UNITED STATES AIR FORCE INTERVIEW

LT. GEN. MONTE B. MILLER, USAF, MC, Ret.

16-17 June 1998
Winchester, Tennessee

Interviewer: James Nanney, Historian, Office of the Surgeon General

---

N: Sir, did you grow up in Kansas City or Independence?

M: In Independence. My dad was a schoolteacher who subsequently became the high school principal and went on to a professorship at San Jose State after the kids were educated. That was Harry Truman s hometown as you recall. Mom was a substitute in Bess Truman s bridge club and Margaret was in Dad s algebra class. The town was only about 20,000 in those days.

N: What were your high school years like? Did you have any particular interests?

M: They were good years. I enjoyed the sciences, and enjoyed the debate team and extemporaneous speaking. We took the state championship in that. I played some sports but got a knee injury in freshmen football, and that ended that pretty well. Those were pretty good years. The scouting program was very active in the Kansas City area, and I spent my summers at scout camp and became a camp counselor even up through early college years. The pinnacle of that achievement was as director of the nature lodge at the Kansas City area scout camp. So I had an early interest in nature and biology and liked people and liked science. Choosing medicine was a pretty easy choice.

N: Did you have contact with the military? I guess scouting was sort of....

M: That was quasi-military. I was in a high school ROTC program, although that was not per se particularly career-attractive to me. As you know, there was obligated military service in those years. They kind of took you when they wanted you, so I when finished my internship out in Tacoma, Washington.... It s interesting too, we chose that because we had never seen that area and it paid the unthinkable sum of $250 a month in those

days, which was one of the best-paid internships going. So we did a year of a rotating general internship in Tacoma. I think there were about eight of us. I spent some extra time in anesthesia. I remember the chief of anesthesia out there, a well-known guy named Bonica, an Italian who has written the classic tome on pain management, who used to wrestle as the Masked Marvel to pay his way through school

Anyway, I was called up a few months after finishing internship. Chris and I both worked (she is a nurse) at the state hospital in Winfield, Kansas, before it was time to enter the service. My CV doesn t really reflect that because they adjusted my continuous time.

N: So this was 1955?

M: 1956 to 1958 was my two-year obligated tour. We were assigned to Williams AFB, Arizona. I was general medical officer for few months and then decided to go to flight school and I got my flight surgeon s rating subsequently. We were flying F-86s in those days, teaching foreign students to fly. Most of my time was in little T-birds, T-33 two-seater trainers, towing targets for foreign students to shoot at.

N: Are you a rated pilot?

M: No, just a flight surgeon. But I was getting my flying time so I could get paid. I have to go back a bit. I went to undergraduate school at Kansas. I decided I wanted to go to medical school and the competition was pretty keen in those days. And although home was in Missouri, there were only two medical schools in Missouri, both of them private. (Missouri University only had a two-year medical school in those days.) The other universities were Washington University and St. Louis University, and my Baptist parents thought they were both Catholic schools, and didn t their little boy to go to one of those Catholic schools. So they scrapped up enough money so I could go to Kansas University. It seemed like about every third fellow I met was in pre-medicine, and a lot of them were Korean War vets at that time, back on the GI Bill. So I was really scared the first year because every other one was valedictorian of his high school class. I didn t wise up until the year was about over to ask them how many were in their class. They were in little Kansas schools six, eight, ten. So being valedictorian didn t amount to much.

I spent my first summer after high school taking physics at William Jewel College near home there in Liberty, Missouri, because physics was one of the tough courses So I got ten hours of physics that summer before I entered KU. I got my undergraduate degree in three years by pressing. I was accepted in medical school at KU as an out-of-state student around 1951. I graduated from medical school in 1955, and then we took my internship in Tacoma and moved on to Williams AFB for two years.

I started to tell you that in Kansas they pioneered the preceptor program. It was an effort to try induce the medics to practice in the smaller communities. In your senior year you spent a month or two with a practitioner in a Kansas town. My classmate had the same

preceptor, and was in practice with him couple of years while I was in the service. They decided they could not handle all the business and then offered me a full partnership if I came and joined them. I did, and we practiced in Garnett, Kansas, the county seat in southeast Kansas, for about four years. We enjoyed it very much and liked the people and the practice. I was doing mostly internal medicine and pediatrics and deliverance of babies because my classmate was the Catholic boy and some those women were awfully scared to be delivered by a Catholic doctor. Then the Chinese started shelling those offshore islands....

N: Quemoy and Matsu?

M: Yes. We had obligated reserve time, and my unit, a Strategic Air Command (SAC) unit, was activated and I was ordered to report as a SAC flight surgeon. Well, that did not really appeal to me, so I was able to apply for and was accepted for a residency in internal medicine at Wilford Hall. That was a good experience. I was very pleased with that program.

N: So you were actually called back to the Air Force as part of your military obligation?

M: Exactly.

N: Could we backtrack a bit?

M: Sure.

N: I am not sure why you went to the Air Force to begin with in 1956.

M: OK. When you were in medical school you were deferred to finish medical school but you still owed two years of service.

N: No matter who you were? You had not volunteered in any way before?

M: No. That was part of the doctor draft business.

N: So you did not even have your choice of a service?

M: Yes. You could list your desires, but not everybody got to go to the branch of Service they wanted. I had listed Air Force first and did get picked up by the Air Force.

N: So why did you go into aviation medicine?

M: It was down at Gunter in those days... no, it was at Randolph, the School of Aviation Medicine.

N: Was that required?

M: It was not required, but it seemed exciting and I kind of liked to fly, and it paid a little more you got flight pay and we were starting a family.

N: That course was about six weeks?

M: I think it was nine weeks in those days. It was called the short course in contrast to the guys who specialized in aviation medicine.

N: Did you actually practice any medicine in those two years, 1956-1957?

M: Oh yes. 1956-58. Yes, before I went to the School of Aviation Medicine I was doing essentially general practice but working the medical wing pretty well. After I was I rated I spent most of my time in the flight surgeon s office. We did mostly outpatient work, but I did make rounds on some inpatient cases.

I had always been very interested in clinical medicine, Jim, and I tried to keep my hand it.

N: So in July of 1962 you came back and went to Wilford Hall for specialty training in internal medicine?

M: Yes. And as a result of that you incurred some obligated time to serve. I was fortunate enough to get teaching jobs subsequent to that. I enjoyed teaching and enjoyed starting a residency program.

N: What was Wilford Hall like at that time? What were the doctors like? Was it a highly military organization or civilian-oriented?

M: No. It was more military than subsequently when all the Berry planners were there, whom you have heard about. General Jim Humphreys, the commander, was fairly militaristic; we stood inspections and did some marching.

N: Even the doctors?

M: Oh yes, we turned out for parades and stood military inspection. But the emphasis was clearly on academics and the teaching programs and the residency programs. Case selection was absolutely fabulous. Difficult cases from all over the world came into Wilford Hall.

N: Was it already the premier Air Force facility?

M: Oh yes.

N: What about the patient demographics? Was it mainly Air Force patients?

W: There has always been a good mix at Wilford Hall. There is a big retired population in San Antonio. There was no dearth of interesting cases.

That continues to be a concern today. If you just treated [active-duty] military you would not have the basis for residency programs in specialties.

In those days basic training for new Air Force people was at Lackland and in the heat and humidity of San Antonio there would be several heat stroke cases which became a big effort to take care of. Let me tell you just a couple of anecdotes about that. We didn t know in those days what we know today about managing heat stress, and all the dorms for airmen basics had big dispenseries of salt tablets in them. I remember several cases where basic trainees would get depressed and decide to do themselves in by taking handfuls of salt tablets. That of course raised havoc with their systems, and they would come in comatose and as soon as you figured out what was going on you started adding fluids to them to dilute the salt. It became known as the "instant man syndrome": you just added water.

I remember another case too, unique to Lackland. The foreign language school is there for students from other countries to come in to learn enough English language before they went on to tech training or whatever. I remember one fellow from one of the smaller African countries who came in just critically ill with malaria. Almost all of his red blood cells were parasitized. We didn t think we would be able to pull him out. Eventually he did survive. We did replacement transfusion pulled his blood out and gave him fresh blood to try to get rid of the parasites when nothing else would work. He survived and they returned him to his home country. Afterwards we discovered one of the reasons for his immune defense mechanisms not being very solid was that he had AIDS. The folks who took him back told me that as soon as they read his chart and found out that he had AIDS they shot him. So we didn t win after all.

N: He had AIDS in the early 1960s?

M: Yep.

N: This was the period in the early 1960s when space was still a strong push in the Air Force, even though NASA was taking over a lot of that. Did the space program affect Wilford Hall in any way?

W: We did some physicals on the astronauts. I didn t personally, but my staff supervisors were doing physicals on them. I can remember some stories I won t repeat about sigmoidoscopy on some of the astronauts. John Glenn was in the hospital a while after that fall in the bathtub that gave him vertigo. Most of the research effort in Air Force aerospace medicine was happening over at Brooks. So I wasn t really involved with that.

N: Was it a tough work load?

M: Oh yes. Residency anywhere is a tough work load. I recall many times being totally exhausted and finishing up finally and going home and just seeing the kids in bed and going right back to work. It was tough, rigorous, intensive, but extremely valuable.

N: What sort of leave did you have as a resident? The normal military leave?

M: I don t recall exactly. But you didn t have much leave. We tried not to lose leave by going over sixty days of leave in the bank. We would negotiate time some so we would not lose leave. Also the residency review committee - the AMA and other specialty societies - limited the amount of time off residents could have. I don t know whether that is still extant or not.

N: Did you start to develop any particular interests at that time? You had three years I believe?

M: Yes, it was a three-year program after internship. That s longer than it is now for internal medicine training. Yes, I was interested in endocrinology and cardiology. The last half of my senior year of residency we lost the chief of pulmonary services at Wilford Hall and I substituted in that role for a few months, but the challenge of difficult diagnosis was what really turned me on. We had plenty of tough cases.

N: I see. Were there any other milestones in that period?

M: Not that I recall off-hand, Jim. There was quite a bit of interest at that time in renal dialysis, and that was fairly new at that time. I remember a couple of cases of severe hepatitis that we tried to bail out by dialysis and succeeded in contaminating the dialysis unit and had to close down temporarily and had to go through quite a rigmarole to get that cleaned up. No, it was mostly hard work and a lot of opportunity to learn.

N: Did you feel like it was really quality training?

M: Oh, no question. I would put that training program up against the best in the nation, undoubtedly better than most. As you know, our Air Force specialty programs as far as board pass rates go stood far above the national average.

N: So at that time you had an obligation to the Air Force. I just wondered at what point you decided the Air Force would be your career.

M: That s a fair question. As I alluded, my interest was teaching, and my first assignment after residency was to Travis AFB, to David Grant Medical Center. It was evident at that time that we were on the threshold of setting up our own residency program in internal medicine. I was assigned as training director or training assistant before I went to Vietnam. When I came back from Vietnam I inherited the chairmanship of the department of medicine and was able to get the residency program started. I just loved the opportunity to teach internal medicine to residents.

N: That was after Vietnam?

M: Yes. I was in Vietnam in 67-68, which was a good experience aside from being separated from the family. Again, great cases, and I authored five or six papers on my experience over there.

N: Those are listed in you curriculum vitae?

M: I think they are in there. Just absolutely great cases. That was an interesting year. I ended up being senior internist in the country for Air Force, and so was traveling quite a bit in a consultant role to various other hospitals in country.

N: Do you remember much about how the Air Force Medical Service was distributed in Southeast Asia?

M: Cam Ranh Bay hospital was our largest Air Force hospital. North of us was Ton San Nhut; south of us was Phan Rhang; further up north was Da Nang, which was primarily a Navy medical facility. Of course we had small clinics at most of the Air Force bases. But when we had a case that exceeded our capabilities and we didn t think they were ready to ship back to the States, we sent them to Japan. There was a good-sized Air Force facility in Japan. At Cam Ranh, though, we had all the specialties covered. We had one ward for local Vietnamese, who presented us some interesting diseases.

N: How would you determine which of the local Vietnamese you would bring into the facility? Certainly you could not take in everyone?

M: No. It was basically on the basis of need.

N: The more severe cases?

M: Exactly. Those who could be handled as outpatients were handled as outpatients. You may remember the medical civic action programs (MEDCAPs) where we went out to the villages and did outpatient procedures.

N: I suppose that was considered a part of the war effort?

M: Yes, it was outreach. We took dentists with us, and they pulled some teeth. We did some minor outpatient surgery.

N: Did you have significant surgical facility at Cam Ranh Bay?

M: Yes. Good-sized and very capable. Two operating rooms I believe, and they were busy. We had a lot of Marines who were air evacuated down from Da Nang. We had a lot of tough cases from a medical standpoint. We had lots of malaria with the Marines; lots of parasite infestations, exotic tropical diseases typhus, dengue, and so on.

I could go on with war stories about Vietnam, but I doubt you are too interested in that sort of thing.

N: Well, the Tet offensive [in February 1968] was a big event.

M: Yes. Well, I was there for Tet. We were pretty well protected at Cam Ranh Bay. The South Koreans had a White Horse division that were responsible for our perimeter defense. They were tough rascals. We occasionally did get some mortars lobbed in and we would have to go the bunkers. I recall several times in our trailer we tried to get up on the roof to see what was going on and the sky cops would come around and chase us down into bunkers, where we were supposed to be.

We had several some of the usual experiences you would expect in that kind of setting with nurses there. We had several pregnant nurses. We had interesting experiences with some of the tour groups, the entertainment groups that came over. One singer, who shall remain nameless, just raised hell with us because we didn t have any birth control pills stocked for her. I remember LBJ coming for a visit and the base was concerned about prettying up that place in the sand, and we had airmen out in the dark with flashlights raking the sand for the President s visit.

I got to Bangkok several times. The air attache s wife was a bit of a cardiac neurotic, and she would be thinking she was having a heart attack and the hospital commander had a girlfriend in Bangkok at the time. So he would grab me and an electrocardiogram machine and we would fly to Bangkok.

N: Did you have any Berry planners there?

M: Yes. We had a few Berry Plan docs. Another anecdote I remember one Texas boy who was a good internist. But I got called over to his hootch because he was having a grand mal seizure. It was a more severe seizure than you would normally expect. We got him in the hospital and brought him around, but things were not quite right. I finally pressured him enough to tell me what was going on, and as I expected he had been taking barbiturates and he was addicted and decided to go off cold turkey, on his own. He straightened out and we kept him. He still writes to me. He has written several articles in a Texas monthly about the balding internist who straightened him out in Vietnam.

N: What about narcotics problems in general over there? You hear a lot about that.

M: You do. But, from what I observed, that was unusual in the Air Force. I can t say from personal experience, but from what I have heard the problem was bigger one among front-line troops than in the Air Force. We had no more than the usual amount of problems with excessive alcohol use given that kind of setting.

N: So you were on a one-year tour like everyone else?

M: Yes, just one year.

N: You didn t get back to the States during that year?

M: I got back once when the wing commander had a heart attack and I came back as his medical attendant and turned around and went right back.

Here is another anecdote about Vietnam. General Ryan, the current chief of the Air Force, had a father over there in Vietnam known as   three-finger Jack,   because he lost fingers in an aircraft accident. I got a call on my radio at Cam Ranh. They were very excited. They couldn   t find my hospital commander, and they thought that General Ryan was having a heart attack down in Phan Rhang, south of us. A chopper was already waiting on the pad, so I had to get on it and go down to see General Ryan. We couldn   t be sure, so we flew him back to Cam Ranh, where for security purposes we had one little offset of Quonset huts where we made him a private room with guards outside. It took about three days to get the chemistries back so we could be sure he had not had a heart attack. So we had the famous General Ryan there, while the inspection group he was with went on to Thailand then came back and picked him up. That was one of our moments of fame.

I was getting combat pay like everyone else was, and I was also getting flight pay. I was still getting my flying time in. I chose to be associated with a transport group supplying the special forces camps with little twin-motor wooden airplanes. You would have crates of chickens, geese, and some local Vietnamese as cargo. A lots of times you could not get radio contact with these special forces camps, which were small and isolated with a small strip they had bulldozed so you could land the Caribou. So you never knew whether the bad guys had that camp or whether they were still good guys. So you would go in on steep approach, land, leave the motors running, and see who came out. If the bad guys came out, you could get out of there in a hurry.

N: Did the bad guys ever come out to meet you?

M: No, thank goodness.

Some of my predecessors were flying the back seat of F-4s, and in that job they were doing some of the targeting. A couple were in on a couple of MiG kills. When that was discovered someone pointed out it violated the Geneva Convention. So that was stopped. The flight surgeons were not flying combat patrols any longer after that.

N: Compared to the peacetime population, what was the Air Force disease, non-battle injury rate there in Vietnam? Did the theater produce an increase in medical problems?

M: Sure. Not only the exposure to some of the more exotic diseases, but the impact of stress, the impact of heat.

N: What were the working and living conditions? I presume there was air conditioning.

M: Seniors officers had air conditioning and trailers. Junior officers and airmen, unless they had been able to scrounge something, were in floored tents and did not have air conditioning. I mentioned scrounging. Like in all situations like that, there was a lot of

trading going on. Occasionally a case of steaks would fall off a truck that was intended for some other place, and it was possible to trade a case of steaks for all sorts of good things. We inherited a jeep from the Army salvage yard down south on the peninsula, and we were able to scrounge some blue paint and put some yellow Air Force numbers on it, so I had a jeep for part of the time I was over there.

N: What about venereal disease?

M: That s interesting. The problem among Air Force people was more perceived than real. When it came time for pilots for rotate back to the States they were always concerned that they might have picked up something. So they would come in and get around finally to asking the doc to check them out and make sure they were not taking anything home to their loved ones. And they were always interested that none of that appeared on their record. But we didn t have the problem really that some of the other forces did.

Let me give you another anecdote, Jim, that is rather amusing. About that time I can t be certain of the time I guess it was after I was back at Travis we at Travis isolated the first penicillin-resistant gonorrhea germ. That became a potential big problem. The Army of course had bigger numbers with GC than the Air Force. It became a real opportunity to do a good study on that with Army units rotating in and out of Okinawa, so that you could have a controlled study, and a good study design was drawn up with one group as the control group and another group as the target group.

The Army proposed this study, but the commanding general over there nixed it because he didn t want to become known as the Clap General of the United States Army. So we didn t get to do the study on the incidence of penicillin-resistant gonorrhea in Okinawa.

I know the venereal disease problem in the Air Force was greater in Thailand than it was in Vietnam, but I don t have any figures on that.

N: What about the pilots living conditions? Did they get air conditioning?

M: Yes.

N: Regardless of their rank?

M: Yes. They were pretty well taken care of. As were our nurses. Speaking of pilots, one of my predecessors was named Frank Leacock. Frank was an endocrinologist who was chief of medicine before I came. We overlapped some. Frank was good bridge player, and he and I teamed up and we would play bridge in the officers club with the pilots. Most of the pilots weren t all that good, and Frank and I were able to supplement our income a little bit beating the pilots at bridge many a night. And they were prone to have a drink or two more than they should have some nights, which kind of affected their bidding.

N: How did they behave in general, especially the fighter pilots? Did you see that the war was having an affect on their behavior?

M: Well, you know, fighter pilot personalities are such that they were in their glory. They probably, when they were not on alert, were drinking a bit more than they did at home. They were often frustrated. You had to get clearances to shoot at anything, from the Air Force as well as the local province chief. It was very frustrating for them lots of time to have known enemy targets that they could not fire at. They acted like Air Force fighter pilots, which is a special sequestering of personality types. It s much like medicine you know. It takes a certain personality to be neurosurgeon. It takes a certain personality to be an internist. It takes a certain personality to be a psychiatrist. Well, you know, the transport pilots (trash haulers) are one personality, the bombers another, and the fighter pilots are another.

N: Speaking as an internist, what kind is that?

M: The stereotype is introspective, intellectual. You know, Andy Anderson s comment in the bios that I considered myself a professor of medicine who just happened to be Surgeon General is probably reasonably apt.

N: I have seen someone report that there were some unofficial family visits to Vietnam and perhaps Thailand. Family members who somehow got over there. Were you aware of that?

M: I never observed that. It did not happen to my knowledge, not in our area. I was able to take advantage of aeromedical evacuation coming out of Travis and going into Cam Ranh. You got hungry for some things. Fresh fruit and vegetables were hard to come by. We occasionally got some lettuce from up north, but you had to soak it in Clorox water to make sure you didn t get amoebae from it.

I am digressing. he whole point of that was that some of friends were able to get some strawberries and occasionally some fresh vegetables on aeromedical evacuation planes coming into Cam Rahn; so I would get a call to come down to Operations and pick up some strawberries and fresh vegetables that were smuggled in on aeromedical evacuation. But I never saw any family members smuggled in. I don t doubt that it might have happened. Not to my knowledge though.

We did have an R&R -- a week I think -- when you could elect to go Thailand or Hawaii or wherever, and Chris, my wife, did meet me in Hawaii and we had a wonderful week in Hawaii. That was a break.

N: But family members didn t come all the way over?

M: No, No. That would have been distinctly unusual. Now if you elected an R&R trip to Bangkok for instance, it was perfectly legal for your wife to meet you in Bangkok.

N: It could be done legally.

M: Yes, but as far as visiting a base, no, I don t think that happened.

N: What about just coming to Saigon?

M: Yes, if they could get clearance to go to Vietnam, and I don t recall whether you had to have State Department approval or a visa to visit Saigon or not. You may have. But if you could get State Department clearance to go to Saigon...

N: Commercial air?

M: Yes, if a guy got some time off and took some leave to go to Saigon to be with his family that would have been possible. But I just don t believe anybody came into the country illegally. They didn t to my knowledge.

N: Did you know any residents in aerospace medicine? Do you see any over there? You were not one yourself?

M: No, I was a short-course flight surgeon.

N: But you did become a chief flight surgeon?

M: Yes, but that s a matter primarily of flying hours. Being in Military Airlift Command (MAC) a good part of my career I got lots of [flying] time, and I ended up with close to a thousand hours. I think you did have to pass a test, but it was no major credit to myself for becoming chief flight surgeon.

N: So did you know any Residents in Aerospace Medicine (RAMS)?

M: Oh yes. Fred Doppelt was a RAM, and several others.

N: How were they used in Vietnam?

M: I don t know of any RAMs being stationed in Vietnam the year I was there. We didn t have any at Cam Ranh. I am sure that some were in and out with aircrews.

N: I was wondering if there was any attempt to use the stresses of the war for research purposes. You would think these kind of RAM specialists would be there for that.

M: I am sure there were opportunities and that they were used advantageously, Jim, but it would have been on a trip to check out body armor or flying safety matters, just trips for several weeks. I am trying to recall. There was some controversy that didn t originate in Vietnam but with some of the SAC crews and some of the long deployments with several refuelings, the use of stimulants to stay awake became controversial. I know the RAMS were involved in several of those studies. But as far as research involved with

the Vietnamese conflict I am really unaware of any specifics. I am sure there was involvement as far as flak jackets, oxygen discipline, fatigue studies related to long flights, the use of sedatives and stimulants. That s about all I can recall.

N: At Cam Ranh Bay was there much general research going on? You said you got several papers out of that experience.

M: Only clinical research. I co-authored and published several medical cases from over there. I can recall several cases of severe falciparum malaria where we resorted to using intravenous quinine, which was unheard of in those days. The National Institutes of Health (NIH) became very interested and sent some people over to look at that. My clinical papers related to the clinical management of typhus. But as far as laboratory research in contradistinction to clinical research, no, the opportunity wasn t there.

N: I think I have just about exhausted Vietnam, unless you can think of something else worth mentioning?

M: No, most of what I would add would just be anecdotal.

N: You had already been at Travis before Vietnam, and then you went right back.

M: I went right back.

N: Is that what you wanted?

M: Yes, the opportunity to establish and direct a residency program was there and that was very attractive. We were very fortunate. We stayed at Travis for a good long time.

N: You were there almost ten years.

M: Yes, a total of eleven counting the year before. Good schools. The kids went through the same elementary schools out there. I faced the decision point at Travis where I was coerced into becoming a chief of hospital services, or professional services. That allowed me to still be primarily clinically oriented, but I left my first love, which was directing the residency program. And then the next decision point was whether I wanted to stay purely clinical or get involved in management and administration. And that s purely an ego thing. I decided that I could probably do as well changing some things I thought needed to be changed as anybody else and still keep my clinical hand in to a degree. So I became commander and enjoyed the experience.

N: So becoming a commander shifted you over to management and administration?

M: Yes. It s unavoidable. You can t continue to see patients ten or twelve hours a day.

N: Did you see any patients?

M: Oh, yes. I had an exam table in my office and continued to make rounds. I took the opportunity to make teaching rounds with residents. I did have my own stable of private patients I saw in the office.

N: Were there any special or memorable military operations you were involved in? What about Operation Homecoming?

M: Oh, yes. A couple of memories about Travis. I mentioned the first isolation of a penicillin-resistant gonorrhea. Another first that isn t well known was the advantage of having Berry plan internists. I really think that enriched the training programs a great deal. We were really getting the cream of the crop. You had an academic reputation in the Air Force teaching hospitals. And many department chairmen and chiefs of service at the better the civilian institutions when their boys were having to try to fulfill their military obligation -- would call and would try to get their best folks assigned to Air Force teaching hospitals. We reaped the benefits of that. It really enriched the residency programs because you had some different perspectives from different civilian teaching hospitals. One of the benefits of that I recall is when we had a couple of fellows who had good ties with Stanford, and we were able to get an isotope of potassium from Livermore Labs and did the first studies on myocardial imaging.

You know one hears a lot about what a problem the Berry planners were. My experience is somewhat narrow, being limited to teaching hospitals. But aside from occasionally having to remind them to get haircuts and to wear their hats when they went outside, it wasn t that much of a problem. In the teaching hospitals I never experienced the malcontents that are talked about when other people refer to the Berry planners. My biggest problem in the commander s role had to do with getting haircuts and wearing the uniforms right. The Line of the Air Force had the idea that because of the Berry planners the medics weren t really very military. Another anecdote I recall the wing commander at Travis driving up past the front door to the hospital when one of my Berry Plan guys ran out as it was starting to rain, and he didn t have his hat on and had his jacket open flopping in wind like Johnny Seagull. The wing commander opened his car door and beckoned the kid over there, and the kid thought he was offering him a ride out of the rain when he really wanted to chew him out for not having his jacket zipped and not wearing his hat.

But by and large in an academic atmosphere of a teaching hospital, particularly if the focus is right, and you approach those guys the right way, they would cooperate. That wasn t as big a problem there as it was in some other places.

N: As a commander, did you feel you had a responsibility to keep the good people in the Air Force?

M: Oh yes. You succeeded to some degree. You didn t keep as many as you would like for understandable reasons. But you did keep some. Because of the assignment of the Berry planners to the teaching hospitals we couldn t offer many of them the advantages of a rat lab and the place to do basic research. We just didn t have that

capability. The sweetness of that bitterness, however, was that you had service chiefs, teachers, who weren t down in the rat lab forty percent of the time. They were on the wards instructing residents. So you had more one-on-one instruction than in most civilian institutions, simply because we didn t have a rat lab, basic research facilities.

We did have the challenge in those days, and I guess we still do, though not to the same degree, with pot smoking. That was a challenge primarily because ... and I think it was true throughout most of the Air Force ... that the Line and the Line inspector generals felt like the medics were all smoking pot. Well, that wasn t true; I don t think our incidence was any higher than it was in the Line. But there was that reputation we had to guard against. So I think we were more vigorous in cracking down on marijuana than the Line was in truth. I may have had to hand out a few Article 15s, but there were no real major discipline problems. Again I think it s a matter of focus and leadership and orientation.

N: How much contact and interchange and interplay was there between Air Force medicine and civilian medicine?

M: At Travis?

N: Yes.

M: The University of California Davis, just up the road from us at Travis, had just started their residency programs and I spent some time running up there doing some teaching, as did some of out service chiefs. We had some cooperative research going on with several of them. It was possible to get some of their service chiefs to come and present some lectures and do some teaching at our facilities. We had good relationships with the VA hospital down in Martinez. We had even some exchanges with UC San Francisco medical people. We had good inter-Service cooperation with Letterman and Navy Oakland; we did some exchanging of talent and experience.

N: Had you formed any general conclusions about any differences in their approach to medicine?

M: Oh yes. But some of that is biased I am sure.

N: This is a chance to be biased on record.

M: I was convinced early on that Air Force medicine was head and shoulders above our sister services in approach and orientation, for some understandable reasons. We liked to think, and I believe there was some truth in it, that we were serving in general a little better educated population, a little more sophisticated if you will. And our orientation was more toward family units, again because we didn t have the deployments in general that Army and Navy do. Our officer ratio is higher. I believe that in general we had a more caring philosophy and attitude toward our patients, particularly enlisted people, than Army and Navy did. I felt like the Army and Navy did not treat their enlisted people with the respect we gave them in the Air Force.

N: Were you involved in Operation Homecoming and those highly visible operations, such as Babylift at the end of the Vietnam War.

M: Yes, I was involved. It had quite an impact on Travis. Let   s relive my memories of Babylift first. Commercial carriers brought them in, not Air Force planes, and they landed at Travis. State Department doctors were supposed to board the planes when they landed and check the kids out and OK their entry into the States and see if any of them needed hospitalization or not. We, of course, wanted to have an Air Force doctor along with the State Department doctors when they went aboard those airplanes. It was quite an experience when they cracked open the doors to those airplanes to go in. It smelled like dirty diapers had been collecting for weeks. Most of the babies were in cardboard boxes with bedding and I was not impressed the abilities and competence of the appointed State Department docs. In the first place, they didn   t consistently show up when they were supposed to. Second place, they seemed rather indecisive about things. After the first load or two it became obvious that we needed our Air Force pediatricians checking those babies. The State Department quit sending doctors out to us. The operation went rather smoothly.

N: As I remember it lasted a couple of months.

M: No longer than two months, Jim.

N: Do you remember how many planes were required and came in?

M: I wish I could. I can   t remember. It seems like there were no more than a couple a week.

N: So did the base hospital take any of these babies?

M: As I recall, there were very few we didn   t feel ought not to go on into San Francisco. Most of them were transported into San Francisco. We did hospitalize a few.

N: And the Air Force was not involved?

M: No, these were by and large commercial carriers. I suppose they were probably contracted. There may have been one or two C-141s, but I think they were all commercial carriers. It was supposed to be a State Department program.

N: How did that compare to Homecoming?

M: That was small potatoes compared to Homecoming. We had ample time to prepare for Homecoming. And we emptied the old aeromedical evacuation staging facility which was adjacent to the hospital. Requirements were laid on by Defense and the intelligence community that they had adequate space for interviews that were secure. They wanted private or semi-private rooms for all of them. The flight line receptions were well-documented and I don   t think I can add anything of medical significance to that. I would

relate, and I think it s been published before, that we had some well-meaning dieticians planning for their return. The fellows had been on fairly meager rations and the dieticians insisted that we equip the planes to bring them out with very bland and semi-solid foods. A bunch of us thought that was a bunch of baloney, but we acceded to their wishes. And of course the POWs wanted steak and ice cream, and the aircrews saw to that. And none of the guys were any the worse for eating steaks and ice cream. By and large, they were in better health than we had anticipated.

I remember that it took some negotiating to get the assurances of the debriefers and the intelligence community that they would not do the debriefings until we had passed on the POWs medically. There were concerns that some of them might not be ready for it. Some of them might have physical problems that precluded early interviews and debriefings. But I must say that that took minimum negotiating. State and the intelligence community were very cooperative in that regard. The base handled security and the press very well; they didn t interfere with the medical job.
Several of the fellows needed some surgical intervention. By and large, the overall impression was that the mental health of the fellows in general was much better than had been anticipated. They were pretty darn stable and had coped much better than anyone expected them to have. I do remember feeling a lot of concern about several of the fellows whose wives had given up on them or remarried or had sought other liaisons that came as a big disappointment to several of the fellows. They understandably as a group were anxious to get their debriefings over with and their medical clearances over with and get back to the real world. They had an intense interest in what had been going on in the world. They soaked up all the old news magazines we could provide.

N: How much direction on the operation did you get from a higher level, like from the State Department and the White House? How did you handle the high-level interest and publicity? Did you have to set up a special team?

M: We were spared that. The Air Force wing provided their own press relations and public information office, and if there were medical questions the wing came to us rather than the press coming to the medics. We were pretty well buffered on that. And of course we did not have to worry about security; the base took care of that. And the location of the medical center at Travis was such that access was easily controlled.

N: Your next assignment was to Norton as team chief in medical inspection. Did you want that particular assignment?

M: Well, I didn t seek it, but when it was offered I thought it would be a good experience to see how the rest of the Air Force worked. I did enjoy it. A lot of travel was involved. It was an opportunity to see how Air Force medicine world-wide worked and to some degree to influence it as far as quality was concerned. Air Force medical inspection is unique. When I think back as to Air Force medical inspection visits compared to Joint Commission on Accreditation of Hospitals (JCAH) visits, there is just no comparison as far as depth, as far as the comprehensive look at things and

recommendations are concerned. The Air Force did a far better job than JCAH did in those days.

N: Who formulated the medical inspection guidelines? Was it the medics assigned to the inspection agency or the Surgeon General s Office?

M: Primarily out of the inspection agency. You have to constantly revise those guidelines; medicine is dynamic and evolving. There was no requirement that the Surgeon General s Office buy off on the guidelines. You would ask for SGO review, but medical inspection was rather autonomous. The interface with the SGO was primarily to see that policy was being implemented, that is, Air Force SGO policy, that it was being implemented and complied with.

N: So the technical term for the medical inspection was the Health Services Maintenance Inspection?

M: Health Services Management Inspection.

N: Did it cover everything?

M: It covered everything; it covered the waterfront, from administration to professional services, to dietetics, to safety, to cleanliness, to leadership, to nursing practices, enlisted practices, the entire gamut.

N: At that time there were already several quality control mechanisms in place. Each specialty of course had its own civilian guidelines I would presume had to be complied with. Maybe the American Medical Association had an effect on the Air Force?

M: Well, yes. But, Jim, I would have to say that as far as guidelines the civilian world and the Air Force world are a good ways apart. There are AMA ethics and specialty ethics, but here were not in those days, and still are not to speak of, practice guidelines. In the last few years some things have developed as far as how certain medical problems should be managed in the civilian world. And even as I have mentioned, even the JCAH is not nearly as comprehensive as the Air Force Medical IG was in those days. Those were pretty much compliance-oriented inspections in those days; that has changed somewhat more recently. It was detailed; it included such things as whether or not the food preparation areas were clean, and whether or not the housekeeping staff had been checked as far as communicable disease was concerned, to the professionalism of the medical and nursing staff, and everything in between. So it was very comprehensive. Recommendations by and large were attuned to improving service at the facilities. Those reports really helped to serve as the ultimate quality control check from a purely medical standpoint, as the eyes and ears of the Surgeon General and representative of the Chief of the Air Force.

The emphasis on Total Quality Management and all that business a la Peter Deming and the rest of the prophets came a bit latter. The major push on that really occurred during

the time I was in the Surgeon General s Office. Quality management was not being preached from on high in the early 1980s.

N: From the standpoint of the facility commander would that HSMI be the most significant outside review that a commander had to face?

M: Absolutely. No question about that. It was of more import to an MTF commander and his boss than an Operational Readiness Inspection (ORI) was for the Line. I think it served a very useful purpose. It was no secret that some MTF commanders and administrators were moved to different jobs as a result of those inspections.

N: And promotions?

M: Oh, yes, very much so. When you outbriefed that a wing commander or to whomever the Line boss of that hospital commander was, it certainly influenced his evaluation of that commander, upon which of course promotions were based.

When you took out an inspection team you would always have a nurse, two or three docs, including a flight surgeon who was usually a RAM. You also would have someone from biomedical science looking at dietetics and laboratory and what not. You would have couple of administrators checking administrative areas. It was a multidisciplinary team, and you put together three or four of these teams when you went to the bigger teaching centers, and sometimes you stayed a couple of weeks. By contrast, a typical JCAH visit was a day or two.

N: Were these periodic, or a mixture of periodic and special event?

M: Mostly periodic. But if there was problem someplace you might be asked to go check it out. The team was also used for looking into perceived or real medical problems that might just be of an individual nature at some places, at the direction of the Chief of Staff through the boss of the Air Force Safety and Inspection Center.

N: This is about the time the problem with surgical quality arose at Wilford Hall began to surface. The William Stanford issue. Do you remember if there was an IG inspection in response to that issue?

M: I don t recall an inspection per se. I do recall that a couple of our docs were asked to help General [Howard] Leaf to look into that a bit. That was pretty closely held, and those reports did not come through the usual channels. The one or two IG folks from the center who were involved were asked not to talk about that.

N: Your next assignment was to Malcolm Grow Medical Center, as commander.

M: Yes.

N: That was your first experience in Washington.

M: It was, and it was my first star. The Travis position had been a general officer position up until the time I inherited that particular throne, a time of cutting down general officer positions. So that was my first star and my first exposure to Washington. Again, a challenging and interesting assignment. Challenging in that besides the ordinary population you served, you had responsibility for some of the senior Air Force leadership medically and a few of the eligible folks in government. For instance, we looked after Barry Goldwater, who was eligible for care in Air Force facilities, and I got to know him a bit. Interesting too in that much like the medical personnel at the Air Force Academy, you tend to hand-pick the people who are assigned there because of the exposure. The size of the place in itself probably doesn t necessitate a general officer as commander there. But because of the exposure its necessary. Additionally, of course the Army and Navy medical worlds are represented by general officers in Washington so it becomes necessary to hold your own more or less.

There were many sensitive issues that came up there, as you can imagine, dealing with senior people. I was fortunate in having a fellow whom I considered to be one of the best psychiatrists in the country to be chief psychiatrist there at that time who dealt with some very, very sensitive issues and some very senior people. We were occasionally called on even to send someone over to take a look at the President in those days.

N: Well, the White House had its own medical staff.

M: Yes.

N: So you had to send specialists at times?

M: Yes. Generally speaking, and I can only speak from my few years associated with Washington, but the President s physician tends to be not as much a skilled physician as he tends to be a facilitator. They have not failed to ask for specialty help and consultation when they thought it was appropriate.

N: Would they turn to the other Services also?

M: Yes. They turned to the person best qualified in the field they thought was necessary.

N: Would that apply only to President, or were there any other senior officials in the chain of command who might have been eligible for military medical care?

M: Yes. We took care of several, and consulted on several. You know the eligibility for care business becomes a less than impenetrable barrier when you are talking about senior people. The rules are bent a bit.

N: What about medical support of presidential travel parties, which often originated from Andrews in Air Force One? Was Malcolm Grow involved in that?

M: I will answer that. But let me say first about eligibility and senior people. I don t mean to imply that this would be free care. If they were ineligible they would be billed, and eligibility would be considered by the Medical Service with discretion as to the need. You could take care of anybody anytime on the basis of an emergency.

Now as far as Presidential trips were concerned, the President s physician s office managed that almost exclusively. Our involvement at Andrews would only be at the last minute if some piece of equipment was missing; or if they needed a certain skill that they didn t have for a particular trip, they would tap us to provide someone. Generally, on presidential trips, the president s medical office will have the itinerary, will contact whatever they feel to be the best hospital or medical facility in the area where they are going to be, and there nearly always will be a stand-by emergency team and stand-by surgical suite, even the right type of blood available for where they are going to be. On occasions that s an Air Force hospital. We at Andrews weren t involved in the presidential trips more than that.

N: The Washington DC area has major medical facilities for each of the three Services. Was there a mechanism for referring high-level people of one Service to another Service s facility if necessary, or did each service try to take care of its own?

M: That mechanism was there and was used. There was not much inter-Service rivalry in that respect. We went back and forth. Of course the size of both Bethesda and Walter Wonderful [Reed] was much more than Malcolm Grow. And occasionally you had Air Force people who wanted to stay in the Air Force system, in which case you could aeromedical evacuate them to wherever they needed to go. That was always a bit of concern in DOD and to some degree among knowledgeable Congressional staffs as to why would you send somebody from Andrews to Wilford Hall when you have Walter Wonderful right up the road a way--Isn t that expensive? How do you justify that? and so on. You could justify it primarily, when you were pinned down, on the fact that you had teaching programs to support.

N: What was the mechanism for cross-Service referrals? Was it informal contact from one center to another?

M: Right. Or one doctor to another. If you knew that Joe did a good shoulder procedure, you were an orthopedist at Malcolm Grow you would call up Joe and say Hey, will you see so and so for me. My experience was the more doctor-to-doctor communication you have the better off you are rather than have to go through several different administrative levels.

N: Right. What about the Chief of Staff? Does he have a personal physician at Malcolm Grow?

M: As far as I know the Surgeon General always acts as the Chief of Staff s personal physician.

N: Even to the point of physical examinations?

M: I always did. If I needed a consultation from somebody at Malcolm Grow or Walter Reed or somewhere I would arrange it. But the Surgeon General is usually the first point of contact for the Chief of Staff. I would say that over the years by and large physicals for Chief were accomplished at Malcolm Grow. I would go there and do the Chiefs myself; but I am not sure all the Surgeons General did.

N: When you were commander at Malcolm Grow did the Surgeon General examine the Chief of Staff?

M: Who was Surgeon General when I was at Malcolm Grow? Murphy Chesney? I believe he would have done those physicals.

N: I believe it was Paul Myers when you were commander at Malcolm Grow.

M: Paul would have been there. But, you know, he was a neurosurgeon; so I am not sure he felt competent to do a total physical exam. But I am sure he would have been in attendance. He d be there. And occasionally if it was a complex problem, senior officers would be sent to Wilford Hall for their physicals.

N: As a commander of a major medical center for one year was there an occasion to go the Line for extra money at the end of the fiscal year? Could that sort of problem arise at major medical center as opposed to an lower-level medical treatment facility?

M: No, not that I recall. Things worked like this. If you were a small clinic or hospital out in the Air Force world someplace and you didn t have enough money to pave the parking lot, often times the base would find a way to do that. If it came to running short of funds before the end of the fiscal year, that money had to be programmed out of headquarters Air Force and then come down. Now, that s not to say that headquarters Air Force might not influence a major command to use some excess money to help out within that major command. But as far as a base commander using his funds directly to bail out a medical facility, I don t think it happened that way. It would usually come down from the top.

N: Did you continue to practice as a commander? I assume that as an inspection officer you did not practice.

M: No, I did see a few patients in the Norton clinic. They provided me an office and when we were in I would hold clinic one day a week or maybe twice a week if we were home that long. Yes, I continued to see patients at Andrews, had a regular clinic, and saw some consults. I never did give that up.

N: So I don t have to ask that question all the way through.

M: No. But there was less of it as Surgeon General because of the time constraints. But there was still some.

N: What was your philosophy for running a major medical center, such as Travis and Andrews? Did you differ from the commanders you had seen at Wilford Hall, such as General Humphreys?

M: Well, somewhat. I think everybody puts their own stamp on things, and that s not to say necessarily better or worse; but I think everybody has their own leadership style. I believed in emphasizing professionalism, both military professionalism and medical professionalism. I tried to emphasize sensitivity to patients needs whether they were real or perceived. And I believed in letting folks know what was expected of them and trying to give them support to do their job and seeing that they did their job. I think if you give people responsibility and the support they need, most of the time they will do one heck of job, and if they don t I think you need to be aware of it and do whatever it necessary to straighten it out. I believed and still believe that you need to be visible. I don t think you can manage a medical facility behind a desk. And I strongly believe that if you are responsible for leading a bunch of doctors you have got to have credibility as a doctor. That s why it s important to keep your hand in. That s why it is important to see patients. Some of our commanders were not as successful as they should have been because they did not maintain professional credibility with their doctors. I think that s unfortunate.

N: In the late 1970s, the medical world, both civilian and military, was getting a lot more patient complaints, some of them leading to malpractice claims. Were you aware of that and how did you try to deal with that?

M: That s a very fair question. We were very aware of it. And of course I would have to say first, as you said, that it was not limited to the military. Part of it was because society in general was becoming more litigious, and it was the result of undue expectations the normal feeling that everybody should be feeling well and nobody should ever die which gets reinforced sometimes by the media and by some our societal mores. I believe, and there are good statistics to back this up, that most malpractice complaints, suits, and allegations are the result of poor communication between doctor and patient, misunderstandings. My emphasis in a command position was to preach communication between doctor and patient, to be sure that the administration did not levy workloads and time constraints (such as you see in many HMOs today) as to how many patients you should see in a hour. I wanted to be sure there was time for patients to ask questions. I did promulgate some learning and teaching examples of sensitivity to patients needs. Finally, as a commander, I encouraged an open door. When you heard of problems you had to be ready to hear folks out who had complaints. The other part of that was articulating to the Line on every occasion that this malpractice problem was not just a military situation. Even adjusted for the fact that active-duty could not sue us, our rates were far less than in the civilian world. Does that answer that, Jim?

N: Yes, sir. Did you enjoy Malcolm Grow more than David Grant?

M: No, because I did not have the pleasure of teaching residents at Malcolm Grow. It turned out it was worthwhile in preparing me for the Surgeon General s job because I was exposed to Washington, knew my way around, and had some insight into the politics.

N: By this time you had been active in the Medical Service about twenty years since you returned from private practice. Did you feel that you had some friends in higher places who would further your career or were watching you carefully?

M: No, Jim, I didn t. I didn t have a godfather. I felt like I had a pretty good background. I had been a commander, a head of a residency program; I had been to Vietnam and got an Air Medal over there, which counts with the Line. I had pretty broad experience. I thought I was as well-qualified as anybody for the top job if the opportunity came. But I did not seek it.

N: Well, sir, your next assignment was the surgeon general out at Scott?

M: Yes. But as couple of my predecessors like Paul Myers said, there is only one Surgeon General, so I was the surgeon at Military Airlift Command. In the field we sometimes were referred to by the Line as the MAC or TAC or SAC surgeon general.

N: You were the MAC Surgeon, with the acronym SG, which means Surgeon, not Surgeon General?

M: Yes. But even that is a misnomer, because not all SGs are surgeons.

N: Do you remember any of the key issues that came up in the four years you were there?

M: As MAC Surgeon?

N: Yes, sir.

M: Those were interesting times. One of the big responsibilities as MAC surgeon was for aeromedical evacuation. Additionally, within MAC you had several of the teaching centers that you had to oversee. And there were some very interesting and strong personalities back in MAC at that time. I remember the dad of General P.K. Carleton, the current commander at Wilford Hall, and Bill Moore, who is now running the Nashville airport. They were all very interesting personalities. I was a lot more involved in contingency planning for aeromedical evacuation operations than I had anticipated. We were into some exercises at that time medical contingency exercises. I guess maybe Red Flag was one. There was some involvement in what we would do about a chemical or bacterial attack in so far as patient movement was concerned. There was interesting planning for the actual movement of suspected exotic diseases to NIH since the Ebola virus and some of those exotic African viral diseases require very close and careful asepsis and special equipment and air filters adapted for military aircraft.

N: Excuse me. You were involved in moving these viruses or patients infected with those viruses?

M: Patients suspected to be infected with those viruses. Those special units are maintained at several depots, one in Washington. They are modular and fit inside a C-141, with special filters designed to avoid any contamination.

N: Were there actually patients suspected of having those viruses who were transported into this country?

M: Yes. It was all very carefully and quietly done. They were taken to special units either at NIH in Washington or to the infectious disease center.

That reminds me an anecdote. When the problem arose of first transporting AIDS patients, when we initially treating all of them at Wilford Hall the problem came up about aeromedical evacuation to Willy Hall with AIDS patients. As the MAC surgeon I put out a directive and policy that the AIDS patients would be transported just the same as a patient with hepatitis, with the usual blood and body fluids precautions, and would be treated with same respect afforded any other patient. It was disseminated to all who needed to hear about it, including the aircrews. I was sitting at my desk one afternoon when I got call to go to the flight line at Scott it was about a reserve crew who were flying an aeromedical mission with AIDS patients and damned if they didn t have on their chemical warfare gear. (laughs) There is always somebody who doesn t get the word.

N: There were some minor contingency operations in this period that may have been a part of the contingency planning you referred to. I am thinking of the Grenada operation that involved rescuing students. There was more publicity that came out of the bombing of a U.S. Marine compound in Beirut, Lebanon, and the aeromedical support for that evacuation. You also mentioned Red Flag, which General Paul Myers initiated out of increased casualty estimates that came out of the Joint Staff in the late 1970s.

M: Right, that followed the Nifty Nugget exercise that said the war casualties in the known scenario would be a war-stopper.

N: Was that when a Dr. Berry of Health Affairs made a statement to Congress that medical support could be a war-stopper in Europe?

M: Right.

N: I assume that all of that did stir the pot at MAC. Do you remember anything specific done to change plans or achieve greater coordination among the Services, an alleged deficiency in some of the contingency operations. Or were those unjust criticisms of the plans that were in effect? There often are unjust criticisms of the military plans and capabilities.

M: Sure. It sort of blends together, Jim, as far as contingency and aeromedical evacuation planning with the readiness division when I was Surgeon General. I think I could probably address the Service cooperation issue more adequately when you get into the Surgeon General period. As far as the Grenada episode, and several of the smaller contingencies during that period, it was all pretty much routine. Aeromedical evacuation worked pretty smoothly. There were no particular problems.

The only bit of contention that I can recall in general in those days is this. Although aeromedical evacuation policy was and still is to transport patients medical facility that has the capability that those patients require. There are several things that alter that. It may be in the Service s best interest for the patient to go to a teaching hospital, which of course provides teaching material. The other thing is that there is always the Service desire to take care of its own, each of the Services. If you have Army troops from Fort Bragg injured in an operation their commanders will, of course, want them to go to Fort Bragg. That s sometimes medically feasible and sometimes it isn t. When it isn t medically feasible it isn t easily understood by Line warriors.

By and large air evac was pretty well run, with good planning.

N: I was wondering about the Civil Reserve Air Fleet? Did that help?

M: Yes, CRAF did. My impression of that is that it was pretty smooth. Operations was responsible for securing those agreements and contracts, with medical input of course. But that went well. And the times it was exercised were by and large pretty satisfactory. The domestic air evacuation concerns were really minimal. There were occasions when - and I am sure it has happened since when the airlift wing commander would use C-9 emergency standby aeromedical planes to fly the band someplace, which was always a concern to the MAC surgeon, in case the C-9 was needed and wasn t available; although, you know, there were backup options.

I really can t think of any insurmountable challenges or problems as far as aeromedical evacuation concerned.

N: Were there enough C-9s and money to fly them?

M: It was adequate. There were times when because of weather delays or because of routing that some of the medical facilities in the domestic system weren t happy with the service being as prompt as they wanted. On the other hand, when it was an urgent air evacuation, the time constraints were always met. There was always a little unhappiness both in the Air Force and its Sister Services as far as the routing was concerned. Each facility would like to have its own private aeromedical evacuation airline, but you have to plan your runs in the most efficient way. I started beating the drum even back then for advanced planning to replace the C-9, but that hasn t happened yet primarily because of fiscal restraints. Those planes are getting some age on them.

There are other aeromedical evacuation issues I feel strongly about that I think we should discuss at the Surgeon General s level.

N: One recent history of Air Force aeromedical evacuation cites an Industrial College of the Armed Forces (ICAF) study of April 1982, which complained the MAC would not be able to handle casualty evacuation in major European war for the simple reason that the casualties generated in such a war would be so high that they would swamp the beds available in Europe, forcing MAC to try to evacuate them even though they were unstable. It sounds hypothetical, but I was wondering if you had heard of that.

M: Oh yes, I heard of that. Again, I was trying to postpone talking about some of this. But it s all right to go ahead. There are several ramifications to that. First of all, I don t know if that ICAF study was before or after we secured the agreement to use the domestics C-9s in Europe. Second, I suspect that is was subsequent to that that we secured the right priority for using the C-130s for evacuation, and, further, I don t think at that time that we had all the host nation beds [in Europe] that we subsequently achieved.

N: So the ICAF study may have addressing a problem that may have been quickly rectified?

M: Well, I don t know how quickly, but I can tell you that by 1989 or 1990 we were satisfied that we had the airlift to handle it, and that was partly because of my concerns about it and the fact we got some smart young guys in operations in MAC who ran the whole shenanigans through the CRAY computer, the only supercomputer in the country at that time. It was so complex you needed the CRAY to figure it out. After that test run we were satisfied we had the airlift to handle it.

N: When was that run made, sir?

M: I can t tell you exactly, but the CRAY run was about the end of my tour as MAC surgeon.

N: About 1985. That would be couple of years after the ICAF report, which in itself was probably addressing documents a year older.

M: And sometimes people get into those ICAF studies without all the information they really need. A lot of the dry runs depend on the current aeromedical evacuation policy on how long you keep people in country before you move them. If you don' t think you can get them back to duty in thirty days, you send them back to States, or fifteen days, or ten days, or five days, or whatever the aeromedical evacuation policy is, which is set by the Line. So you can see how that vastly influences the amount of aeromedical evacuation traffic. Now please remind me to talk about my concerns about Army aeromedical evacuation in Desert Storm.

N: Were you, as MAC surgeon, dual-hatted as a joint and Air Force officer? In the Gulf War the MAC Surgeon was dual-hatted as the surgeon of the joint transport command, TRANSCOM.

M: No, I was not dual-hatted in that position.

N: From November 1981 to April 1985 you were at Scott AFB--three and one-half years. Did you extend or was that a normal tour?

M: There was no specified tour that I know of. There was no extension. I guess my boss must have been satisfied with job I was doing. I didn't ask to be moved until I was offered the job at Willy Hall. I didn't realize I was at Scott that long.

N: When you went to Wilford Hall, was it different from what it was in the 1960s? A massive expansion was completed in the late in the 1970s. How much bigger was Wilford Hall than, say, Travis or Malcolm Grow?

M: I can't answer that exactly. I think the capacity was about a thousand beds. I just can't recall how big it was when I was there before. But the size was not daunting at all, other than having to learn your way around the nooks, crannies, by-ways and highways. Clinical representation was essentially the same except for some of the smaller subspecialties that you don't have at the smaller medical centers. A lot more going on in areas like dedicated pediatrics, neonatal intensive care; intensive care units for some various specialties; and vascular and cardiac surgery capability we had not experienced before. But by and large, it was an expanded scope on the same principles basically that I was used to. It sounds egotistical, thought I was well-prepared for that job. I didn't have any problem with it.

My biggest concern was trying to swing the place to be more patient oriented. You know, if you have got an academic institution the system tries to arrange things for the convenience of the physicians rather than for the convenience of the patients, and you have to constantly guard against that. The medics will put up signs that say, essentially, don't bother me. The technicians will leave patients waiting past their appointment time and be sitting out front drinking coffee instead of explaining to people why there are delays. Dietician aids will put a food tray in front of somebody who has had eye surgery and has eye patches and will expect them to eat. Because of my background I was attuned very much to maintaining the academic excellence of the teaching programs, fostering professionalism and affiliations across town with Brooke Army Medical Center and the University of Texas Health Sciences Center. We had to take care of lot of retired four-stars in San Antonio who needed a little hand-holding. We had a newly dedicated research building with the problems and concerns that brings up. We had a really active Society for Prevention of Cruelty to Animals group in San Antonio who wanted to picket you if you were experimenting on animals. There was the usual concern about how trauma patients are routed in the San Antonio area There are a lot of car accidents in San Antonio and if you are running an emergency medicine center and trauma center you depend on some of that to train people with. And occasionally there would be a little

town-gown rivalry as to where patients should be sent, which you needed to be attuned to. There is always what I call the prima donna factor in an institution that size, with all those specialties and super-specialties. The super-specialists sometimes decide they need Tuesday and Thursday afternoons off to go play golf, if you don't help motivate them properly.

It was a good job. I guess I enjoyed that most next to having my own residency program in medicine, because there was a chance to influence the attitudes of the place.

N: We hear a lot about an increased emphasis on readiness in the early 1980s. Was that affecting Wilford Hall?

M: Yes, indeed. We had our exercises. I had my own policies in that regard. I didn't subscribe to sending surgical teams to smaller places to do surgery (as is being done now) on the justification of enhancing readiness, because I felt that a surgeon operating on someone was responsible for the follow-up. That s good medical practice. I didn't agree with sending departmental chairmen and service chiefs to Saudi and backfilling with reserves, for a couple of reasons. In the first place, if that deployment is more than very short, your residency training programs will be in jeopardy no matter how well qualified the incoming reservists are, because the residency review committees want continuity as far as program directors are concerned.

N: Didn t you had almost an entire reserve unit there at Wilford Hall set to move into the facility in case of a major war?

M: Oh, yes. The 11th Contingency Hospital. But that is far different scenario than Desert Storm.
That's a personal difference and probably should not be expanded on a lot. When I was Surgeon General I would have sent the reservists over to Saudi without moving reservists in to take over the training programs at Wilford Hall. But, be that as it may, I don't think any permanent harm was done. The deployment was short enough that it didn't have any impact.

N: How much emphasis was there in the Medical Service up through the mid-1980s on prevention issues and lifestyle education?

M: Well, certainly not as much as there was in the late 1980s, although there was some emphasis. There were weigh-in requirements; you had to meet standards; there was some campaign about smoking, although not nearly as much as developed subsequently. You had to physically qualify once a year, as I recall, and that was not a good idea. You could get out there and run your mile when you were not in shape and suffer for it for a week afterwards. Lifestyle means a lot of different things to different people.

N: Occupational medicine has always seemed preventive in its essence.

M: That has been the long suit for the RAMs. I think there were pretty good efforts for the time as far as occupational exposure to toxins, and that was pretty well under control. If you include some of the perceived harassment and sexual discrimination that's getting so much attention today, it certainly didn't receive that kind of attention then. I can remember a couple of cases of minority individuals coming to me feeling they had been discriminated against, and that was fairly easily resolved by talking to the right people, promoting some understanding, and laying down the law a time or two. By nothing comparable to today or even to the early 1990s.

N: How about education as far as diet was concerned?

M: Certainly not the emphasis on the anti-Big Mac campaign that we see today. There was certainly some emphasis by dieticians and nutritionists on the food pyramid, who have talked about that since before the pyramids were actually built. But to be very frank with you, I believe that's a little overdone today. Certainly folks in high-risk groups need to be paying some attention, but it has become almost an obsession in a good part of our society. I can't really address whether that is overdone in Air Force medicine these days or not.

N: What did you feel about the relationship of Wilford Hall to higher medical authority? Was the supervision of Wilford Hall appropriate or was it too controlling?

M: The idea existed that Wilford Hall was its own kingdom. I don't think that was perceived when I was there as much as previously. Of course I knew General Chesney pretty well and knew several folks in the Surgeon General's staff, so that the communication lines were pretty open. Although from the perspective of the SG Office staff, Wilford Hall always spent the most money and because of its size tended to have the most problems that reached the Surgeon General's Office level of attention. So it was quite natural to say "All those guys down there are running their own show and are not part of the Air Force." That feeling really didn't exist during my tenure. I am sure that some of the bean-counters in the SGO, as far as money and expenses were concerned, still felt that we weren't controlling expenses as well as we might have; but that's hard to judge from afar, as I learned, and some economies perceived by accountant types don't turn out to be true economies.

N: What about the major command you were under?

M: That was Air Force Systems Command. Lackland AFB was under Training Command, but the medical center was under Systems Command, which had in the past been a little a problem and concern in that base authorities didn't feel like it was their hospital, although we maintained a troop clinic on the Lackland side. That was pretty evident when I arrived, and I started going to the weekly staff meetings on the other side of the base and reopened those communication channels, and the line senior people came over to the hospital on occasions. I think we helped to tear down that wall.

N: Did you at Wilford Hall have any sort of relationship with Brooke Army at that times?

M: Yes, but not like now. We on the teaching side exchanged grand rounds and teaching seminars, and utilized visiting professors to go to both places to share conferences. There was coordination in disaster planning, as to how we would sort patients given a local disaster. There not much sharing otherwise.

There was no consolidation of residency programs. That idea wasn t really surfaced in my time. We did share some cardiology staff and utilized the best of each place as far as cardiovascular surgery was concerned. But that was the extent of it; there was no combined residency.

Although this opinion is biased, I think the Wilford Hall residency programs were far superior to those at Brooke Army, and I was not anxious, nor were my teaching department chairmen, to combine those. As you know, that has since been forced upon us.

N: Was there any discussion of it? When you had already gone to Europe, DOD Health Affairs in June 1986 directed the Army and Air Force to submit by 15 October 1986 a plan for a jointly staffed military medical teaching consortium in San Antonio. They eventually worked that out, and it was abolished several years after that.

M: Yes. I was opposed to the Joint Military Medical Command (San Antonio).

N: Did that issue come up at all when you were still at Wilford Hall?

M: I can t recall exactly the timing on that. I was certainly aware of the JMMC and was opposed to it. It was another attempt by Health Affairs to centralize, and we were opposed to it. Some of the rumblings of that may have started before I left. I just can t be certain about the timing of that.

N: Your next assignment was as the U.S. European Command (EUCOM) surgeon, or was that EUCOM surgeon general?

M: Just surgeon.

N: What did you know about that position before you went over there? Did you know much?

M: Not much. I knew it was joint command. I knew what their area of responsibility was. I anticipated that there would be quite bit of emphasis on readiness and contingency planning. I knew that it had been a rather small office and outfit before I went. That's about it. We were excited about going to Germany though. I thought we would enjoy the country and we did.

N: Did you know your predecessor in that position, General Greendyke?

M: I knew Bill but not well. Bill was a radiologist of course, and I don't think that Bill and the Assistant Secretary of Health Affairs in DOD saw eye to eye on some things. I can't remember the details but there was some controversy associated with the Bill's assignment.

N: He had been struggling with the criticisms of readiness that came about in the wake of the bombing of the Marine barracks in Lebanon. So that would have been in the area of contingency planning.

M: I presume so. I hesitate to comment too much on that because I just don't know the details, but I think Bill left rather precipitously, and there was no overlap. He was not there when I arrived on the scene.

N: Were you called over there fairly quickly?

M: Yes. It came as a bit of a surprise.

N: You had no immediate plans to go anywhere else?

M: No.

N: Had you been looking forward to that position as your next assignment?

M: Not at all. It was an out-of-the blue situation.

N: How big an office did you have? Did it expand?

M: Yes, we expanded it considerably. I suspect there were no more than six or eight people assigned in the surgeon's office. When I left we had in the neighborhood of a couple of dozen anyway. The increase was primarily in the contingency planning staff.

N: Did you feel that you accomplished anything particularly valuable while you were there?

M: Yes, I did. I had a good staff, and they deserve a great portion of the credit for our accomplishments over there. We certainly made progress developing the contingency plan, especially the 4102 plan, and were able to acquire some more contingency hospitals on the continent. We were able to work a deal with the drug companies so that the stockpiled medications and IV fluids were rotated so that they did not become outdated. We achieved considerable savings with that. I made some interesting contacts with my counterparts in all the European nations, so that there was I think much enhancement of cooperation with NATO surgeons. I made some valuable trips within the area of responsibility that included North Africa. I established some friendships, and those communication channels always have value in the future. We had a great group of the

NATO surgeons who met several times a year, usually in some very interesting places. I recall a great deal of pleasure -- when the Greeks hosted the group on the island of Cos -- sitting under the plane tree where the teachings of the great Hippocrates occurred. I continued what General Bralliar had started as far as setting up contingency hospitals. The facility at Donau-Eschingen was an interesting one with a small airfield. Its name translates as "the site from which the Danube river begins."

N: As joint surgeon did you have to expand your horizon a bit to take in the Army and Navy to some extent?

M: Oh, yes, to quite an extent. There was more contact of course with Army than with the Navy, primarily because of the geographic separation. The Army medical headquarters (I guess you would call it) was in Heidelberg, fairly close. Frank Ledford was the Army surgeon over there. Frank, of course, subsequently became Army Surgeon General, and was in that post at the time I was Surgeon General of the Air Force. The Navy was headquartered in Naples, although we, of course, had Navy representation on my staff, as well as Army.

I guess it would be fair to say that during my tour there we were successful in fostering better inter-Service relations than had heretofore existed. The Army had a previous history of going it alone, and it took some effort and time to create a joint philosophy as far as the medical world over there was concerned.

N: In your end-of-tour report you refer to "united attitudes." Does that refer to the better inter-Service relations, or more generally to better cooperation with the Europeans?

M: No, that's exactly what that's intended to say. I noted at the time that there were still a few occasions that involved EUCOM that were initially worked autonomously. I think we succeeded in turning that around some. We certainly did increase our credibility with JCS J-4 and the Assistant Secretary of Defense for Health Affairs, who was Bud Mayer at the time. He made several trips over.

N: You also referred to the CSS. What was that?

M: I am sure that refers to the Contingency Support Staff. Those acronyms grow like weeds in the spring and if they are not in context they can be misinterpreted. On the other hand, it could be Casualty Support System. I note I said I was concerned about the funding of the deployable medical systems, and that is probably contingency support staff or systems that suffer when money is scarce.

N: Under "wartime host nation support," you say there is good progress but there is still frustration with the political scene, particularly in the South. What was that problem?

M: Not a problem except in context. In Spain, in particular, they had some reluctance to provide us contingency hospitals. That was not because the Spanish medical folks were not in concert, but because of the politics of Spain in hesitating to go into an agreement

with us. We felt that we needed hospital space because of possible air evacuation routing out of Europe. But the senior Spanish medics were extremely cooperative and worked very hard on our behalf with the Spanish government to try to secure some contingency space for us.

N: In the next paragraph you say, "More recently the idea of a NATO medical CRAF " I don't understand what was going on there. Was this an idea of creating a NATO civil reserve air fleet?

M: Yes.

N: Would eliminate the need to deploy C-9As to Europe in a contingency?

M: Yes. That was some of the thinking of the joint planners. It didn't make sense. I didn't think it was dependable. I wasn't sure just how it would be managed. I felt much more comfortable with our plan to deploy the domestic C-9s in support of the C-130s to handle the patient load. I wasn't happy at all when the idea was floated about a NATO civil reserve air fleet.

N: In this paragraph you refer to the importance of SOF forces?

M: Yes. Special Operations Forces. The special ops folks by nature tend to keep their operational planning very closely held, so that only at the last minute do they say "Oh, we might have some casualties and need some medical support." So my efforts were directed at getting the medical planners involved in special operations planning from the start instead of it being a last-minute request.

N: Did you have any luck?

M: Yes, some success, but not to the degree that I desired. It is the very nature of special operations that they need to have tight security on their plans, and they are always fearful of leaks, and the old adage is that the more people who know, the greater the risk that plans will be blown.

N: Under "peacetime medical support" you say "Although I have not been as deeply involved as I would prefer " So here you are referring to the peacetime medical support that was ongoing while you were there?

M: Yes. Army, Navy, and Air Force.

N: So you are saying you focused more on contingency issues.?

M: Yes. You know, because of my background I wish that I could have spent more time the hospitals and clinics in Europe than I was able to.

N: In the last item you refer to a medical evacuation working group guided by Colonel Jim Truscott. What was the goal of that group?

M: Truscott was Army and was my executive officer. A good man. We had very insufficient evacuation plans in theater, and I noted that air evacuation, ambulance trains, and host nation of ambulances (motorized or air) were not coordinated. Everybody was going their own separate way. The Army was thinking of acquiring some ambulance trains. The Navy was still working their own stream of LSTs. There was no coordination regarding how to helicopter onto their landing ships. The whole process needed to be tied together. Jim Truscott made great strides in coordinating and tying that together while I was there.

N: Could you comment briefly on your remarks about a unified medical logistics system ? Was that a new creation at that time?

M: Not totally new. The need for it had obviously preexisted. What this refers to really is the need as I perceived it, as opposed to having each component acquire their own supplies and equipment through their own channels. There needed to be some way to do that in joint fashion and realize some savings, distribution of things better, and realize some economies of scope. It refers in part to what I said earlier about being able to rotate the stockpiles of medications, intravenous fluids, and what not.

N: Were you satisfied that you had good agreements for the rotation of those supplies and keeping them up to date?

M: Yes. That was solid. In some other areas we made progress but it was not the point where I was totally comfortable or satisfied with it when I left. I am sure that my successor continued to make progress in that area.

N: When did you get an invitation to become Surgeon General of the Air Force?

M: I was in Europe I guess. I just don t recall the exact time. I know we had to leave on fairly short notice.

N: How did you go about selecting a successor at EUCOM?

M: It was the Army s turn to staff the EUCOM surgeon position, but the Army was in the throes of cutting down the number of general officer slots, so they didn t want it. I felt like it was an important position for Air Force, and I suggested that Rusty Sloan take that job. That was approved.

N: How about your deputy in the SGO?

M: I wanted someone I knew, trusted, and whose abilities I could count on, so I asked for Jerry Sanders and that was approved. He had the right background, and he was a good organizer and thinker.

N: What was his specialty?

M: He was an OBGYN guy, as is Chip Roadman.

N: When you came to Washington, did you have any particular issues you wanted to concentrate on?

M: I don t think I had any preconceived notions. I had been at Andrews AFB and on occasions had been tapped to go over to a staff meeting when the Surgeon General s folks were tied up. So I had a fair concept of what it was about. About the only goal I had set, perhaps not even on a totally conscious level, was to try to continue to encourage my past efforts as far as patient sensitivity, improving access, maintaining professionalism, and maintaining the quality of the programs that about says it, I think. Clearly there was a continuing challenge as far as readiness was concerned.

N: That was the No. 1 job?

M: Absolutely. There is no question that that has to be the reason for the existence of the Medical Service. But quite honestly, I think that readiness and contingency tail tends to wag the whole dog a bit more than it should on occasion. By that I mean, the medical world is doing in peacetime essentially what they would be doing in wartime. You are actually doing readiness when you are practicing peacetime medicine in the Air Force. So there could be a tendency to concentrate too much on wartime readiness at the expense of diluting patient care skills .... there has to be a balance.

N: In one of your early SG articles on access, you refer to the problem of patient access to care. What did you have in mind?

M: You know, I am enough of a curmudgeon that the philosophy of health maintenance organization and gatekeepers that you must see a general practitioner before you can go to point B, and you can t pass GO is wrong. I believed that if you don t provide a way for a patient to see a doctor in a reasonable period of time, the patients will stack up in the emergency room and the quality of care will go down. I think it is an artificial barrier when the patient decides he wants to see an orthopedic surgeon and can t make an appointment with an orthopedist.

N: How much of that was due to gatekeeping as opposed to the general philosophy of managed care, or to the lack space available in facilities for retirees? There are different aspects to Access.

M: There are. It is a complex picture. There are different degrees. You know the good part of this problem I believe stems from the time when we took the Church and the nuns out of running the hospitals and put the M.B.A.s in as administrators. The focus then became on how to make the most money, how to be the most efficient. Patient care has suffered to a degree ever since then.
Managed care was the way to go in those days. That was fostered and we had to support

managed care, and to some degree that s good. But it s how its managed. If it is setting up impediments to a patient getting timely and proper care, then it is wrong. We should not let administrators, bean-counters, and accountants determine how medical care should best be delivered. Though I am waxing too long and eloquent about this perhaps, I see that as one of the big problems in American medicine today. It is wrong for the economic factors to determine how care is delivered. That s one of the main reasons I stayed in Air Force medicine if I felt that a patient needed a special study that was expensive I did not have worry about whether or not there was going to be milk in the refrigerator for their kids. I could order it. Today, there are some impediments to that in managed care systems and HMOs.

N: I reviewed quite a few items on managed care from your tour as Surgeon General. One thing I noticed was the concept of diagnosis related groups and diagnosis-related management. This concept was actually implemented DOD-wide just before you became Surgeon General. I am not a specialist in hospital administration, so I do not really understand that concept. How does that affect patient care? What was the goal of this device, which sounds like an MBA invention?

M: Perhaps simplistically, it involved dividing certain diseases into categories and following almost an algorithm as to how each case should be treated and what was the appropriate management for each related disease group.

N: We are looking the Air Force Physician s Diagnosis Related Management Working Guidebook published in 1989 by St. Anthony Hospital Publications. It has an introduction that refers to possible negative impacts on patient care of the DRG system, and therefore says that the Air Force Surgeon General has encouraged a clinical focus in implementing DRGs.

M: Those are interesting words. The key to this DRG business is again the desire of politicians, accountants, and the bean counters wanting to allocate resources (money basically) based upon certain disease groups. In other words, it is an attempt by accountants and business managers to decide how medicine should be practiced according to diagnosis. It is a bunch of baloney. It has created within the military medical services this situation: if you have a patient on whom you want to do a certain procedure, a non-active duty patient, you now have to call whomever the mogul is for the area to ask for permission to do that procedure, because the companies are under capitation budgeting. It s what the doctors call Dial 1-800-Beg-A-Nurse, because it s likely to be a nurse on the other end of the line deciding whether or not he can do the procedure he wants to do. I get very upset with that issue. It s wrong in my opinion. It is a step backward for American medicine.

N: So this is basically an attempt to control costs?

M: Yes, and costs have gone up over the last two decades. I pointed numerous times in Air Staff meetings that, yes, medical costs were going up, but Air Force medical costs increased at a much lower rate than they were increasing in the civilian world.

N: The handbook assigned a numerical weight to different disease conditions.

M: Yes, it was all coded; it lended itself to computer analysis. And if you had a hangnail it didn   t earn as many beans as if you had an acute appendix.

N: Does this mean you will get only a set amount of reimbursement for treating each disease condition, based on the weights?

M: Right.

N: It reminds me of fixed-price contract for services: the contractor can do it for less than the contract reimbursement and make a profit.

M: That   s exactly right.

N: And if you run over the fixed reimbursement you incur a loss?

M: That   s right. That   s the incentive to keep costs down. That   s what   s happening in American medicine today. Most of the underwriters for the HMOs and PPOs   the managed care system   are contracted under capitation budgeting. If you have a thousand patients enrolled, you get so much money per head times 1000 patients.

If among those 1000 patients   though I am oversimplifying   you have 100 cases of leukemia, you are going to lose a hell of a lot of money. If you order too many X-rays or too many expensive lab tests, it   s going to cut into your potential for profit. So it is tempting to manage how medicine is practiced. And although there are some abuses admittedly, this is an unnatural way to force physicians to practice. And that   s beginning to show in today   s medical culture; you now have physicians turning away from HMO-type organizations and organizing themselves under independent practitioner groups, with an administrator, in order to reap the benefits of economies of scale in acquiring resources yet retain some management prerogatives.

N: Would this latter grouping be considered a Preferred Provided Organization?

M: No, that   s different. I am referring to IPAs, independent practitioner associations. They are sold on the stock exchange now, and their stock is going up. I think it   s going to be an interesting item in the future. The difference between and HMO and a PPO is this: in an HMO you belong to the group and go to your assigned doctor; the decision is made whether to refer you to someone else or get a consultation with specialists or a superspecialist. In a PPO you, as patient, can select what physicians you want to see within the organization. That   s basically the difference.

N: But they are still reimbursed on a capitated basis?

M: There is some incentive to reduce costs. You know, with the accountants, there have been several PPO court cases where physicians have been denied some test or some

procedure. Here again there has been litigation over physicians not being able to explain all the options for treatment. There have been instances where HMO physicians income is less because they ordered too many expensive laboratory tests. There are incentives to keep it simple and sometimes I think that could stifle the physician s better judgment.

N: Would you say that in contrast to this move toward managed care which began when you were Surgeon General, that the AFMS had an almost unlimited budget before that?

M: No, that s certainly not true. But it is true, as I have noted, that before the fiscal year was over there were occasions where we exceeded the budget. But that didn t mean there were no constraints or that you were not under pressure to keep within the budget as much as you could. If it was in a patient s best interest and the best interest of the Air Force from the standpoint of money and avoidance of adverse publicity to do what you felt was right even though you knew that it would strain the budget, you still had the authority and responsibility to that as long as you could justify it. There was no third party telling you how to use your resources.

N: I find in our files that 1991, your last year as Surgeon General, was the year when managed care seems to achieved high visibility. In the SGO papers Brig. Gen. Peter Hoffman in October 1991 was asking for OPRs [officers of primary responsibility] and OCRs [officers of collateral responsibility] for managed care in the SG Office and in the MAJCOMs [USAF major commands]. There were a series of managed care conferences starting in January 1991, during the Gulf War, to proliferate managed care throughout the Air Force. Some more were held the rest of the year. Looking at the description of managed care in this talking paper by Colonel Luby it seems like the basic components of Air Force managed care became the components of DOD s Coordinated Care Program and then the current DOD TRICARE program.

M: Yes. There were many, many similarities. The motives were still the same. I guess I would comment, Jim, that managed care was clearly the way to go. There wasn t any alternative and there were potential savings. The challenge of it was to keep it so focused and so organized that the clinical aspects of it were not overcome by the economic aspects of it.

N: Achieve a balance?

M: Exactly.

N: You were concerned about preserving some provider physician autonomy to some extent from the budget people?

M: Yes. I think that says it rather well. My basic philosophy was and is that if you provide the information and the education to the physician staff as to the appropriateness of their procedures and lab requests, they will pretty well police themselves and try to

achieve the economies at much as possible, in contradistinction to setting up a hierarchy to monitor that.

N: I am not sure I understand the difference between primary care gatekeeper functions and utilization management and case management. And what is a primary care provider ?

M: That term could be a physician or an independent nurse practitioner or a physician assistant. The gatekeeper role can be filled by all three. I object to setting up fences around specialty fields, where patients cannot get to a specialist without passing through the gatekeeper. The alleged problem is that the patient will abuse the specialists and overutilize more expensive resources. I don t totally subscribe to that.

Utilization management and case management are basically questions like Has the patient been kept in the hospital longer than necessary? or Could a patient who was sent to a civilian network for a special feature return to an Air Force facility for ongoing care sooner rather than latter?

Precertification admission is again one of the things I object to that s where it s necessary to use "1-800-dial-a-Nurse" to get an authorization.

N: The next two bullets seem to refer to some kind of oversight over physicians.

M: Precisely. Still today, both in the civilian and military world, there is a perception there that is overuse and abuse of mental health. And in fact there have been some examples of diploma-mill psychologists continuing therapy in outpatient scenarios where it may have not been justified. And there is always the problem of cost containment in long-term care.

N: Did the Air Force actually start to implement some initiatives during your tenure?

M: Oh yes. It was necessarily to do so, hopefully maintaining some balance between cost containment, resource management, and clinical judgment.

N: This talking paper refers to the catchment area demonstration that are a prototype for Air Force managed care. These demonstrations began in March 1990 at Luke and Williams at Phoenix, Arizona, and at Bergstrom, Texas. Did these demonstrations involve these kind of approachs we have talked about?

M: Yes. Basically so. I guess the only difference would be in how closely it was controlled. At the beginning it was a little more loosely controlled. But the demonstrations were basically about trying to manage a patient group in a geographic area.

N: Did these demonstrations actually assign CHAMPUS funds to the local commander so he had control over all the medical expenditures in his area?

M: I can t be absolutely certain in recalling that. Though to the best of my memory there was no pot of money they could manage. I don t believe DOD wanted to turn that over. They kept track of it, but I don t believe there was a dedicated pot of money.

N: So it was more on management principles than on financial control?

M: No. It was possible I can t tell you how far it went there had to be a record-keeping of the monies so they could monitor if there were any significant savings. But they didn t have their own pot of money to use.

N: Thank you, sir. I think that covers managed care.

M: Yes, but I it would be interesting to know what my successor, Rusty Sloan, thought about how that continued to develop.

N: Yes, I will try to interview him.

We referred earlier to the JMMC that was just beginning when you left for Europe. When you came back to Washington was that issue on your desk? Or was that issue solved at some other level, when it was abandoned in 1991.

M: I will admit to taking some credit for its abandonment. We didn t support the idea. We followed the requirement, since it was laid upon us by DOD. But I didn t hesitate to critique it, hopefully from an objective standpoint.

N: Did it lead to anything, such as combining residency programs?

M: I can t pinpoint how much residency combination was a result of JMMC. I can tell you that after my tour I know that several of the residency programs were combined in San Antonio...

N: After you retired?

M: No, not after I retired. Probably when I was still there, but after I left Wilford Hall.

N: So there may have been some combination under JMMC?

M: Yes, loosely so. At least it was beginning. Explorations were beginning. And I would have to say that was the motivation for that. I believe cardiology and cardiovascular surgery may have been the first ones, followed by orthopedics. Some combined program in cardiology started while I was still in Washington. Orthopedics came later I believe.

N: How did you go about getting JMMC disbanded? Did you have to talk to someone in Health Affairs?

M: Yes, the three Surgeons General met frequently and had a good relationship in Washington, and we met with Health Affairs rather frequently, and very frequently during contingency operations. But at least biweekly in times that were not crisis times. I continued to speak out, as did the other surgeons general, and I think we eventually convinced Health Affairs that the problems were greater than the gains. This was really an attempt to drive what is called purple suit military health care or a Defense Health Agency, to which of course we were very much opposed.

N: Did you get a specific Health Affairs proposal to create a Defense Health Agency while you were Surgeon General of the Air Force?

M: No, it was not a specific directive. But the idea was promulgated and discussed and it was obvious from the various moves of Health Affairs that that was their aim. The Assistant Secretary of Defense for Health Affairs publicized and spoke of the advantages of a Defense Health Agency. The senior Line of all three Services were opposed, and I believe that it was primarily because the senior Line of the Air Force and Army and Navy spoke out that the program was resisted.

N: Are speaking of as high a level as the Chief of Staff?

M: Oh, absolutely. I discussed this on occasions one-to-one with my Chief as I am sure my counterparts in the Army and Navy did. I am quite certain that that position was made known to the Secretary of Defense. I suspect, though I don t know that, that Health Affairs was told to cool it on that issue.

N: Do you know for a fact that the Army and Navy Surgeons General were also opposed?

M: Oh, yes. I can say that with great conviction, at least during my tenure. The historic and you may have run into some of the this situation was that the Army was less opposed than the Air Force and Navy because of their numbers and they could see themselves as the driving force in a unified or joint medical command. But both General Ledford [Army] and the Navy Surgeon General during my tenure were not in support.

To the uninitiated that might appear to be Service rivalry, but there is a real difference in culture among the three Services. That has to be articulated to the Senate and House Armed Services Committees, because the staffers on those committees don t really understand. You know, to them appendicitis is appendicitis regardless of the color of your military suit. But the culture and missions are different and consequently the way that care is delivered has to be tailored to some degree.

N: What about Congress on that issue? Did they get involved? Did you actually have to explain that to someone on the Hill when you were Surgeon General?

M: I don t know how much Congress was involved, but I can tell you that I certainly did my best to articulate my concerns to both the Senate and House Armed Services

Committees. As you know, you can t really seek out appointments to lobby for that sort of thing, but in testimony both on and off the record it is possible to make your concerns known.

N: Another relatively issue you might comment on was the Medical Service s creation in September 1988 of a single ambulatory services manager at each hospital, shortly after you became Surgeon General. Was that a step toward managed care?

M: Not really. That was to ensure that outpatients who came in were properly treated, that they were provided the right kind of access, that someone would explain why there were delays, if there were delays. To look after the patients interests, primarily.

N: I see. Sensitivity?

M: Exactly. There is a need in outpatient settings particularly for some sort of leadership management so that everybody doesn t take off for a meeting with no advance notice or cancel appointments without just cause.

N: When you became Surgeon General, readiness training was an area you wanted to improve?

M: Yes.

N: What was the problem?

M: I don t think I would characterize it as much as a problem as a need for more training. We had the concept of contingency hospitals. There was a need to exercise them so that people knew how to set them up, work in them, and make them efficient. The basic medical care skills were really not that much different, but having some experience or foreknowledge in how to work in a wartime environment has a big advantage.

N: Fieldwork outside of a fixed facility?

M: Exactly, and we did a fair amount of that. The program down at Sheppard for setting up a contingency hospital in a tent-like atmosphere though that s an oversimplification was in near full-time use, rotating medical groups in and out of there for training. It wasn t limited to that of course; we had other units that they set up and took down and exercised. You try to avoid some of the medical problems and take advantage of some of the medical lessons learned in the past, not always with success. There was some indoctrination as far as wound care, as far as the dangers of closing wounds that had been contaminated and had been open for some time. There was some emphasis on how to handle so-called battle stress. There were efforts in getting more of our people, including non-surgical types, through advanced trauma life support courses.

N: Were there any obstacles to getting people exposed to some kind of wartime training?   Were there any physical problems, or arranging the proper time and place?

M: Not that I recall. Certainly nothing sticks in my memory as being insurmountable. We had good support as far as money was concerned. The biggest challenge was as I recall was that your appointments in your peacetime facilities suffered a little if you had folks away for a week or two for training. But those were the priorities and military patients generally understand and accept that.

N: I guess that time was something of factor with the reserves?

M: Oh yes. But that scheduling is handled very well through the Reserve components, the Air Force Reserve and the Air National Guard, and they worked it so that during their two week's summer encampment they went to one of the sites for contingency training. That was handled rather well, and the Surgeon General   s Office really can   t take much credit for that. The need was known and passed on to the senior people in the Guard and Reserve medical elements and they scheduled it and arranged it, and it went rather well.

Let me go back to illustrate by one example one of the main values of contingency training for doctors. I recall during exercise of a reserve unit there was an accident. I can   t remember if it was a truck that ran into a bus on or near the site. There were several surgeons in that group who had expressed lots of concerns about being able to do adequate surgery in a contingency hospital type environment. They were used to having laminar flow operating rooms and all the niceties of state-of-the-art, stateside medicine. They afterwards commented that they had not realized that with more Spartan equipment and surroundings you could do a very adequate job. And that example probably typifies one of the main values of contingency training for doctors.

N: So after analysis of the Persian Gulf War did you think that the Medical Service was adequately prepared in its training, for that particular experience?

M: The short answer is yes, Jim. Clearly there was no real problem that I perceived in after-action reports as far as inadequate training of the medics.

I would make several general comments about medical preparedness in that scenario. First, let me tell you that I felt at the beginning we were devoting more medical resources than were necessary. Nevertheless, certainly the joint command could pretty well ask for what they wanted and we were obliged to support it. But the other side of that was that I was contacted, as I am sure my counterparts in the Army and Navy were, to assure members of Congress that domestic military medical care would not suffer as a result of sending everything to Desert Storm. I interceded and pleaded along the medical chain on several occasions for a little more reason as far as what their demands were for medical support. As it turned out, we were way over-manned and over-stocked for that scenario. The casualty estimates were of course way too high, not that I had the wisdom to foresee that.

One of the biggest and most significant factors to come out of Desert Storm confirmed a suspicion I already had that the Army was capable of maneuvering in such a rapid fashion that there were not sufficient mobile and deployable medical assets to keep up with them, to provide medical support. As a consequence the Army reopened their concern about needing their own dedicated, fixed-wing air evacuation. The Army ground advances outran Dust Off chopper range. After the war, economic constraints have also forced the Air Force to plan to transport injured and ill patients when they are just "stabilized," versus stable. I admit that you can save medical resources if you can move patients out of the theater quickly. But I believe that policy will cost us as far as mortality and morbidity is concerned. Ideally the patient is stable enough to withstand air evacuation, because in spite of having well-trained, surgically capable teams on board aircraft, the fact remains that there is not a hell of lot that can be done on board on aircraft. It can be difficult even to maintain an IV line. Furthermore, you are theoretically at least, at the mercy of airlift. How hostile is the environment to airlift? What are the weather factors? How willing are the Line forces to dedicate airlift for patients versus ammo or black boxes that need to be fixed.

So I am very concerned for the future that we will not have sufficient resources dedicated, deployable assets that can keep up with the forces.

N: When you say the Line may not want to dedicate airlift to medical evacuation, is that such a big problem since most aeromedical evacuation in retrograde cargo and CRAF planes -- empty aircraft being used for a medical purpose?

M: Let me explain a little more. If you are talking strategic airlift, you might be using CRAF to fly back across the pond or to fly a good distance with patients that s one thing. If you are talking up at the first, second, and third echelon of care where you are having to use C-130s in a combat environment to move patients out of there to some facility whence you can use strategic airlift that is another matter. It is the latter I am referring to.

You are dependent in almost any scenario for that mid-range. Chopper range is limited. Dust Offs can bring patients into a staging area, if they are within range. From that staging area you have got to have fixed-wing aircraft C-130s in our case to fly patients to facilities from when they can be further stabilized to fly back across the pond or greater distances, which is strategic airlift. Tactical aeromedical lift is really at the mercy of weather, enemy action, and dedication of aircraft. Those C-130s, or whatever we are using at the forward sites, may or may not be available.

N: They might be moving warfighters and warfighting supplies?

M: Exactly, from area A to area B. Although in the planning process you strive to get certain priorities established ahead of time for a certain number of planes and pilots in the tactical aeromedical evacuation system, that could easily all go out the window if warfighting demands became such that Line commanders decided they needed those

planes worse for something else. The medics don t have the authority to control that, and properly so.

N: So in a combat theater you might not have the airlift capability to get people out quickly to the communications zone for definitive care; you might need that significant care in the combat theater.

M: That s precisely what I am talking about. But I don t think that current plans whereby you have a skilled surgical team aboard an aircraft makes up for that.

N: Did you have any concerns about tactical aeromedical evacuation in Desert Storm, even though the tactical system was not heavily tested in that war?

M: It s true that there were relatively fewer casualties than were anticipated. But it was enough of a test to lend some credence to the Army s plea that because of the rapid movement of forces that they needed their own dedicated, fixed-wing aircraft, which could go distances beyond chopper range. But for the European War, the 4102 scenario, we were satisfied that there was sufficient tactical aeromedical lift, because we had studied that in great depth. In future Gulf War-type scenarios there is a big question in my mind, particularly with current plans and forces outreaching where deployable medical assets are provided.

You asked about money support for contingency hospitals and plans and exercises. I found that one of the most effective ways to sell that to the Chief and senior Line staff was to point out, Jim, that if any enemy intelligence was half as good as we thought it was, the enemy realized the value that our culture placed on human life; that having medical facilities and contingency hospitals and blood available indicated a willingness to take casualties, and would signal as strongly as anything that our intents were serious as far as deterrence was concerned. That philosophy seemed to sell rather well.

N: Did that sort of readiness training come out of the Medical Service budget when you were Surgeon General? Or was it a line training item?

M: We didn t have a separate pigeon-hole in the medical budget for contingency training. That basically came out of hide. But the expenses were diluted by the fact that we got Line support at no cost to us of course, and by the fact that our Reserve Forces and Air National Guard forces had their own training sites and that we had a set-up training site at Sheppard AFB. The budget impact was really not a major concern. I was more concerned about the impact on peacetime care for our dependents.

N: With high casualty estimates for Desert Storm you referred to, did you really put much credence in the casualty estimates you received? Or did you as Surgeon General even get the casualty estimates that were developed basically by Central Command in Southwest Asia? Did those estimates reach back to Washington to help in planning?

M: Well, there are models for casualty estimates. Those models are obviously based on historical data. And those models were used for casualty estimates in Desert Storm. They were too high because they were based on a different scenario from Desert Storm. They were based more on a European, World War II, or Korean War conflict, where one would expect much higher casualties. But of course the chemical and biological warfare threat was also unknown for certain at the time. If I had been Schwarzkopf s surgeon, I would have wanted as much medical capability in-theater as I could get. As Air Force Surgeon General, my perspective was a little different because I was under some pressure from Congress to maintain domestic medical capability, and I didn t want to sacrifice our teaching programs unless it was absolutely necessary. I didn t feel like we should deploy our teaching staff unless it became absolutely necessary, which I guess in part explains my concerns when Andy [Anderson, Jr.] sent his department heads and service chiefs at Wilford Hall over to Saudi Arabia and used Reserve backfill to replace them.

N: Well, sir, quite a few reserve medics did deploy, either to Europe or to Southwest Asia.

M: Yes, and they did that quite well, by and large. There was early criticism by some of the highly trained specialists in the reserves who thought they weren t properly utilized. But that soon faded away. By and large, they did a great job. One of my concerns early on, when it became evident that we needed Reserve medical forces beyond what had been originally allocated, was to convince JCS that we needed to call up more medical reserve units. But we were successful in that, though there was some delay.

Those were interesting times. Health Affairs felt they should be in charge of the medical deployment; the Services did not feel that they should be in charge. Specifically, Health Affairs was interested in what was being deployed, where. The Line felt like that was none of their business. It was a path to tread. Bud Mayer wanted to be in on everything and be calling the shots. He criticized the Army a great deal for not deploying their stuff quickly enough. And the Navy didn t position there hospital ships soon enough to suit him. We of course were in much better shape and looked much better in that regard because we had air transportable stuff and we got it over there. But there were some real controversies at a very high level as to whether or not Health Affairs could be the daddy-rabbit for operational issues. That still has not been settled completely, I believe.

N: I did not know that. I did know that the medical section of the Joint Chiefs of Staff played a role.

M: Well, there were really no medics in JCS J-4 (Logistics) but we fell under that division. The JCS was basically calling the shots and did not feel that Defense -- Health Affairs particularly were supposed to be in an operational role. Bud Mayers even pulled out some obscure reference that Barry Goldwater had made as to who should be in charge of operational issues from a medical standpoint. And he interpreted that to mean that Health Affairs was in charge, rather than the Services and the Joint Chiefs. So it was a very interesting time.

N: How much attention did biological and chemical warfare get at the Surgeon General s Office?

M: Quite a bit. We were concerned first of all to ensure that there were adequate supplies of gear. We did not feel that we had a reliable detection system. We realized it was clearly impossible to provide sufficient chemically-hardened medical facilities given the worst-case scenario. There were considerable discussions and decisions that went to the Chief s level as to whether or not we should be administering pyridostigmine and so on to our pilots and people.

To give you a side anecdote that illustrates some of those things reasonably well Colin Powell was chairman of the Joint Chiefs. He asked for medical briefings fairly often because of his concern about the BW/CW threat. The Army at one time, because of concerns about some of the contagious diseases endemic in the area, had proposed using a broad-spectrum tetracycline prophylactically for all the Army troops scheduled to go over there. Specifically, they were talking about doxycycline, a member of the tetracycline family. I did not want to use it on Air Force people, the main problem being that it sensitizes a good many people to ultraviolet sunlight exposure. You can get some hellacious sunburns if you are on that stuff. Of course there is a lot of sunlight exposure in the Arabian peninsula. That issue came to General Powell s attention and he asked about it. I explained to him why the Air Force did not think that was very wise. He did not understand and did not have the medical background to understand. I tried to explain again in more lay terms and he still didn t quite get about, and asked again about why we were concerned. I said, General Powell, us honkies will sunburn like the devil if we are over there taking that stuff. He laughed and understood it then.

N: You mentioned pyridostigmine bromide. Do you recall any anticipation of any difficulties with that?

M: Well, like with everything else, there are some side effects. And the best medical advice was that we didn t want people taking it unless there was a fairly imminent threat. A possible controversy is always about what an imminent threat is.

N: But that was mainly just a concern about side effects, not long-term consequences?

M: That's right. But when you are in that kind of situation you are going to have people coming out of the woodwork claiming that they had long-term side effects, much as we had with Agent Orange, much as we had in World War I with a number of disability claims we were paying. Mustard gas exposure claims exceeded at least 100-fold the number of people who possibly could have been exposed to mustard gas. You have the same thing with oil well fires now, with people claiming they have disabilities as a result of that. It s always a risk to be weighed.

N: What about the other anti-nerve agent substance, diazepam?

M: Yes. Diazepam is basically valium. And we also had provisions for using atropine and atropine-like substances by injection. Aircrews were instructed how to use it. Thank goodness that wasn t necessary.

N: What about anthrax immunizations?

M: That was debated some. The vaccine was, from what I knew, acceptably safe to administer. You are always going to have some idiosyncratic reactions to things of that nature. And I am sure that Army people were pressing to get more of those things over there. But again it s priorities beans and bullets are first.

N: Did anyone in the Surgeon General s Office know when the air and ground wars were going to begin. If so, why was it felt necessary for them to know?

M: It was probably not necessary to know the exact day and time. Generally with an operation like that our planning division would know within a few days of actual onset of activity (without getting into technical terms). But the tendency, of course, is to hold that for security reasons as long as possible. For planning purposes there is some need to know the timeline as you get closer to it, in order to be able to position aeromedical evacuation assets that aren t already on station. So we knew a few days ahead of time.

With some of the other smaller operations we may not have had quite that much notice Just Cause, for instance. I think I mentioned some of the special operations; they didn t let us in for planning purposes as soon as we would liked to have known. Special Ops folks are by nature kind of macho anyway and it s hard for them to accept the fact that there might be casualties.

N: How did you follow up on the Gulf War?

M: I talked to some of the key people involved. But that was not nearly as valuable as the formal after-action reports that go into considerable depth and detail. Personal conversations don t really give you the details you need for corrective actions or further planning. After-action reports tend to be pretty comprehensive, and that represents the whole gamut of the operation.

N: I saw a lot of unit after-action reports, but no Major Command reports.

M: The Major Commands usually just compile their units reports. Central Command, I am sure, was tasked and did provide an after-action report. I don t recall having seen that, but I am sure that happened. I suspect that is on file back in our readiness division, and is probably classified.

N: It sounds like you would have preferred to see more Reserves deployed to Europe and Southwest Asia, although I believe the medical deployment actually included about fifty percent reserve component medics.

M: I have given you the wrong impression there. My comments about that refer only to my concern regarding the Wilford Hall staff. That was because of my abiding interest--having been there, trained there, commanded the place. I was concerned about the sending of the Wilford Hall teaching department chairmen and training directors abroad, creating a potential weakness in the teaching and training programs.

N: So the Medical Service should not deploy teaching and training programs?

M: I would not, until it was absolutely necessary. Andy chose to do that. I found out about that after the fact, and was concerned. I would not have done it that way, and it caused me some concern.

No, I was very happy with the deployment of the reserves. The reserves would by and large prefer to be deployed rather than serve as backfill. You know that in an all-out scenario where you do everything you can, you will have to do some backfilling of medical facilities. That s reasonable and proper. But in that particular scenario I was concerned about it because we did not know how long it would go on. If you leave your residency and internship programs with their full-time, responsible directors gone for an extended period of time, you will be in trouble with national accreditation authorities.

N: The congressional interest in maintaining stateside health care was that interpreted as maintaining full staff in the stateside facilities?

M: Yes. That request was rather direct from several members of both House and Senate committees Doc, reassure me that you are not going to have to cut care at your facilities.

N: Did these people call you directly? They didn t go through Health Affairs?

M: They called directly. They don t feel they have to go through anyone else.

N: So they insert themselves right into the Department of Defense at any level they think is important?

M: Absolutely. I am sure you have heard some other examples of how politics works as far as the military services is concerned. I was called over by a senator, whom I shall not name, who said to me behind closed doors, Hey, doc, you need some more money for some programs? I said, We can always use more money, Senator. He said, Well, I think you need some more social counseling training. I replied, Senator, we have been doing pretty well in that regard. He answered, Well, it just so happens that a small college in my district has a program you ought to benefit from, and if you really need some extra money I could probably find it for you. That s sort of thing goes on. Of course you can t talk about, and you don t dare assent to it. That was an eye-opener to me. I had not been in Washington in the Surgeon General s office more than two or three months when that happened.

N: That actually got in a bill, did it not?

M: The money got there, and my agreement was that I could not legally send any business that way. I said I would certainly open it to bids. If that college happens to win that bid, that s fine, but I can t guarantee that. It so happens the college did make the low bid. But not because we engineered it. He was happy enough with that. He may have had sources who could find out about the bids, but not through my office.

N: General Paul Myers told me about his problem in that regard.

M: That happens, and they don t have the constraints that we do as far as channels are concerned. Every time there was a congressional junket to someplace, we nearly always provided the medical support from our office or out of Malcolm Grow. You would always get some taskings out of those junkets. Those people in Timbuktu really needed a new ambulance, Doc; can you see that that happens? They great at getting into micromanagement on the basis of their junkets, because they go over there and they are used to pleasing their constituents and someone wants something, so they say they will take care of it. So they get back and call the Surgeon General s Office and say, Will you see to this for me?

The worst of that sort of thing happened with Senator Inouye and his number 1 assistant, Pat DeLeon, who is a psychologist on the board of directors of the American Psychological Association. It was during my tenure that they put into the language of the appropriations that ill-conceived pilot study on allowing psychologists to write prescriptions. Psychologists are not M.D.s and don t have the background to do that. The GAO finally said it was unnecessary, unwanted, and too expensive. That ended up being one of Tom Brokaw s examples of the fleecing of America. I testified that that was illogical and ill-conceived. But once it s in the appropriations language you can t get Health Affairs or anyone else to buck it because Congress may cut off some money. So we had to set that dumb thing up, and it was finally discontinued last year on the basis of the GAO report. But it s resurfacing again from what I hear. That s one example of the way that politicians influence things.

Incidentally I have been out to the California legislature three times the last two years to testify to a committee out there, because the psychological association is now trying to get California which starts so many things, good and bad -- to allow the psychologists to write prescriptions. The psychiatric association out there researched my earlier testimony on that and asked me to come out and relate my experience to that committee.

N: Did you enjoy your tour as Surgeon General?

M: Yes. I would say I did. It was a tremendous challenge, an opportunity to influence things at that level. It was really very worthwhile. I enjoyed getting to know the Chief. He was a great guy. I admired him a lot, and we had a good relationship. I enjoyed the travel, except from being away from home. I did not enjoy the excessive social responsibility -- dinners and cocktail parties and public relations appearances. I am glad

to not have those responsibilities any more. All in all, it was a good experience, and I like to think that I made some differences, as small as they may have been.

N: You showed me the minutes of one of your Senior Medical Service conferences. Those were held at least starting in the 1980s.

M: I suspect that s when they started, but I am not sure.

N: Were those meetings of real substance?

M: Yes. That was one opportunity to get the MAJCOM surgeons and others you needed together along with the Surgeon General s staff, not only to establish some working relationships on a one-to-one basis but to go over major issues and communicate concerns from both sides. I found it very, very worthwhile. I presume my predecessors started that, and assume that my successors have continued to do so. I found it very valuable time spent.

As you can see from that last one I happened to save, those meetings were pretty comprehensive. They covered the waterfront as far as the major issues were concerned.

The Surgeon General does not have command authority at all. He is purely a staff officer. But having said that, it s pretty easy to talk to your teaching center commanders and MAJCOM surgeons and be certain that those communications channels are open and that they know what policy is and what the concerns are at Headquarters Air Force.

N: I have never quite understood that distinction. If the Surgeon General s Office determines policy that has no command authority from the Surgeon General, how do we enforce policy?

M: Let me illustrate by example. If there is a major disregard for important policy and you as the Chief of Staff s no. 1 man for medicine can t call that hospital commander and straighten him out or he won t listen to you, and you go to his boss in the Line, with the Chief s approval, and say Hey, Joe, Dr. Jones isn t doing what he is supposed to do, and it still doesn t happen, then you write a letter for the Chief, saying Get with it, boys, and sign it for the Chief. That gets action.

N: Finally gets action.

M: But I have never had to do that. And the major command surgeons and the hospital commanders know that you have the authority in your left hand, if not in your right. So it s never been a real problem. You know, in the medical world going doctor to doctor with reason and logic works, and medical people and I suppose non-medical people as well respond a whole better to This is the way I think you should do it, rather than This is the way you will do it because I said so. The strict military-order rationale just doesn t work as well with the medics as it does with the Line.

I think that by stint of training and selection and probably other things, doctors and most of the medics tend to be more independent thinkers. They probably tend to be more self-reliant, more egotistical. That s why I go back and reiterate that effective medical leadership begins with establishing your credibility as a doctor. The big stick approach do it because I say so doesn t work nearly as well as leadership by example, and logic and reason. The fact you are purely an adviser to the Chief of Staff without command authority has never been a problem.

N: As Surgeon General you became a little exercised over something known as Corporate Information Management. Do you care to comment on that?

M: Certainly. There were two issues I became concerned about. First, CIM, or Corporate Information Management, was a concept that basically allowed the money managers to funnel all the money, expenses, and accounting through a central computer and consequently be able to manage financial resources throughout the Air Force.

N: Not just medical?

M: That's right. But medical would be included. The Comptrollers already had their hands into the various funds and so on as far as the Air Force budget and resource allocation was concerned. But not to any great degree down to the medical treatment facility level. The concept was that medical care would all be funneled centrally. Immediately Health Affairs would have access to that, and I thought it would not be very long until they were micromanaging our financial resources. And the other thing that would do, in my view, would be to enable the bean-counters to start making comparisons and analyses without really knowing what they were doing. So I knew we would constantly have to answer and defend comparisons when they were really comparing apples and oranges. That was potentially a real headache for the Medical Service.

The other issue was the automation business the CHCS [Composite Health Care System]. That was an absolute fiasco in my mind. The folks that were pushing that were interested in providing a far more comprehensive and complicated system than we needed. It was so difficult to bring off and so complex that by the time it got to the field it was already obsolete. I pleaded and pleaded for some off-the-shelf capability, which would have given us everything we needed, but to no avail--again, in part because of the tendency within DOD to want to centralize and be able to control. I can remember several sessions, when Donna Shalala was in DOD, where I argued how we could save millions and how much simpler we could make it if they would just let us. There was some Congressional interest in that program, and I suggested several times that it needed a GAO look. It was stupid. The people developing that had the great concept that you go to the user and ask them what they need and then design the system to meet their needs. Well, the only problem with that in our world was that when you went to the dieticians, they said they needed to know what the patient s IQ was and serum potassium was yesterday, which was absolutely ridiculous. That kind of overdesign was built into the whole system.

We finally prevailed in some areas. The laboratory reporting system was not bad, and the prescription, pharmacy part of the system was not too bad once we got some of those bells and whistles taken off. For instance, we convinced them that putting up red flags whenever some medications might be incompatible with others the patient was taking that that caused the lines at the pharmacy to stack up and forced patients to wait hours and hours to get their prescription, because the pharmacist had to get hold of the doctor to make sure he knew this to protect himself medically and legally. The system finally worked reasonably well. But the whole damned system never did work as well as it should, and as far as I know the entire program has never been integrated in the way it was intended, which was a far grander design than was ever necessary. Millions and millions were wasted over that. I still feel strongly about that as you can tell.

N: Under cost control you refer to efforts to divorce military medical end strength from the Line end strength, in order to beef up the medical strength and save CHAMPUS costs. I presume that s what you were aiming at.

M: Yes, that s basically it. That effort never was successful. But you see if you gain more medical spaces in certain conditions: if the there is an absolute end strength to the total force, and if you gain more medical spaces to provide more care for more people, hopefully at bigger cost savings compared to the civilian world, those medical spaces come at the expense of the Line numbers. So that staffing concept was awfully hard to sell. You need to split that up and divorce that. The other thing of course has to do with the rank structure. It's absolutely absurd that the Line has to be penalized for the fact that the rank structure among the medics tends to be higher than it is throughout the Line. I never was successful in getting that done either, but I sure there should continue to be efforts to break out.

N: I don t see anything like that happening now. The pressure is to drastically reduce the size of the Medical Service, and that is coming from the Line.

M: Oh, exactly. And it has to be, because they have an endstrength to fight. And when you do that it cuts down on the number of senior positions and if you can t promote doctors, and they can t look forward to promotion, there are pretty green pastures out there. So you don t retain them.

N: Did you discuss that issue with the other Service surgeons general?

M: They all felt the same way, although each Service is a little bit different as far as how end strength is figured. But its pretty much the same. But there is not much profit in discussing that with the other Services. There is more profit in bring that up with the Armed Services committees and trying to get Line and congressional support to do that.

N: Why would the Line the oppose separating the two?

M: Because they feel like they would take some cuts regardless of the fact that they were broken out from the medics. You can understand that their endstrength might suffer if we were broken out and given more spaces.

N: If the medics got more?

M: Yes. Because the Line might still have to take less spaces as a part of total end strength. And they would lose control over that.

N: I would think that Health Affairs would like to see that done, hoping that they could get control of it.

M: Sure. I could get support from Health Affairs on that, but Health Affairs is just a small part of DOD. I am sure that Health Affairs would like to have control of the medical endstrength.

N: I wonder if you care to comment on the role of aerospace medicine in the Air Force Medical Service? That was the specialty that stood out in the origins of the Medical Service. The Army Air Force medical system in World War II was heavily oriented toward aviation medicine   just the support of fliers. After the Korean War the fledgling Air Force Medical Service really got into peacetime healthcare in a big, but there was still a core of aviation medicine in the Medical Service. Do you think that has received enough support   budget, people   over the years to function effectively?

M: Well, yes. But I would say that no member of the medical family ever feels like they have had enough; that s a given. Then I would comment that there are those today who would say that we need to go back to just taking care of the fliers, having a flight surgeon s office on every base to take care of the fliers, and that is all we need to do and the rest can be civilianized. There is no question that flight medicine, aerospace medicine, is the very heart, the very core, of the system; it always has been, and always will be. But over the last couple of decades, Jim, there has come an increasing awareness that pilots tend to be a little bit older, tend to be married and have families, as do our support people. There has come a bigger realization, certainly since the Korean War, that aircrew effectiveness is certainly enhanced for deployed people when they know that there is good medical care available for their loved ones. That s the basis for developing peacetime care really.

I think aerospace medicine has received adequate support and time in the sun. Now, if you talk to George Schafer or other folks who were more oriented toward aerospace medicine singularly, you might get a little different story on that. I did find that (though it s a glittering generality) that the aerospace medicine guys, the long-course people, tended not to have the skills of leadership and management as far as command function in medical treatment facilities in general as some of the other specialties. That was probably more by stint of their training and background than anything else.

N: In what way? In what way does it affect their ability to be leaders?

M: I am not sure. But I feel fairly confident in that observation. Again, it s a generality and I am sure it does not apply to all of them. But I think their orientation was more exclusively toward flying and aerospace problems rather than to general medical concerns and family medical concerns. Their perspective was not as broad as you might like for medical command and leadership. They tended not to do as well in my experience. That is not a blanket indictment at all, but an observation.

N: What about Human Systems Division and the Human Systems Center, which focuses on medical-related issues -- was that appropriately located in Materiel Command, not under direct medical control? Has the medical community had enough oversight and input and control over that?

M: I think so. I think it fits pretty well there. There is more opportunity there to keep in touch with the operational and research demands for medical input than any other way I can imagine.

N: Thank you, sir. I do not have any more specific questions. Looking back at your tour as Surgeon General, what are you most proud of accomplishing?

M: I would like to think that I deferred the Defense Health Agency efforts. To some degree we encouraged professionalism and enhanced the reputation of the Air Force Medical Service within DOD as well as within the civilian medical community. I think I had some degree of success in bringing the various members of the sorority together. Chip Roadman alluded to that a bit during our meeting of former Air Force surgeons general a couple of months ago, to my embarrassment, when he said he remembered me saying that I wished everybody belonged to the Patient Care Corps instead of to the Nurse Corps, or Medical Service Corps, or the Medical Corps. I had some success in improving sensitivity to patient care and accessibility. As I have said before, often times that the physician in the community who has the best reputation is not the best doctor. He may not be the smartest or the most capable, but he is usually the most caring. To some degree we needed to emphasize the caring aspect, the art of medicine a bit more than we had in the past. I hope some of that came through. I also take some pride in our readiness capabilities, even though we were able to obtain a lot more resources for contingency operations than even became necessary to use. But maybe that is a worthwhile price to pay for deterrence. And I guess I conclude by saying that I am proud of the fact that I survived it.

N: You certainly had a lot going on during your tour. With managed care popping up, renewed pressures for centralization from Health Affairs, and then the Gulf War.

M: Well, Jim, it was challenging time. But I think that right now we were building it is a heck of lot easier to be building than to be having to come back down, which is what Chip Roadman is contending with now. There is no question about it. A lot easier.

N: We sometimes refer to the fall of the Berlin Wall in 1989 as the beginning of the end of the Cold War. But you were not concerned or thinking yet of coming down in medical end strength, even in 1990 or 1991?

M: That   s right. We were beginning to be concerned but it wasn   t looming as a bad cloud on the horizon yet. It was out there.

N: I think it took the major Line downsizing to start to put the pressure on the Medical Service.

M: That   s true.

N: You mentioned the five separate corps as opposed to the   patient care corps.   Do you think it is a good idea that the Medical Service has those five separate promotion ladders, which are managed separately?

M: There are pros and cons to that, Jim. You know, I think each denomination needs its own representation, but we need and I tried to emphasize the common mission rather than separate missions

N: Stovepipes?

M: Stovepipes in some degree, but not in the usual context of stovepipe organization as the Line uses that concept. The medical administrators need a daddy rabbit to have a representation at the planning and policy making level. In fact, I think there is a need for representation of each denomination; but they all need to understand and be dedicated to the mother church as it were.

N: A couple of years ago we folded some of the corps chiefs under a single directorate, the Directorate of Force Management, so the corps chief offices now are four-letter (division) offices rather than directorates. In that sense they have been brought together organizationally but still there are these separate lines for promotion.

M: It makes little difference as to how it's done. As far as the corps chiefs were concerned, I felt that I was their daddy rabbit and did not need someone between me and the corps chiefs. But I think that   s personal preference. I think it   s important that the corps chiefs recognize that while they are representing their denomination they all contribute to the same church as far as mission is concerned.

N: So it is not an organizational issue, but an issue of attitude?

M: I sure see it that way. I am not sure you can always solve those kind of representational problems by mechanics, and by that I mean organization and reorganization.

N: Have you kept active in any of these many organizations you were a member of as Surgeon General? Such as some of the boards? Do you still participate?

M: Very little. I haven t been to an AMA delegates meeting since I retired. I haven t been to an American College of Physicians meetings or governors meetings since I retired.

N: AMSUS?

M: I guess I went to one when it was in Nashville. I just don t feel like there is much I can contribute any more. I don t want to be seen as criticizing or interfering with the people who have responsibility today. I have really done very little in that regard. I did get talked into taking a job after I retired in a consultant capacity developing a teaching hospital in Saudi Arabia. I spent a little more than a year off and on at that. I found out that that wasn t all that satisfying, and that if we watered the soup occasionally we could get by without that income. I haven t done any more of that. The only other real involvement I have had in the medical world was, as I mentioned, was testifying before a senate committee in California, on the issue of psychologists prescribing drugs. I turned down several offers to practice or consult. I felt that I had really done a fair amount and it was time to look at other fields of endeavor.

I haven t really missed it, Jim, I must say. As you know many of our senior officers have trouble with retirement. Some of our four-stars have had pretty significant depressions when they retired. You know, one day they are pretty close to God and the next day they are nothing. People who knew me well, including my permanent roommate, were really concerned that I would not be able to retire, that I would soon take a pressure job again in order to be happy but to their amazement, though not to mine, I haven t had a bit of problem with that adjustment.

N: I am glad of that, sir. Again you have succeeded. Thank you very much for your time.