are very different. And I've never had problems stepping forward and doing things. With Admiral Koenig, there was no problem with that. And as we went on in his tenure, he was very comfortable with me and I was very comfortable with him. And I knew what I could do and what I couldn't do. And usually I'd just do it. And we almost worked as pure alter egos. When Admiral Nelson came in, we had a period of adjustment. I had to learn how far can I go and not go. And he had to learn what could he trust me with, and what couldn't he trust me with.

And I think at this stage of the game in our careers, I'm back with, you know, almost, if not a complete alter ego of his, very close to it. And we think a lot alike. With Chris Hunter working for both of us, you might as well say for both of us, or with both of us, I guess would be more appropriate. The communication link between our two offices and the mind meld that we're in, we're a very, very strong team. One that the other services don't enjoy.

**I want to just take you back to your Director of the Corps again. What was the issue that really consumed you in that position? Was there an overriding issue that you really had a lot of trouble dealing with?**

Not a lot of trouble dealing with, but it consumed a lot of energy. And that was constantly fighting the line Navy away from doing away with the Medical Service Corps. There's a tremendous amount of lack of understanding of the Medical Service Corps in the line Navy, particularly in those days. And with Navy Medicine struggling with credibility with the line, with all the different reorganizations and the rest of it. It was a feeling, we don't need Medical Service Corps officers.

First of all, the mental set was all Medical Service Corps officers are administrators, which was not true. So you had a huge educational process to help them understand that that's not true. We've got all the other non-physician, nurse, and dentists in Navy Medicine. All those officers, in all walks of life are Medical Service Corps. So once you sort of got them to agree that, yeah, maybe, and they constantly slipped off the understanding rail, but you drove that point home.

Then you had the fight in regards to okay, Medical Service Corps, anyone can do that job. It just takes a good leader. We were standing up the 1,700 community, which was the female officers of the Navy, creating a niche for them, which was shore support. The idea was, well here are jobs for them. We'll just make them all, we'll just take all the Medical Service Corps administrator jobs and create jobs for the 1,700 community. There were, well let's just civilianize them. Let's just do away with them. It won't make any difference anyway, a doctor can do that. And all those kinds of battles and we were constantly, during my tenure, fighting those.

And those fights went well into Ed Phillips, his era. During my era, while not tied to the Medical Service Corps, and Medical Service Corps was only, that's a part time job. My regular job first as a Flag Officer, was Medical IG, which gave me good exposure to over one third of the commands of Navy Medicine. And looking at leadership styles and the rest of the things. And after doing that for a year, and at the time of the change of command, change of office with Charlie Lore, I then became Meadow 3.

While in Meadow 3, the constant attack of how large should Navy Medicine be? You know, should we really keep the Medical Service Corps or not? I got involved with Admiral Hagen, looking at developing a model for justifying the size of Navy Medicine.

So I pulled together a group of five individuals, Scott Archer, Julie Clark, Rod Ferrick, Wally Melnechek, four people, I don't think

I'm leaving anyone out. And we developed a model for sizing Navy Medicine. And we took the logic of, if the need is, the justify of our in strength is all the platforms we send to war. So we need to have manpower for the day-to-day operational stuff, as well as the wartime operational stuff.

Well, and we also need the overseas stuff. Well, people can't go overseas, overseas, and it needs to be a seashore rotation built in. And in doing it all, we can't do any double counting. So it shouldn't be a huge aggregate, but it should be a sub-set of our numbers of today but yet be able to do all those platforms. That was known as the Fisher Model for a while. Well we did it all on a piece of paper. We hand counted the billet file, put them all in these categories, and the rest of it very, very laborious.

Scott Archer was the expert on the manpower piece and did things like that. We had people who were experts on platforms and computers and the rest of it. So we came up, interestingly, with a number. I briefed that, the methodology and the number back up the line to Charley Neimvacous, who was the Comptroller and the NMRA for Navy, and a cast of thousands.

Basically, they were okay with it. They liked the logic, they couldn't argue with the logic. They didn't like the number, the number was too big as far as they were concerned. So we agreed that we would, if we were going to go through this, it had to be a dynamic thing. So we hired CNA to computerize the work we did and the liaison for that was 931, with Ed Phillips in the lead for 931. And Dan Snyder was over there at the time. And that model then became known as the Fixer Model.

**I was wondering when that term came into being.**

Yeah, we decided, you know, you really shouldn't carry a persons name on it. It needed to be descriptive of what it actually did. And that's where the Fixer.

**It was a refinement of your Fisher Model.**

And in fact, the numbers that we came up with, were less then 200 off from the numbers that ultimately came out of the model.

**The long hand numbers.**

The longhand numbers. Very, very close.

**So it validated the whole process.**

Yeah, and again if you look at the near history from that, is that again, people don't like the numbers, but they, PA and E included, cannot find a niche in the logic of it to say no, this is totally wrong. So, and now having it computerized basically, if you

change a platform, dynamically, that will change the numbers of the model, and will create a difference. So you can do game playing or what ifing and the rest of it.

The neat thing though beyond that though, that Ed Phillips then did with people like Tony Whitmire and others, was that he took now the numbers after the model came up with, this is the number of people we need. He developed and Dan Snyder developed the Chism Model, which basically, okay, I have this platform, how do I distribute those numbers. And it was done on an epidemiological approach.

The purpose of the hospital is not taking care of patients. It's to maintain clinical skills of your people that go out on the platform. So if that subtlety is the difference, then you look at Pensacola, Florida and see if there's enough morbidity there to maintain the clinical skills of the people that will be on the platform that will be housed in Portsmouth.

**So each platform had to be evaluated on that basis. So you knew that you had the right mix really.**

Exactly right. And then you had to fence the manpower so Pensacola couldn't say, gee, I don't need two surgeons today, I think I only want one and I'll convert the other to family practice. So that's when we developed the component UIC, so the CO gets a couple of manpower documents. One, with the fix that he can't touch, and that's the platform he's responsible for.

And then in addition to that, he has other manpower and that additional manpower can be done of a cost basis, cost benefit analysis. And you can tweak it according to the skills that you really need to optimize the institution. And in essence, that's where we're going. And how the system is moving forward with the optimization plan of today doing that business case analysis of what else do I need there.

**It's a further refinement then really.**

It really is.

**But the basis is still the fixer.**

The fixer is still the basis for that.

**So that was the biggest and the most time consuming aspect of your, lets say your tenure as Director?**

Yeah, those kind of battles.

**Yeah. Now that you've been Deputy for five years, what are some of the issues that you had to deal with in the beginning that were critical issues?**

Well, one is when I was Meadow 3, we started what was called the Small Hospital Study, where we looked at Newport, Rhode Island. And the model that we used in Newport, with a super ambulatory care clinic and doing our in patient care downtown, with our physicians being able to have admitting and practicing privileges at a local hospital. Worked well in Newport, made a lot of sense that way you don't have to maintain a huge expensive infrastructure of a hospital, keeping all your inventories in the OR and all the rest of the kinds of things there, to be able to meet the professional needs and all the clinical needs of your clinicians working.

We looked at that and in replicating it and identified Pax River, Maryland, Corpus Christi, Texas, Millington, Tennessee, and Groton, Connecticut, and Charleston. Well, because again of the political time of it, I was scared to death to try Charleston. So we looked at places where we thought we had a reasonable chance to get political support for doing it. And also being able to pull it off. So the first was Millington, then Corpus Christi.

#### **Why was Charleston a non-issue?**

Well because of the strength, it had just gone through Bragg, and the politicians in Charleston felt quite honestly that they'd been done in. They thought that they were okay, and then lo and behold, out it came and it wiped the base clean. So there were huge sensitivities in Charleston. To walk in there and say, gee, everything else is gone, we don't need a hospital here anymore, with a heavy Flag population in Charleston and a very, very active retired population in Charleston.

Our fear was that we wouldn't have a snowballs chance of being able to pull that off. It would take a long amount of time. And as it turned out, having that as the vision of where you want to get to, but not being in a rush to get there, I think is going to pay off in spades. I think we need to talk a little bit about that also. But Corpus Christi, we learned a lot from, when we did Corpus Christi.

Again, the retirees of the town were absolutely up in arms. So I was called up to Congressman Ortosa's office and really chewed out about what we're doing. And we persuaded him to at least allow us to go along and support. We worked out some compromises. One compromise was the word hospital. Even though we would be a super ambulatory care clinic and really not a hospital per se, Congressman Ortosa's agreement was that we would never change the name hospital.

And the reason for that is, it is my hospital. You have a bunch of people that identify with the term, not what a hospital really means, but term. Maybe hospital is the vision of the place that I got care. And it is a place but not necessarily a full up around hospital.

**An institution that they can identify with.**

Right. They can identify with an institution. If you change the name hospital, you're closing and walking away. And that's, when we said we're downsizing, we're closing the hospital in patient side, and doing ambulatory care with in patient in the civilian sector, the headlines were, Naval Hospital in Corpus Christi to close which creates an entirely different image that we're walking away.

And so by not changing the hospital, with title hospital, the hospital never closed. It never went away. And now they're delighted with the care that they're getting in the local civilian in patient facility, and the ambulatory care provided in Naval Hospital, Corpus Christi. So, there are some interesting sensitivities we learned in that. Well, in the Charleston example, we had this beautiful big hospital but with no one home. With the ships and all pulling out and closing the base, and the reworked facility and all, the population to serve wasn't there.

Well, we got the Medical College of South Carolina to come visit and they loved the spaces. And they said, gee it would be wonderful if we could have this place. It would make a wonderful pediatric hospital. We'd be able to do all sorts of things with it. It would solve some problems. So what we did in Charleston was we let the local hospital be the point with the ideas and all the rest of the stuff.

So it was not Navy coming forward with an idea to downsize. But it was the local hospital touting, gee we'd like to take over this institution because look at what it can do for the community as a whole. And therefore, the palatability of any kind of change with the local hospital going to a Newport model institution, all of a sudden became a lot more viable. And we're moving along quite well there.

And ultimately, my expectation is that Charleston will have a wonderful institution, which is in good shape, which is the old Naval Hospital. And it will be an absolutely win win for everyone.

**Sure. Well, the Medical College of South Carolina has a fantastic reputation and it's one of the best in the country.**

It does. And the leadership of it is very, very well politically connected I think, with the president being a former governor of South Carolina. So working the legislative issues and the political issues, as well as trying to get money augmenting our budgets so that we can build a ambulatory care clinic where we need to be, where our population is, would then, the local hospital arrangements we already have, it will probably evolve within the next few years, and probably work out just fine.

Yeah, well that's a unique situation because of course, Charleston was certainly a Navy town. It's no longer a Navy town. That's correct.

But there certainly are a large number of retired people who chose that to stay in.

It's a wonderful community.

My parents live there, and my brother lives in Mt. Pleasant, just north of there, and it's beautiful place.

Well I think that we'll be able to meet the needs of everybody and be a good win win for Charleston, if we can pull this off, and that's the way it looks like it's going.

So it's looking good then?

Yeah.

As you, say wind down in your career and certainly in this position here, it is a high point. You know, a lot of people don't have that advantage. You certainly had so many experiences. What are some of the issues that you're kind of working on now, that you're kind of leaving to your successor?

I don't know. There are a bunch of issues out there. Every year you'll have a budget issue. Every year you'll have issues like that. The ones that I'm driving to either get close to being done or done, or far enough on the way that it'll go on automatic, and not leave a burden to my successor. One was the reengineering of the readiness. Back when I was at FMFPAC, I never knew who was going to come to the Marines to augment my troops.

It was controlled by BUMED. The numbers games were controlled by BUMED, but yet it was the local discretion of the commanding officer of the MTFs in regards to who would come. By reengineering that component UIC Distribution System we talked about before, that changes that whole picture. So the readiness picture for Navy Medicine in the future is rock solid.

The CINC will be able to know exactly what his manpower looks like by going in to his personnel distribution system, not being beholding on Navy Medicine or anyone else. But he'll be able to look in the standard personnel system to see who's sick, who's on humanitarian assignment, all the rest of it. To look at the billet body gap for his platforms, it's all in the standard distribution system. That is done. We're finishing up the component UIC process right now.

So that will be a tremendous step forward from my perspective

and assurances, that if and when we have to go war in the future, the manpower will be able to be identified, you'll be able to know whether they're trained or not, you'll be able to work the system, and you'll have the unit integrity that we've needed for years. The second one is that been driving on is the computerized patient record. The computerized patient record is moving forward. I was the Chairman of the Clinical Business Area, or the Executive Agent as we call it for the Clinical Business Area. The alpha testing of the computerized patient record will go live on 11 May, in Hawaii.

So I will see that before I retire. We've worked hard this last year on the clinician computer interface. The guidance that I gave them is get me to wow. I want when it hits the field, people say wow, why haven't I had this before, wow, this is just what I need. My understanding is we're real close to wow. And then the OT and E testing will be done in the Tidewater area again this year.

My expectation is that that will be a tremendous item also. So within the next three years, you'll be able to be seen in San Diego today and Bethesda tomorrow. And Bethesda will have access to your records and everything from San Diego. And I think we're there. With then further refinements coming on down, but a solid product, solid product there. In conjunction with that, I'm hopeful to be able to get a pilot test started with the Smart Card. Navy military ID cards are going to go to Smart Card. Smart Card has three technologies on them.

It's got a chip technology, it's got a bar code technology, and it's got a mag stripe technology. What I want to do is a pilot test in Sugar Grove, West Virginia, where you test all three of those. The chip technology will hold a 120 medical data elements, which is the identified data elements that we need for a portable patient record for wartime. So I want to have Sugar Grove load the 120 data elements on it. When a person comes to Bethesda for a sub-specialty consult, Bethesda will be able to read and write to that chip and have the medical information available to them that way.

#### **They can write to the chip.**

So you can read and write and that will be a transportable thing. And we'll see how that works. The bar code on it potentially can be used in pharmacy where you can go in the pharmacy, and the pharmacist will read your bar code, which will related\ to CHCS and CHCS says you need this medication. All of the medications in the pharmacy are bar coded. So CHCS will tell you what the bar code is for that medication.

So in essence, dispensing will be bar code to bar code, which should reduce medication error also in dispensing. The mag stripe on it that I'd like to see used, probably the most important

technology on the card. And that is when you walk into a military treatment facility, you swipe the mag stripe through a reader, it interfaces with DEERS, also interfaces with CHCS, calls up your electronic record that we have already. So now there's only one Todd Fisher in the system. There's no possibility of typing error or calling me something different.

**That's a big issue over the years.**

The other piece of it is that I'd like that mag stripe also used in the isolated cases where family members get their care from not a military treatment facility, but from a civilian provider. Where now the family member goes in, swipes their mag stripe in the machine, it relates to DEERS and says yes, this person's in Prime under the old system. We're waiting for the law to go through this year, but under the old system is yes Mrs. Fisher, you owe \$15 for the visit. And Mrs. Fisher pays \$15 and that's the end of the hassle for her. It also then creates connectivity between the doctor's office and the bill payer.

So on the screen in the doctor's office will come up with a template. He just types in the information from the visit. Electronically it's sent by bill to the bill payer. And in 48 hours or so, he'll get his payment electronically back in but totally solve the hassle for the family member. And Jan, were in a whisker's wink away from having it. We've identified the vendor that has the technology to make it work. We, I think we've already written the interface to go to CHCS. We're doing new DEERS in August of this year. It'll be built in to do that interface. It's the bill paying thing that we're just sort of muddling through right now, and having to be careful with that.

**Costly?**

No, the cost is interesting. The individual that we're looking at, I guess his cost is a fee for service from the provider. He's calculated that the typical provider is spending between ten and 13 percent to get his bills collected. And if he can go in and charge two percent, and give a guarantee that his bills will be paid if he submits a clean form, and here's your template for a clean form, within 48 hours, it's a win win for both of them. And the guys got his own money.

**So that the holdup then is technical?**

It's probably more political in that getting it through TMA, getting it okayed by managed care support contractors, and the current bill payers in the system. So that we don't incur an unexpected bill from the thing. But that's moving forward also.

**Any other major things going on at the moment, personnel wise or?**

Well personnel wise, things seem to be pretty well on track. One other one that I have a do out before I retire and that's to working with Kevin Magnason and others to get the billet file and all pretty well cleaned up for the Medical Corps. So that you know how many people you've got in training and the rest of it, so that you've got proper documentation. We went through quite an era where people said, gee I need a doc on my staff and we gave them a doc on their staff, but the billet didn't follow.

They didn't buy a billet so we've got stashed doc's and stashed billets all over. They need to be cleaned up and organized and that's well on track also. The challenge that I see not so much necessarily for the Deputy, but for the Medical Corps and for Navy Medicine. We've gone through, I think my whole career, where the physician end strength is less then what the billets call for, they're less then 100 percent manned. In the last two years, they're over 100 percent manned.

It's a whole lot harder to manage a community when you're at a 100 percent manned, then when you're short or "any doc will do" because when you're at 100 percent, if I'm over in strength on surgeons, then by definition, I'm short something else. And it's hard to manage all of the sub-specialties to keep them on track in as close to a 100 percent manned as you can. And that's where I see the challenge, the biggest challenge manpower wise for Navy Medicine in the years ahead.

I think that, you know, we go through peaks and valleys, and we're going to see that. Nursing applications in college right now are at a low, so that means four years from now, nursing will probably have difficulty recruiting. But I see with the physician manning now, up right around 100 percent, and looking at the scholarship programs and the other things, I see that stabilizing out. So that looks good. Medical Service Corps will be fine. Hospital Corpsman Rating will be fine. They've got a model and I think they've just got to wait for the model to be able to drive what the numbers are within the different NECs.

**I'm told that the military personnel situation seems to be fairly well, but the civilian personnel situation never seems to work right.**

No, and that is a huge issue, quite honestly. We're still in the throes of the latest reorganization of civilian personnel. I like to use the term, it's a seamless transition, yeah, it seems less and less everyday.

(Unintelligible) interfacing is just a disaster. It's been a disaster and it continues. It doesn't seem to improve much.

Well, and I don't know what the long-term answer is on that. We don't really own it and it's very, very difficult to influence.

I know I was having a chat with Captain (unintelligible) the other day about the number of outstanding personnel actions from the Bureau, held over there, not being dealt with. I've had my own. Virginia retired in December. I put in paperwork immediately for her replacement and it's gone nowhere in three months. So we're trying to deal with that. Apparently there's going to be a meeting with Deputy Council. I'm trying to remember what the meeting is going to be, sit down and try to prioritize. (Unintelligible) but he said you need to come and you need to justify why yours needs to be placed somewhere near the top of the list. So I need to do that. But I'm glad to hear at least the military aspect appears to be working right because we're just hurting.

Military, I think is pretty stable. The civilian side of it, you're absolutely right, there's some real trials in that. And I don't know what the long-term solution is on that. The good news, there's sort of a good news, bad news. The good news piece of it is that, remember the old days where you were governed by the number of ceiling points you had, ceiling points and dollars. They've done away with ceiling points. So now you can have as many civilians as you want, depending on your budget limitations. So that's good news.

So the command now has got a lot more flexibility in working its budget and also the manpower that it has. The bad news is that the effectiveness and the responsiveness of the civilian personnel (unintelligible) organization is still a real problem. I think another thing as I pull out, in my Deputy role here, what I've worked to do is to empower the deputies here. The deputies are the continuity. The single digits are gone so much of the time.

In regards to doing the work of Navy Medicine here on the Hill, the deputies really shoulder that work. And what I've tried to do in my tenure as the Deputy, is nurture that deputies group here, empower them so they take collective management responsibility of running the Hill. Breakdown the stove pipe kind of structure that's so easy to fall into, and manage the Hill collectively.

I think one of the really exciting things to me anyway, has been how they took on the issue of ISO 9000, to get the Hill certified in ISO 9000. The certifying inspection is going to be done next week. My expectation is we'll be certified but what that has done is we now have documented processes. Those processes that cross the codes here on the Hill are documented. You know where the interfaces are.

You know who does what, you know how it's done. Most, if not all of the processes within the codes have been documented. So now anyone here on the Hill can look at that, they know what to do and if steps in it don't make sense, say why are we doing A, B, and C, why don't we just jump from A to D. There's a process to put that on the table, do a critical review, and revise it for continuous process quality improvement here on the Hill.

**Well there used to be SOPs, then we kind of did away with that idea. You come into a new job here, where you did in the past, there was a manual. This is what's expected of you, this is how this job is done. And then we kind of got away from that and the lead-time, getting someone up to speed on another job, it was just a tremendous thing.**

It is, you know, and I go back to the culture change. Since 1988 the year, when I got here, people came to me and said, may I go over and talk with Johnny Jones in Meadow 1. I said why are you asking me, go do it. Oh no, I don't want you to yell at me. You know, the culture was you keep things within your code. Well, I think that that culture is pretty well broken down and gone. So that we're really working well communication wise. There's a matrix organization, people Meadow 1, 2 and 3 are all working together on various issues. And truly working together on them.

The next thing is that we've got a strategic plan for here on the Hill and it's working. In fact, we're on the second integration of that. The first one we accomplished about 75 percent of it, primarily habitability kind of things, quality of work life kinds of issues. Fixed the gym, and you know what's going on with all the buildings around here, and what a marked improvement that is since the 1980's when I first got here. An orientation program for newly reporting people. A Staff Action Officers course to teach them how to do basic staff work.

So from a quality of work life here on the Hill, I think we've taken tremendous steps forward. But I think one of the most important of all is the Deputy's Council and how it's really, it's not dependent on me of being there to provide the leadership. But they're working together dealing with Hill issues and moving the processes forward, and really working well as a team. So that's another accomplishment that.

**I'll get to see how it works when I go.**

Well hopefully it will continue on.

**So what do you have planned for your retirement?**

I haven't done a lot. The retirement ceremony itself will be

in front of the tower at Bethesda, that's where I came in 1965, so I thought it was very appropriate that that's where I go out.

**Sure, what could be more appropriate than that?**

And beyond that, no plans. I still operate on, if my in baskets got stuff to do that takes priority before anything else. So I haven't even written my CV for looking for employment yet, much less anything else.

**You probably owe yourself a little time, some with your family and have a little fun before, you know, many people just go right, one day and they're going to take a week and then they're into another chapter of their lives. They never really have a chance to reflect.**

No, I think my plan right now anyway is to take at least until the 1st of June to relax and calm down, between the 19th of May and the 1st of June. And then go from there.

**I guess you don't know who your successor is going to be yet?**

We do, but I don't if I can tell you right now. It's someone that probably knows the issues as well as I, and should be able to step in and take off. I think the other thing, the changes that I've seen in my tenure here as Deputy is the working relationship between the three SGs and the three Deputy SGs, with health affairs and TMA. Probably the most effective body to resolve conflict to move systems thinking forward and make the DHP work better, is the Deputy's Council there, where we meet every week with Diana Tabler, who's the Deputy for TMA.

And the three Deputy SGs work together very, very closely in resolving issues and trying to make TRI Care and the military health system better. And that's been a lot of fun, working that as well as the information management systems with the Deputies, and thinking really DOD on those kinds of issues.

**Well, you've seen the pendulum swing from the time you came in and the parochial aspects of three services hardly ever except in time of war did we ever cooperate with one another, and now we do it on a daily basis.**

Yes.

**I go to Bethesda, I see everybody over there. I see Army and Air Force guys walking thorough the passageways. Where as before, that was a rarity to see that, that whole joint, whole joint.**