UNITED STATES AIR FORCE INTERVIEW

LT. GEN. PAUL MYERS, USAF, MC, Ret.

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Wilford Hall Medical Center
Lackland AFB
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Interviewer: James S. Nanney, Ph.D., Historian, Office of the Surgeon General

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EARLY CAREER

N: Sir, one thing I would like to ask about your early career concerns your choice to go into neurosurgery. You've mentioned that a colonel in the early 50s spoke to you.

Myers: Yes, Colonel John E. Pleunneke.

N:. And you said you were already interested in that field, to some extent, on your own. He talked to you about it, and that was when you made your decision to go into that field. Would you elaborate on why you were interested in that field? What were your first thoughts when you looked at that specialty?

Myers: To put this in perspective I need to go back to the last year of medical school when we did clinical rotations, as fourth year students, as seniors. The [Korean] war was on. The former professor of neurosurgery at the Albany Medical Center at Albany Medical College was the commander of the 33rd General Hospital. I don't know if you realized that in those years there were reserve hospital units and when there was a call-up the whole unit went. And they came out of one particular hospital. They went out of Boston, Harvard, Baltimore, San Francisco, and this one went out of Albany. The professor of neurosurgery, a man named Elbridge Campbell, was the commander. He took that hospital unit all through North Africa and the Italian campaign. That left the neurosurgical capability at the medical center rather slim. The associate professor became the acting chief. There was one resident, and they had to fill in with a lot of helpers, because it was a busy service. So when we had a rotation open, I just choose neurosurgery and, because there were so few people, had an opportunity to do an awful lot as a young medical student. The resident was very kind to me -- a man named Paul DeLuca was the chief resident -- and the associate professor was very kind man named Robert Whitfield. Between the resident and Dr. Whitfield, I just did an enormous amount

of things in the neurosurgical world, far more than any fourth year student would ordinarily have an opportunity to do. I became enamored of it. But when the rotation concluded, I decided that I was going to go into obstetrics and gynecology. When it came time to chose an internship, I wanted to go somewhere where they would pay me, and at our university it was considered a mark of achievement if you were selected to become an intern there at the university hospital. I was so selected, but I had to turn it down because I was married and I needed some income. I went to my hometown hospital because they were paying a salary. So I went from zero dollars, which was my potential at my university, to fifteen dollars a month, which I really had to have because I was married. And I got caught up in obstetrics and gynecology. I finished my internship and started that residency.

I was into it about three months when our first-borne son had some severe difficulties because of some congenital defects which were making him have seizures as a baby. The investigation of that problem took place over in Boston, and I had to give up my residency and go to work to support that child because they were going to put him in an institution. So I left the residency and had the opportunity to go into practice out in the country as an associate with Dr. Walker. I finished that tour in the country, then went into practice by myself.

Along came a telegram one day, early in 1949, from a fellow named Louis B. Johnson, who was the Secretary of Defense, and it said if you had been in the Army Student Training Program in the war years and had never served as a medical officer, we need you now. It was 1949; there was a buildup and there were very few medical officers in the armed services, and they wanted people to come in and do two years.

I am going on a rather circuitous route here to get to the answer to your question, but it all ties together. So I got a fellow who graduated a year ahead of me to take my practice and I said I'll come back and we'll do this general practice together. Meanwhile I will go serve two years in the Army. The surgeon whom I admired most in our hometown and had been a surgeon in the Army, and his commanding officer just happened to be the commander of the hospital at West Point. So when I told him I was going to go and do two years, he called this man -- his name was Charles Kirkpatrick. Kirkpatrick said "I need a man down here at West Point; have him come down and talk to me." So I went down and talked to Colonel Kirkpatrick and was assigned to West Point as the medical officer in charge of the corps of cadets.

At West Point in the early postwar years were young colonels from the Air Force who were called TAC officers, tactical officers. They were very impressive, because none of them were more than 36 or 37 years of age probably; all full colonels, highly decorated, and I thought "Wow, this Air Force is really something." And they got me interested in going out and doing a lot of flying with them, out of Stewart Field. Then I said, "Well, here's an opportunity. I will go into aviation medicine. That sounds like a real exciting thing to do."

So I transferred to Air Force in 1951 and they assigned me to Stewart Field where my boss was Colonel John E. Pleunneke at the Eastern Air Defense Headquarters. They made a wholesaler out of me. I was on a team that went with a veterinarian and a bio-science expert, and what we did was look at all of the bases and all of the early warning site areas with an Eastern Air Defense Force and make sure that our troops were getting adequate medical care.

That didn't appeal to me at all, because I'm very people oriented, and when I had done that for more than a year, I went to Colonel Pleunneke and said I am very disappointed. I don't think I want to continue. I think I'll go back and leave the service. So he said go to Washington and talk to the people in the Surgeon General's Office. Well, I went in and said I would like to leave the service. Korea had already started in 1950. I will never forget the Colonel that I talked to. He turned and said "you see that pile of paper on the floor." It must have been two and half to three feet high. "Those are people who have submitted letters of resignation. They are going nowhere and neither are you. We've got a thing going and you are going to have to stay. We don't know when you'll get out." So I went back to Colonel Pleunneke, and I said, "Well, have you got any suggestions?" He said, "I sure do."

Colonel Pleunneke was a wise old man. I thought he was a wonderful person. He said we're building the Air Force Medical Service. It's going to be a major entity, and we have very few basic clinicians. We are going to need a whole cadre of basic clinicians. He said, "Why don't you think about doing a specialty so that once you finish your training it will be so confining they will assign you to one place and leave you there for a long time." And the light came on. I said, "My God. I've had this irritation in the back of my head all these years of wanting to do neurosurgery and never had the opportunity." I went home excited and said to my wife, "Gee, I know it is going to be hard because it means going back to the beginning, four years all over again. I'll never be home. I will have to do a year of general surgery first and then, in those days, three years of neurosurgery. And she said, bless her heart, "If that's what you want, let's do it."

So I immediately went back to Dr. Campbell who now had obviously returned from the war. And I said I would like to be a resident on your service. I would like to train with you. He said, "How old are you?" I was 28 or 29 at the time. He said, "Married?" I said, "Yes, sir, with four children." And he turned and in his own inimitable way said, "I think you are mature enough." So we arranged for my year general surgery back at the place I interned in Schenectady. I finished that and then went to serve as Doctor Campbell's resident for three years. And the last year was an extraordinarily tragic year, a very difficult year for me, because in February of that year Doctor Campbell died. He had disseminated cancer of the stomach. We had become as close as any professor and resident ever get. He was a role model for me. I just worshipped the ground he walked on. He was a very intense man, a very hard man, very ethical, very honest, very straight-forward. It wasn't until I spent at least two years with him that by using the telephone I trained him to call me by my first name. He would always say "Myers," and that just irritated me. So when I would call him to give him a report I'd say, "Good evening, Doctor, this is Paul," and I kept doing that over and over and over [General Myers

laughs]. Finally in that last year he gave me more to do as a Chief Resident before his death than any other Chief Resident ever had. He had gone through an experience with two untrustworthy residents. One was particularly untrustworthy, a man who had lied to him, and that soured him severely. But when he found somebody with a military background and with his own love for the Army, we got along famously. And that's how I got into neurosurgery.

N: In an earlier interview you mentioned that you were in charge of the out-patient clinic at West Point, where you tried to get your people to make "house calls" if they were necessary. I didn't know that any military medical service provided that kind of patient care. Are you aware of any other Services ever doing that, the way the private medical systems used to operate?

Myers: We had a wonderful community at West Point. There were opportunities for most officers and senior NCOs to live on the post. As I was taking my responsibilities initially with the Corps of Cadets, there was an out-patient department. Colonel Kirkpatrick called me in one day and said "You're the only officer on this staff that has ever been in private practice. I'd like for you to take over the out-patient department." I said "Well, sir, I'll do it on one condition: that if you'll let me apply many of the principles of private practice, I think we can turn this whole thing around into something very positive." He said "What do you have in mind?" I said, "I'd like to take all the physicians that are assigned to the out-patient department and divide up the people who live on the post and assign x number of families to doctor A, and x number of families to doctor B, and so forth, and we'll cover everybody. They will be the contact point for their families; they will be their family doctor. And that means that when someone in that family is sick, whether they are active duty or a member of the family, that they call that doctor, whether he is on duty or not. They call him and he responds. If he is going to go away for a meeting or holiday or whatever, then he of course passes the call to someone else. But why don't we give that a try?"

He said to give it a go, and that's exactly what we did. That was impanelment, that was enrollment, that was an HMO [health maintenance organization]. That's the way it was. When Captain so and so had a sick child, he called his doctor. His doctor would go to the hospital, if it was a non-duty hour, and meet him at the emergency room. The people loved it, absolutely loved it.

N: We're trying to get assigned primary care providers established now. That's one of the new initiatives. Is this similar to your initiative?

Myers: Yes, except that it now has a different connotation. Today the concept is not only a primary care provider, but also a gatekeeper. Today they've got the key to the gate. You can't get in the damned institution to get care unless you go see one of these people, which is a private bug that I have. If we have time I'll talk more about that.

So, it was a wholly different concept. Now the house call business was that if someone is too ill to come to the hospital, you pick up your bag and go to the house. It's right there on the post. You just go on the post and make a house call.

N: Have your ever heard of military doctors going off the post to see people who are living off base?

Myers: No. We did it just like a good general practitioners would do out in a real practice.

CAREER IN THE AIR FORCE -- 1950s and 1960s

N: Thank you. As your career developed in the 1950's, were you looking around in the Air Force for future neurosurgery? Did you see something there? Did Wilford Hall enter your mind?

Myers: No, I didn't even know there was a 3725th USAF Hospital --which was what it was at that time -- because the Air Force wasn't oriented in those days towards major medical centers. The Air Force orientation in medicine was were going to put the hospital at the end of the runway, literally, so when the pilot lands he can get out and go into the hospital. While he's busy doing his missions, we will be able to take of his wife and children. And we don't have to have highly trained specialists; we can move them on into Army medical centers. But it gradually became apparent that the world of American medicine wasn't taking that direction, and that we really needed some great clinicians, and the first two great clinicians, we had, one was here at Wilford Hall, the Chief of Anesthesiology at that old cantonment hospital that used to be across the road. He's the clinician who started the very first residency program in the Air Force in anesthesia. Another was Dr. Jim Hammond, a great internist and the Chief of Professional Services at Parks AFB out in California, a big 750-bed hospital. He was a true clinician, really professorial, and he was an inspiration to me.

But when I was at Stewart Field I had no perception of all of these things. It wasn't until later that Dr. Pleunneke said to me, "That's the way the Air Force is going, find yourself a specialty get trained in it, and then go somewhere where they can't touch you." Well, I finished my training at Albany and I was assigned to Parks AFB in California. That's how it all begin. At Parks, although it was 750-bed hospital, we were going through a time not unlike these times of base closures. The Korean War had ended. Parks was going to shutdown. They said, "Where do you want to go?" and I said "Well, I think there are only two places. One is Travis and one is Lackland. I had visited Travis several times. I was not overly impressed with the physical plant. It looked confining and we just decided, my wife and I, that we would come down here [to San Antonio].

N: Had you ever been here before that assignment?

Myers: Yes, I had. I visited once because we had a meeting here of the Society of Air Force Clinical Surgeons. We only had 500 beds here. The first wing that was built was

500 beds. We used much of the old cantonment area. When I came down we then added another wing, the T-wing over here, which put in another 500 beds, and that gave us the thousand-bed capability. And I was awfully glad that I come to Wilford Hall because the opportunity to develop a real academic neurosurgical program presented itself and I started the residency here.

N: How did you come aware of that opportunity? By talking to the people who were here before you came?

Myers: Yes, there was a man named Wallace who was here, who had been chief of neurosurgery. He told me it was a very busy service, and that's what I wanted. I had a feeling too, and I don't think it was as deeply ingrained in my mind at the time as it is now when I look back on it, but I felt there was an opportunity for this particular hospital to become the flagship of the Air Force. And not only would I have the opportunity to be surrounded by other very well-trained clinicians, but there would be the kind of leadership provided here at this institution that would be forward-thinking and progressive. And that turned out to be exactly true.

N: Were you satisfied in your first years at Lackland?

Myers: Absolutely, absolutely. But we started under some very difficult conditions. When my family arrived, all of us, into this semi-tropical climate, we wanted to live on base. So our first set of quarters was the bottom level of an old barracks. There were four apartments in those barracks, and they gave us the two apartments down on the bottom floor. So we had two kitchens, two dining rooms, two living rooms, but four bedrooms because we had four children. It was right across the street from the officers club. Up above us lived the Red Cross girls who were assigned to the medical center. It was a noisy place on Saturday night, no question about it. We had no telephone when we arrived. So when I got calls at night the air police would have to come and rap on the door to get me up so they could tell me I was wanted back at the hospital. Well, that lasted just a short time until we got telephonic communication.

But it became very apparent that we were drawing patients from all over the Southwest. It wasn't long, a couple of years, before the service had grown enormously from perhaps 30-35 beds into almost double that number, and then became the largest surgical service in the surgical department. Indeed, toward the end when the residency program was working very well, we were the largest single service in the whole institution. We had over sixty beds, and were getting patients from around the world.

N: You mentioned that one of the extra-curricular activities early in the 60s was the Hiawatha Society. Was this professionally-oriented towards medicine and how did you approach it? Did you read books and articles? Did you give presentations?

Myers: Well, my background as a country doctor gave me a very broad perspective of medicine, in contrast to the individual fresh out of medical school who goes on a single narrow track and gains very little appreciation except for that particular discipline that he

has chosen. I had a very broad view. I wanted to know what was going on in the whole world of medicine. I wanted to stay up on the latest in each and every field other than my own. There was no way to do that formal studying in our daily work. Although each department had its own little training session, presentations, and grand rounds and all of that. But I also wanted to develop some comraderie. So the idea came to me that if we took the chiefs of all of the services and we met and had dinner together once a month, then at each one of those dinners one chief could get up and very briefly review, in terms of all that he could understand, what was developing in his particular field. What was an opportunity for a social commitment was an opportunity for us also to learn more about things that were going on outside our own specialty.

Dr. Ed Underwood was the commander at the time. He enthusiastically supported that concept when I briefed him on it. Coming out of the Mohawk Valley, which was my home, and steeped in the traditions of Indian lore and the Five Nations and what not, I thought, gee, if we are going to have a meeting of all the chiefs, what better term to call it than the Hiawatha Society, a meeting of the chiefs of all the tribes. That's how it got started. It was very, very successful.

N: How long did that last?

Myers: It went on until the time I left. That was lots of fun.

N: Getting back to the early 60s, what did you hear about plans for Wilford Hall's future when it started to shift over to Systems Command away from Training Command? I think it was about '61 or '62. Did you see a change in mission? Did the new space program look like it was more likely to make Wilford Hall more likely to be flagship of the Air Force Medical Service?

Myers: We were very, very fortunate in the 60s have as our commander here General Jim Humphreys.. General Humphreys had been a cavalryman and loved horses as his first career option. But he had gone on to train in general surgery and was a marvelous general surgeon. He practiced general surgery as the commander here. He was an inspiration to all of us. We used to have on Saturday mornings 'black Saturdays.' He would have all the colonels in on Saturday morning, and he would have a leadership session for all of our colonels, teaching us what was important in the medical service of the United States Air Force -- how to lead, how to decide, how to be inspirational, the requirements for ethical behavior. And he was as hard as nails. We loved him, all of us. In fact there was a small group of us who thought so much of him when he left, we gave him a plaque, and we signed it 'Humphrey's Rifles.' We called it 'Humphrey's Rifles' because we told him that at the last minute of the last hour, when the wagons were all surrounded, he could count on us.

During the time we were supporting the Manned Space Program I traveled a great deal with General Humphreys, as did a lot of us, to go to Cape Canaveral. I got to know him much better as a human being, his aspirations, his dreams, and his desires. He had a vision and it was called Project 7O. He talked about how this would be the major

institution, academic institution, a placing of learning for the Air Force, where we could be training for this dual mission, both in peace and war. Where the senior staff would be living in relatively nice housing surrounding the medical center. Where we would have nice accommodations for our enlisted personnel. There would be a huge complex here, even to the point of having things that weren't called that in those days, but something like the Fisher houses, where the patients' families could come and stay inexpensively. Where we would even have a place where children who required some kind of institutional care because of severe genetic defects could be cared for at a rehabilitation center. It was a marvelous dream. General Humphrey lived for that. He just wanted that in the worst way.

When he went to Vietnam, I was suddenly thrust into the command position. It was very apparent that we were hampered in our work because of the space limitation. Fortunately, most fortunately, at that time General George Schafer was the commander of the Aerospace Medical Division at Brooks. He was very sympathetic to our cause, and General Gen. George Brown was the commander of Systems Command. Both were caught in this vision also, very supportive. And the role that Systems Command played in those early years to bring about some solution to the problems we had, and the response to some of the dreams that General Humphreys had resulted in what you are sitting in here today -- a $100 million project.

N: Well, sir, the thing that I wondered about is that it's clear that he had this vision in the early 60s when he was commander. Then you go through the Vietnam war and virtually nothing gets done. It's only in the 70s that the vision becomes real....

Myers: He [General Humphreys] was never able to energize the Air Force institution, for the simple reason that there were problems in Vietnam and that was least of the Air Force's concern at the moment. When General Brown...by the way, General Schafer was also (the interdigitation of these personalities is important to understand.) General Schafer was seventh Air Force surgeon and General Brown was the Seventh Air Force Commander as a three star. General Bob Dixon was his Deputy. General Dixon was a patient that I had operated on. I had operated on him for a ruptured disc before he went to Vietnam, when he was Commander of the Air Force Personnel Center. So here we have my relationship with General Dixon. General Dixon's with General Brown, George Schafer's with General Brown. I got to know General Brown in Vietnam. It just all came together. The timing was right. The people were right. We had community support that began to build, and we had Congressional support. So it was just the right time and the right place when all of this took place, where it couldn't have happened any earlier.

[Dr. Nanney shows General Myers a historical memoir that General Humphreys wrote about his tour as Wilford Hall commander. General Myers had not seen it, and Dr. Nanney asks him to comment on it.]

Myers: Now, regarding this memoir by General Humphreys on his tour as Wilford Hall Commander in the early 1960s. It's true that he did a lot to bring to staff together and

impart a military bearing to our operation, because the staff initially had very little loyalty outside their small office circle.

For instance, he had to order people to go to a dining-in, a hospital dining-in. General Humphreys initiated those. Well, it was interesting to see the number of people who would suddenly have to go on leave or TDY or the numbers of relatives in far away places that were ill and emergency leave was required just to get out of going those dinings-in. It was an exercise in how to beat the system.

General Humphreys, God Bless him -- now that he is gone I can comment on what he says about his reorganization of the hospital's relation to the Lackland Training Center.

He says, "the reorganization also allowed for the director for the base medical services division to be named the base surgeon of Lackland AFB. This relieved the hospital commander, a general officer, from serving as the staff officer for basic military training center." He did that, true, and that was a mistake.

Right after I was appointed commander I called the military training center commander, General John Samuel. I said, "General Samuel, I am inviting you to come over here to the medical center for lunch." He said, "You what?" I said, "Please come over here for lunch." "Well, I'll be damned. Nobody has ever called us over here to come to lunch. I'll be delighted. What day would you like me to come?" He came over and we had a marvelous meeting. I said, "Sir, I'm here to serve you and the troops on Lackland." He said, "My God! What a change in attitude." And from there on in it was easy going.

Nobody had done that. Humphreys had said, "I don't want to be a staff officer."

N: I suppose his attitude contributed to that IG problem in the late 1960s.

Myers: Yes. Because the training center got away from him; he wasn't looking at that. As General Humphreys himself says here, "That [policy] was not too acceptable by the commander of the Lackland military training center. It was not acceptable to the surgeon of the Air Training Command." [General Myers laughs.] General Humphreys' successors never changed that.

Part of this memoir also shows how Wilford Hall began to become a major referral center. As he says, "It began to indicate not only the staff itself but the outside world that we were a major referral center much more than a base hospital."

Now I didn't know what he says here about his attempt to get the hospital named a medical center. This proposal was "met absolutely with a flat 'No' from the surgeon of the Air Training Command and from the Office of the Surgeon General."

All in all, this is a good review by General Humphreys.

N: Right. At Wilford Hall in the 1960s, was readiness for Europe ever brought up as an issue for a European conflict? This became an issue in the late 70s, for reasons we can discuss later. Here we are in the 1960s in the middle of the Cold War, yet I don't remember reading anything about medical readiness really being an issue.

Myers: I'm thinking very hard. I think I can with reasonable assurance tell you that I never heard the word "readiness" in the 60s. What we developed was a team....called the "Eagle Team," or something like that. The name doesn't make any difference; but certain of us were designated as key personnel, and we had to keep up with our immunizations for world wide capabilities. We were on alert for rapid movement, but we never went through a training exercise of any kind. It was just presumed that if something broke somewhere we would be called as a team and sent out. In fact, I really didn't become much aware of readiness until well into my command here at Wilford Hall. That's not to say the issue was not being addressed at levels that I wasn't privy to, and I'm sure it was.

N: At least in the late 70s readiness became something that almost everyone was aware of, everyone in the medical circles. Did you notice any change in the patient load at Wilford Hall in the 60s, in the demographics, the origins and nature... not some much clinical nature but duty type...active duty versus family versus retired... and was there a shift in their geographic locations, local versus CONUS-wide or world-wide?

Myers: I wish I had some statistics to bear this out. I'm going to have to give you my impression at that time. We were truly a medical center. We were drawing active duty patients from around the world. Wilford Hall was the center, with the very active air evacuation capabilities that we had. Active duty patients would come here from everywhere, dependents of active duty would come here from everywhere, all over the United States. Indeed, as the reputation of Wilford Hall grew, General LeMay met with other Air Force chiefs of staff from other nations and talked about our capabilities. One result was that -- when we were very friendly with our neighbors in South America -- I began to get patients, senior staff members, from the Chilean Air Force. I had members of the Argentinean air force come here for care, because they had learned through General LeMay that we had capability here.

At the same time, we were developing more and more technical expertise. There were two people here. Doctor Bud Conrad, who died a terribly tragic death after his retirement, was a hematologist. His reputation grew.

Doctor Charles Copeland, who is now the Director of the Cancer Institute here in San Antonio, was our oncologist, and he was so far ahead of his contemporaries that we nominated him one year for the Air Force Scientist of the Year. When Dr. Brown was Secretary of the Air Force he established that award, and Charley Copeland won that award. Air Force scientist of the year, a clinician; it had never happened before in history. That's the kind of people we had. So our reputation was drawing people from all over. We had an outstanding nephrologist who was a good researcher, and we began to develop the renal transplant program. We had a huge dialysis service, a huge cardiology service, a big service for cardiothoracic surgery.

So, I guess to answer your question, we were drawing many, many people from the Air Force itself. At the same time we were taking care of our local retirees. But then, as I see now, in the latter years when I was Surgeon General that world-wide power diminished somewhat. As the greying of American was taking place, we were seeing more retirees coming from this area. So yes, there was a shift.

THE VIETNAM WAR

N: What about Vietnam War? Were casualties and illnesses from that conflict noticeable here?

Myers: No, although we drew some of the air persons from the Vietnam War.

N: There wouldn't have been that many Air Force casualties.

Myers: We didn't have the casualties that the Marine Corps and the Army had. We were never anything like Brooke Army [Medical Center] with the multiplicity of wounds that they had over there. What we did have, however, was a center for the care and the medical assessment for our POW's. We had those airmen that were released from Hanoi. Most all of them came through here. It's about that too that we got into this world of drug and alcohol rehabilitation. We had a big rehabilitation center developed here.

N: In regard to Vietnam, you mentioned that you had some special assignments they took you over there. They apparently had some influence on your selection to be Commander at Wilford Hall. Do you remember what those assignments were and how long were you over there? Do you know those reports are still available? I haven't been able to find them.

Myers: I was in Vietnam on two occasions. On one, the major occasion, I had gone with General Towner to the Philippines. General Towner came home as I can best recall, but I went on into Vietnam at the invitation of General Dixon, who was the vice-commander for Seventh Air Force. General Schafer was the Seventh Air Force Surgeon at the time. My job was to have a look at the whole system of casualty management, interface with the Army. I went up to DaNang, talked to the Navy people that were taking care of the marines up there.

N: The joint perspective?

Myers: Yes. I looked at how all the services were interfacing,, how the air-evacuation system was working. I went out on some medevac flights on C-130s and picked up the some casualties where they taken by Dust-Off choppers. We triaged them and took them back, and just learned first hand what it was all about. As a matter of fact, I got off the airplane at the Cam Ranh Bay and went right to the operating room because of a casualty we had brought in with a head wound.

But General Dixon had said, "In your movement around the country I want you to look at everything." I said, "That's pretty broad directive." He said, "I mean it. I want you to

look at morale, I want you to look at the officers' clubs. I want you to have your ears and eyes open." Everything. So, I wrote up a very personal report for him that covered a lot of subjects which I don't think I should repeat at this time. I covered a lot of things that were not medical, and provided that report to General Dixon. I'm making the presumption that he shared that report with General Brown. I'm not attaching any undue importance to that, but it was quite unusual for a medical officer to be asked to looking at things that were not medical.

N: How long were you there?

Myers: I was there for a matter of several weeks. Less than month, but it was a very intensive kind of experience. I had been designated the Commander at Cam Ranh Bay and was preparing to leave Wilford Hall, when the call came to General Brown that I was to be the new Commander here at Wilford Hall.

N: What were your impressions of the Air Force facility that came on base?

Myers: It was a good hospital, very good. It had the usual problems that we had in any organization that was in Vietnam. There was a informality that was for me, having come out of the disciplined world of West Point, hard to accept. I couldn't help but feel that we seemed to be other than the kind of folks I thought most of us were. There was a whole lot of grumbling, bitching about everything. It was very difficult.

THE LACKLAND TRAINING CENTER

N: Looking at an alternative scenario for your career, half of your patients at one time came from training center over here, which was under Training Command, and you yourself got along very well with the commander of the training center, as you have pointed out here. If you had been under Training Command in the 60s and the 70s, could you have done as much to Wilford Hall as you did under the Systems Command?

Myers: Well, that's a very difficult question and there are a lot of presumptions in it. I wouldn't want to go back to...

N: I know it's hypothetical for the time you were in command here. But now the medical center is back under Training Command.

Myers: Well, the difficulty came between Wilford Hall and Training Command when in the late 60s, the medical center was not oriented to the duality of its responsibility. There was not an appreciation, a deep, ingrained appreciation for the fact that while Wilford Hall had a responsibility to be a world wide referral center, its primary mission was to support the people that were on this base in the training element, and at times that got to be eighteen thousand. Those young people had first call on the services here. That wasn't understood by the Wilford Hall hierarchy.

N: In the late 60s?

Myers: Yes, that was not understood. That's the way it should have been. We needed as many outstanding people in health care delivery on that side of the base in the training area as we needed in the medical center, to be part of the training center to be working with the training center. The medical center commander needed to work in conjunction with the other center commander, the training center commander. Having the realization that every day that a trainee is lost out of training is an expensive proposition. That's putting it on a cost-effective basis. But we also needed to realize that those young people had been sent here by their mothers and fathers in the hopes that they are going to get excellent medical care during their training.

That came unglued. It really did. That was the big blow up in that Systems Command inspector general inspection that brought the house tumbling down and was the reason for my appointment; that precipitated all of that.

Now, to get to your second question about how receptive Training Command would have been. Training Command at that time, if it had assumed the Wilford Hall responsibility, also was operating a major medical center at Biloxi, at Keesler AFB, and was operating at big regional hospital at Sheppard. So it had its assets spread. Could Training Command have had the same intensity of purpose in trying to develop the $100 million dollar addition/alteration with all those other requirements, all its other budgetary needs? I would think that it would be reasonable to say that the intensity wouldn't have been as great; not the desire, but the capability. Systems Command was into the weapons development and acquisition business. There was always a place to find enough money to put over here and to keep things moving well. I think that played a role.

N: Sir, to get back to the IG inspection a moment. Was this a Systems Command IG report that really took the medical center to task for failing its responsibility to the training center?

Myers: Yes. That was a major part of it. There were also deficiencies in the operation of the facility here itself. I can remember the words in the IG findings were that "basic trainees on sick call are managed like a herd cattle." I'll never forget that phrase. Of course, the Chief, who was at that time General Jack Ryan, just said, "We're going to clean it up, and we are going to get it cleaned up by tomorrow morning."

N: So this was a high priority when you became commander?

Myers: The priority. General Ryan came down to visit shortly after I had been made Commander. He took me aside under one of those brand new barracks over there that has the area underneath where the young man and women can drill in inclement weather. He took me behind one of those big concrete buildings, and he put his finger right almost on the end of my nose, and he said you're going to fix this aren't you?" I said, "Yes, General Ryan," and he said "You better."

N: So how long did it take?

Myers: Now, General Ryan went on to say later on in other conversations to General Brown "We're going to give you the assets to see that that gets done; but you've got to provide the game plan." In fact, I went over personally to see young airmen on sick call and held a clinic over there.

SPECIAL INITIATIVES, THE 1960s

N: At Wilford Hall in the 60s, were you involved with the origins of aerobics ? Did you know Kenneth Cooper?

Myers: Ken Cooper was working over in the lab. We were always proud of the three things we did at Wilford Hall: patient care, research, and medical education. We did those things well. So, we had a fine research capability, and Ken Cooper was involved in the doing of this kind of thing in the research lab. I knew Ken, I knew what he was doing to some degree. General Richard Bohannon, the Surgeon General, became intrigued with this. It was all happening about the same time that that Canadian ten point program came out. We had that re-published and handed out to everybody. General Bohannon thought it was absolutely wonderful and it ought to be applied Air Force-wide. He gave Ken Cooper a lot of license to work in that arena and that's how it all came about. Of course, when Ken left the Air Force he certainly was able to capitalize on that program and become a multi-millionaire up in Dallas. And I don't say that with any rancor at all.

N: Going through the records of the Surgeon General's office, I've come across quite a bit of material on the creation of the USAF Hospital System in 1969. In conjunction with this, Wilford Hall Hospital became Wilford Hall Medical Center. The name was changed in conjunction with creating the system. The briefing on the new system suggested that the intent was to equalize patient load to some extent among the regions in the continental United States, shifting some capability away from Wilford Hall or at least building up capability in areas apart from Wilford Hall in the United States, in other centers. Were you aware of this creation of the so-called hospital system and did it have any influence on the patient load at Wilford Hall in the late 60s and early 70s?

Myers: There were two actions being taken in parallel, one which I was quite familiar with and another I'm a little vague on. The first was DOD-level. Richard Wilbur was the Assistant Secretary of Defense for Health Affairs. He wanted regionalization on Tri-Service basis. There would be a regional responsible agent. There were six regions developed in the U.S. I was the youngest, youngest commander among the three in South Central Texas. I was younger than the Brooks commander, younger than the Corpus Christi Naval Hospital Commander. For some reason they said to me, you are the regional coordinator; put this all together. So the Air Force had responsibility here. The Army I guess had it in the Washington Area.

Secondly, the Air Force at the same time was on a parallel track. It decided to get away from that previous concept that I had described, with the hospital sitting on the end of the runway, in order to build a system where there would be a tertiary-care center. Then there would be regional hospitals, and then there would be the small base units. If you got sick,

you went to the base unit. If you needed more care, you went to regional, and if regional couldn't handle it, you went to tertiary. That was the endpoint of care. As those centers were developed, it was at the time that we were beginning to show a profit in the early investment that we had done in training people like myself. We now had more neurosurgeons than we ever had before, more cardiologists and what not, and we could put those people in those tertiary-care centers.

N : Not necessarily at Wilford Hall?

Myers: No, not necessarily at Wilford Hall. But Wilford Hall would still have some of the unusual things. It would be the only place that would do a renal transplant. But at these tertiary-care centers there would also be medical boards and PEBs, physical evaluations boards, so that assisted in the evaluation and processing out of those people who were no longer fit for world-wide duty. So in keeping in with what was being driven by the Department of Defense (DOD) the Air Force was moving in that same general direction. You asked me, did I see some kind of a shift in the kind of mix that we had in patients? I could only say that I drew fewer people, for example, with neurosurgical problems out of the far southwest, Arizona, because they were going over to Travis. I would not get anymore of the Gulf Coast because they were going over to Keesler. I wouldn't get any out of the upper midwest because they were all going to Wright-Patterson, at Dayton.

That system provided the state of Texas a system so that an air base at Big Spring, when it was open, could send its people to the regional hospital at Sheppard. If Sheppard couldn't handle a case, they would airevac the patient to Wilford Hall. So that was in marked contrast..... that was a whole change in philosophy of health care delivery, peacetime health care delivery, from what we had earlier, back when the Air Force first had a medical entity, when we had this "put it at the end of the runway" approach. Oh, yes, have an ENT man, a cardiologist, a general surgeon - but that's about all we will need -- and put the Flight Surgeon in charge. "

COMMANDER OF WILFORD HALL MEDICAL CENTER, THE 1970s

N: I think you indicate that there were some staffing problems at Wilford Hall in the 70s, with nurses, enlisted technicians, and physicians in some areas. Am I correct in that summary?

Myers: Yes. But let me quickly point out that we have never had staffing stability, and you never will have in a federally-operated enterprise. We have never had adequate staff to do the kind of work that we are capable of doing, because of the manpower restrictions imposed by the Congress and by the Service. We never had the staffing ratios that we should have had. Let me give you a glaring example. At the Baptist Hospital in Memphis, Tennessee, which was one of the big neurosurgical centers in the whole world, the Simms-Murphy Clinic, which operates out of the Baptist Hospital, for every neurosurgeon there are about fifteen support people. At Wilford Hall for every

neurosurgeon we had about three. That's true all the time. We're always playing catch-up ball.

N: This was true even when the draft was in effect?

Myers: Even when the Berry Plan was in effect. You see, the Air Force was never effected by the draft. We never had to draft a single person in the Air Force. We never drafted an enlisted man. We never drafted an officer. We were all-volunteer.

N: Was there any sentiment in the medical community that maybe we ought to be drafting some people?

Myers: No, all we wanted to do was to get the formula that said you get the staffing according to the work you do. But we had it accounting practice that didn't reward you for work with staff. That's been one of our major deficiencies over the years.

N: The disconnect between the work load and staff?

Myers: Right. Yes, absolutely. And the old "fair-share" business. If the Air Force was going to take ten percent manpower cut, then that meant everybody, including medics. "You medics have got to suffer like everybody else." Well. that's an arguable point; but we I think, with the stress on quality control that we have today, we just have to enough staff to be able to give absolute top-quality care.

N: What did you think of the Berry plan?

Myers: Well, I thought it was a great plan. Unfortunately, there was a element in that group, individuals, who were terrible anti-military and who had no concept of what's required. There was no loyalty to the parent organization, none whatsoever. There was no pride in the wearing of the uniform. There was the constant, constant barrage from many of these individuals who said "doctor first, officer second." Well, I would was use some strong language, but that was poppycock. There is an absolute requirement to be both and they can be very adequately balanced. And the traits of a good physician are the same traits of a good officer. That's one of the things that I get emotionally waxed on.

N: You mentioned DoD programs that were influencing in the Air Force in the 70s, such as the regionalization program. At that same time, in the late 70s, DoD begin to experiment with capitation budgeting, and the whole point here is to avoid automatically rewarding increased workload with more resources. This movement has developed in the 80s and is now coming to fruition with capitation budgeting throughout the military health system. The perception was that somehow the workload-based funding just generated more workload, while the main point now is to control costs. There are different formulas for arriving a particular budget based on the number of enrollees in each health system. I wonder what you think of that movement towards capitation budgeting?

Myers: I didn't have any personal experience with it as the Commander at Wilford Hall. I understand the concept, and I can see the good point and the bad points. What it gave the facility commander was the capability to control the funding of what it was he was doing, based on the numbers of people he was serving. I think there is merit in that. It's not unlike budget preparation, for example, when you really ought to have a line-item veto. There has got be some local control. I think that is a good issue.

The big problem is we are having today, no matter what it is that is put together, is that in devising solutions in a piecemeal fashion.... I may be getting way ahead of the story here, but, for example, when we come up with Tri-Care as a system of cost containment and capability of providing kinds of care that we need to provide as we began to draw down with the military medical model itself --- that's a great program if you're under the age of sixty-five. The minute you're sixty-five years old you are out in the COLD, and that to me is criminal.

N: In the 1970's, did Wilford Hall have a regional goal, within its assigned portion of CONUS vis-a-vis the other services? The point of the DoD programs was to foster cooperation, but to some extent I think there was competition for resources and beneficiaries within the region among the services. Could you comment on the mix of cooperation and competition in this area, especially with the Army?

Myers: I stepped out very positively when Dr. Wilbur was pushing regionalization. Because the Navy was saying help us, things worked very well. We sent clinicians to Corpus Christi to the Naval Hospital where they were whole clinics. That worked out very well. The Navy was very pleased with that. We were very pleased with that.

I never found the Army to be as willing. It was very difficult to get data from the Army. It was very difficult to work co-operative programs with them. I don't know whether that was a fear that the Army was going to lose some of its turf control. I never felt that the Army entered into these cooperative ventures with the same kind of gusto that we did. So, what am I saying? Well, if you already have what you require, you don't need much help; but if you are out there and you are in need, you are very cooperative. We did get some fairly cooperative training programs. But we could have done a whole lot better. We really could have.

N: On one particular issue, in trying to get the major construction program through for Wilford Hall in the late 70s, you pointed out that you had lots of contacts with the local community, in particular the San Antonio Chamber of Commerce. It sounds as though, in your earlier interview, that they supported Wilford Hall in its attempt to build itself up at the same time that Brooke Army Medical Center was also trying to build itself up. The San Antonio Chamber of Commerce favored Wilford Hall over Brooke Army Medical Center. Is that correct or incorrect?

Also, in the 70s there was a tremendous increase in the number of medical malpractice filings in the civilian community. The litigation exploded. How did that affect military medicine ? How did that affect Air Force medicine? How did it affect Wilford Hall?

Myers: Well, we had always been very careful to see that consent forms were provided and filled out adequately. We were very certain that in our records reviews we saw to it that a record was complete, that the data truly reflected the state of affairs that was going on at the moment. None of us ever had any fear that we were going to be sued. There was the feeling that we had a general protection. That if somebody brought suit against one of us, it would be against the government of the United States rather than the individual. We never carried malpractice insurance. That shouldn't be distorted. Someone hearing should not draw the conclusion that we really didn't care. That's wrong; that's wasn't the case. I t was that we felt that we had a standard of practice that was very high; we wanted to maintain it. We did. We had quality control devices in place -- mortality and morbidity conferences, chart reviews for every service. Those were done with regularity. We just felt that we lived in an environment where we had also a different kind of a consumer. We had people who wouldn't have the mind-set that if they weren't restored to perfect health that would result in some kind of retribution on their part.

Just as aside, we have a population that doesn't quite understand that once they are ill, we have a very poor capability of making them well. We have the capability of making them better. I think a good analogy in the individual who was severe angina, who is discovered to have some difficulties in coronary flow, and you do a coronary bypass operation on them. You relieve the pain of angina, but you haven't made them well; you've made them better. Over the years the public has come to expect wellness rather than betterment. When wellness isn't reached and they reach only part of the goal that they have set for themselves, they will be very quick to blame it on the practitioner. Now, that's setting aside the glaring errors -- taking out the wrong eye, removing the wrong leg. That is gross malpractice. I wouldn't defend that for one second.

The requirement to carry malpractice insurance if you are a civilian physician hired by the Air Force is sometimes a great drawback for retired military doctors. After I retired, I wanted to come back and work part-time in the neurosurgical clinic here to help out when they were short-handed. The malpractice insurance premium was more than they were going to pay me. I just gave up and threw my hands up in the air.

N: Within the Air Force medical service or in the Air Force as a whole, were their any voices that did not favor having a single flagship medical center? Did anyone favor spreading the resources around? Historically, the Office of the Secretary of Defense has advocated into spreading medical resources around equally among the Services? Was there any Air Force sentiment for a similar equalization within the Air Force? Did you ever have any kind of Air Force opposition of any kind whatsoever to the central status of Wilford Hall?

Myers: There were among my predecessors some who were not as enthusiastic about the medical center concept as others. To call them anti-medical center people would be overkill. They were people who hadn't had experience as medical center persons. Remember that most of my predecessors are in the Air Force had come from World War II experience or they had grown up in the aviation medicine world, in the flight surgeon's world. They were not medical center oriented people. I think the concept was a little

difficult of them for the simple reason that they saw our requirements for providing quality health care at every base that we were operating, throughout the world. What was the right balance among those multiplicity of bases, between clinics, small hospitals, base hospitals, regional hospitals, and medical centers. What they were simply saying was that we can't put the major part of our effort -- manpower and money -- in the medical centers because we have responsibilities around the globe.

Now that is a difficult equation to balance. Not only is it a difficult equation to balance in the matter of manpower and money but on a personnel basis too. A highly trained young person comes out of training program to do very sophisticated vascular surgery. Then we at the Surgeon General's Office start looking around through the Air Force personnel world, and at every center we find we already have a highly trained vascular surgeon. So we send the new person to Minot, North Dakota. What is his opportunity to do vascular surgery in Minot? Zero.

Two things are going to happen. Either he becomes so disenchanted he becomes very vocal and is disruptive, or he tries to find relief for those talents to keep his mind and his hands working properly, and he starts going downtown. He can go downtown in two ways: legal and illegal. He can moonlight, or he can set up some kind of capability that when that kind of case comes in for an Air Force eligible, he'll take that individual downtown and with some arrangement with the CHAMPUS payment plan he can do the procedure down in a local hospital. That got to be a very sticky wicket.

Those who sat in the chair long before I came along, were seeing this kind of thing take place. I didn't find it very easy to resolve that. My own feeling really came down to: after somebody finishes school they ought to see the Air Force operate at the operational level; that means at the base, operational base. How long do you leave them there before the skills begin to deteriorate and you can bring them back in? The best method is to take that fellow who says I want to do vascular surgery and say "Go serve in the field two or three years before your residency begins. Get that background. Have an appreciation for what the Air Force mission is. When you come back we'll give you your residency and then assign you to a major center." Now, trying to get all those trains to arrive and depart from the station at the right moment is very hard.

N: As someone whose experience is mainly center, do you think the center has had a significant contribution to the operational side of the Air Force, to the pilots down there on the field? How important is it to the physicians who attend them to have the stimulus of center work? Is there a synergy between the two worlds that's necessary?

Myers: There are two elements that get involved in this action. One is the giver and one is the receiver of the service. Let's look at the receivers first. There is a general feeling which still runs deep to this day that I want to be taken care of by my own people. There is a sense of security, there is sense of pride, and a sense of comfort in knowing that you are going to be taken care of in a blue-suit medical community. That has a great deal to do with the recovery capability. If you got confidence in your medical givers it influences your ability to get well. In our Air Force history, I think that those who came to seek our

own medical services were comfortable that they really got good care. If you have a need for some major surgical procedure and it's done in the civilian hospital, the people on the staff at that civilian hospital aren't going to know anything about the Air Force mission or how you fit into that world that Air Force world. Or have much of a concept of your own commitment or dedication.

One classic example of this was the senior four star on active duty in all of the Armed Forces, General Lawrence Kuter, who had lumbar disk disease. General Kuter had consulted some people at the Mayo clinic, but he elected, when he was Chief of NORAD, to come to Wilford Hall to be taken care of. He said there were two reasons for that: one, it was his service, his hospital. He believed in using those facilities which were provided to him Secondly, he said he just great confidence and trust in his fellow airmen.

On the giver's side, there also should be enough knowledge to know that what they are going to do will help maintain a career. And I think when you can do something sophisticated to somebody and correct the problem which ordinarily would have diverted them from a career and you have been able to assist them in maintaining that career track so they can go on to great success and fulfill a lifetime of service that is a real contribution. I think we had a noticeable influence on many individuals, because of the skills that were present in the medical centers. We were able to correct some of those deficiencies and sent them back and let them do their work.

These remarks, of course, are pretty much directed to peace time healthcare, but always lurking in the background is the requirement that we be appropriately ready for management of combat casualties. That just goes without saying, that's a given.

N: As Commander of Wilford Hall, did you have any much direct contact with the Air Force Surgeon General's Office?

Myers: On day-to-day issues, on budget issues, manpower issues, general topics of management leadership, no, I did not have contact with Surgeon General's Office, because it wasn't required. We had very strong leadership and wide open communications between my office here at Wilford Hall and the Commander of the Aerospace Medical Division at Brooks AFB. That was the beauty of the arrangement with Air Force systems command, because we had over there at Brooks AFB the Aerospace element of the Air Force, studying man and the machine moving off into space, and sitting over here at Lackland was the clinical side. That's a great marriage and that worked beautifully. General Schafer and I enjoyed good relations with the four star Commander, General George Brown. General Brown had a great interest in his Aerospace Medical Division (AMD) and in Wilford Hall. He told his staff the same thing: "You people better have an interest in AMD and Wilford Hall. They are part of the family." That continued through General Evans, General Ferguson, and others. These were men who preceded General Brown. (Evans came after) We never wanted for capability. We could get the comptroller for Systems Command to come down here to help us plan and budget. We could get the manpower guys to come down here and talk manpower with us and then carry our case

on up. It was just this wonderful wide open flow... I had more loyalty, to be perfectly honest with you, to Systems Command than I did to the Surgeon General's Office.

These were action-oriented people, and that's what was appealing about them. Not to say that Surgeon General's staff wasn't, but remember the Surgeon General staff was advisory in capacity, and you know that the Air Force has a much different kind of organizational structure when it comes to the medical element. The four-star Commander is the man who owns the assets in our Air Force world, and, boy, that's the best arrangement there is, no question about it.

N: Yes, sir. You've described a lot of things you did here. With that priority early on as Commander and later the construction priority, did you get any chance at all to travel and see more of the Air Force in the 70s?

Myers: Yes, I sure did. I traveled a great deal. I always had a marked interest in a mission capability of the Air Force, because I knew that whatever I was doing somehow played an important role in the capability of the Air Force to fulfill its mission and requirements.

SELECTION AS AIR FORCE SURGEON GENERAL

N: On your selection as Surgeon General, it is not clear who made that decision. Was that General Lou Allen?

Myers: There were some fine candidates. I have never been privy to how the decision was made, other than to tell you that there was a board that was convened, which is the way the Air Force does these things. There was a selection board convened and the board chose me. Correction -- the board recommended me. I was required to visit with the Secretary of Defense and the Secretary of the Air Force and the Chief of Staff. I had interviews with all of them, as the nominee. It wasn't until after the nomination had been approved by the Chief and the Secretary that I got the call that I had been approved.

N: You mentioned you were at Langley AFB when you got called for the interviews?

Myers: No, I was at Biloxi a meeting in the Society of Air Force Clinical Surgeons when I went up for the interviews. When the final word came, I was at Langley, at General Dixon's retirement in April of 1978, Tuesday 18 April. I remember there was a black-tie dinner for General Dixon at the Langley Club. I was asked to go our and take a telephone call in the lobby and I did. General Benny Davis, who was the deputy chief of staff for personnel then, was on the phone and I wrote down here in my book "Call Jenny. Got word from Benny Davis -- the word. My God, I'm the new SG!"

But I had written something else down only the month before. I had been asked if I would be the commander at Clark AFB. I turned it down because we had two young daughters that were getting ready for college. One little note in March read, "I just had a feeling as of this moment that I will not be the SG." I also wrote when I turned that appointment

down at Clark, "I probably cut my water off." [General Myers laughs.] But that's the only thought I had given to it.

N: And who asked you to take that position at Clark?

Myers: That came out of the Surgeon General's office. But later there was an accusation that I took certain actions because I didn't want to ruin my chances to become Surgeon General. All I knew is the time was that I was senior enough to be under consideration. To be Surgeon General was not my overwhelming desire. That was not my goal. I didn't dream of it day after day. My philosophy was "what will be will be."

ORIENTATION TO WASHINGTON, DC AND THE PENTAGON

N: Sometimes when there is a change of office, there is an overlap to allow the new person to get used to the system and get some guidance from the person who's leaving. Was there an overlap period when you became SG?

Myers: During the time that we were driving the program for the addition/alteration, doing all the briefings in the SGO and Systems Command, visiting members of Congress, testifying before committees on the requirements we had here, General Schafer was extraordinarily supportive. When he became SG, each time I would visit Washington for whatever purpose it was he had a standing invitation that I would stay no where but with him at his quarters, with him and his wonderful wife Marge. I had an opportunity on so many occasions in an informal setting to be able to talk issues with him. He was extraordinarily gracious and invited me wherever he went to go with him when I would be in Washington. Obviously, I didn't go to Chief of Staff meetings. This gave me an introduction to the world in which he lived. I got to know the staff of the Surgeon General's Office. Pat Bragg in particular, some of the other very responsible people up there -- the Chief Nurse, the Chief of the Dental Service, the Chief of the Bio-Sciences Corps, all those people. Then when the announcement was made from that moment on -- all of May and June and even July, because the change over was on 1 August -- each time I went up he would give me a new series of briefings, formal and informal. He made everyone aware that they were to be helpful as possible. He made the transition enormously easy. Taking me over to the Pentagon, [showing me] which door do you go through, how do to get to this floor, what's the best way to get to that office. Then he took me around and introduced me to the members of the Air Staff. He just was the most gracious individual there ever was. So my transition became very simple, nothing abrupt about it at all.

N: Did you set yourself a self-orientation plan perhaps of readings, things that you felt that you had to get up to speed on, or did you ask for particular briefings? Were there things that you were particularly interested in? How active were you in that process of reorienting to Washington?

Myers: Yes, there was a requirement to have a lot of deposits made in the knowledge bank. The first was the operation of the SGO. That required a study of the wiring diagram

of the SGO. What really did the Deputy Surgeon General of Dental Affairs do? What were his responsibilities? The Chief Nurse -- what were her responsibilities? Legislative Liaison -- how did the Air Force Surgeon General fit with the rest of the Air Staff: the Vice Chief, the Assistant Vice Chief, the Chief, the Secretary, all the Deputy Chiefs for personnel, manpower, budget, and the comptroller, all of these people, the Chief Lawyer, the IG, the whole group of individuals. How did that all fit? Particularly the learning experience of how to do business with Congress, how to work with legislative staffers, both in the House and the Senate. What's the role of the House Armed Services Committee versus other committees in the House and the Senate? Authorization was number one, and also appropriations. What was their relationship?

Then it was necessary to know what was going on in the field. That meant making contact with all the four stars and saying, "I would very much like to visit your command and talk to your Command Surgeon. May I have your permission to do that?" I was welcomed always with open arms by the Tactical Air Command, the Strategic Air Command, Military Airlift Command, Far Eastern Air Command, Europe, and I visited all those places. Then I went down in the depths of those commands, starting out in the headquarters and then I went down and saw representative installations, all over the world. I talked to those people. I made a practice of getting together in sessions with all the enlisted personnel, all the NCOs, all the officers, and then all the physicians. So the first several months were filled with filling in the blanks, making sure too that it was well understood that I was there to do work. What I wanted to do was visit Minot N. Dakota in the middle of February, not in the middle of June. What was it like to be in Minot in February?

So after gathering all of that data, I began to consider what alterations should we make in our mission. Where are the deficiencies? And I immediately made a commitment that we will be the best. We will deliver high quality health care in peace and war and work to that end.

I decided that everyone who had a capability for health care delivery, no matter what role they were currently playing, would spend some of their time in doing health care delivery. That meant every physicians would see patients. Every nurse would take care of patients. Even if she was a Chief Nurse who sat eight hours in an office, she would spend one day a week taking care of patients. Every physician would have a clinic. Every dentist would see patients. I wanted to maximize the use of our manpower.

Then the realization, of course, came later on that we had a big hole in our readiness capability.

N: How much of this was new? How many providers were not actually providing when you became SG? How many were into management and just not keeping up?

Myers: Well, they separated themselves from the clinical world. It was easy to understand how that took place. But we were being criticized severely by members of the Congress that we had physicians who weren't doctoring.

N: How could you exert yourself in setting that kind of policy? Could you do it through regulations or directives? Did you have to go through the line chain of command, or could you do it strictly on medical grounds?

Myers: I had a wonderful relationship with the Vice Chief of Staff, no matter who it was, and the Assistant Vice Chief of Staff, the Vice Chief being a four-star and the Assistant Vice Chief three-star, as well as with the Deputy Chief Staff of Personnel. I would discuss these things with them, and say these are the things that I'm trying to attain. Do I have your backing and assistance on all of this? The answer was always yes. I would also be very careful that in discussions with Command Surgeons that they were very much aware of this and that their four-star bosses were also aware and were supportive. I had the opportunity to present these concepts to the four stars, both formally and informally at the CORONA conferences. With their enthusiastic support I was able to do it. I couldn't have done it without them, obviously. They saw that this was a whole new ball game. They were very delighted to see this kind of positive step forward.

N: You mentioned that you the Surgeon General did not really have a seat on the Air Force Council when you arrived.

Myers: No, that came later. It came after a couple of years. In fact, when we got into readiness planning and how we were going to go about it, General [Herbert V.] Swindell was my deputy for that particular area of activity. It was his suggestion. He came to me one day and he said what do you think about sitting on the air staff. I said that would certainly give the Surgeon General an opportunity to know intimately what's going on a day-to-day basis. It would be terribly time-consuming because it was everyday, but I thought that was the way we ought to go. He said, "I'm going to make some proposals." So he worked it up to the various board and the Chief approved it. I was invited to join the Air Staff. I was the first Surgeon General in history who ever sat on the Air Staff.

Until that happened, if I wanted to personally deal with the Air Staff, I often had to go over to the Pentagon on Saturday mornings to catch some of the key people when they were putting in some extra hours. Once I got a seat on the Air Force Council, I had to go over to the Pentagon almost every day.

N: Are you saying that you were able to get a lot of things done your first two years, but it became easier once you got a seat on the Council?

Myers: Yes. And became easier for me to have a better grasp of all the Air Force all the problems that were facing the Air Force, such as budget and manpower. Because we would sit and laboriously go through the budget, line item by line item, hour by hour. I could see where my resources, the things I was requiring, were competing with something else. Over a cup of coffee, out in the anteroom, I could counter somebody. I would say, "Let me give you a little input on this. Here's why we should really have this." I worked a lot of the issues in that way. It was an opportunity to interface with my colleagues. I had as much a vote as than any member of the Air Force staff, on any

decision. That was the unique. I learned a tremendous amount about the operational Air Force.

N: Another re-organization that took place almost immediately was the mandated split of the Surgeon General's Office. Did you have any strong objections to that?

Myers: [General Myers laughs.] I inherited my objections from General Schafer. I don't know if you knew this but that was called "the closet plan." Let me go back very quickly. Jimmie Carter wanted to reduce the presence of the uniform the greater capital area. The administration began to seek out ways to get this done. The Army always says, "We have a big commission studying the problem." The Navy answers, "What did you say?" The Air Force answered like always, "Hey, we already have a plan ready to go." So General Allen's predecessor developed "the closet plan," and that was to put many of the activities that normally had been in the Pentagon for years out elsewhere, in the field. The Air Force commissary service headquarters had to go to Kelly AFB, and information headquarters also went to Kelley AFB. We split the Surgeon General's Office. We left the elements required for business with the Congress and the Air Staff in Washington, and sent everybody else down to Brooks AFB.

The funny part came after those guys moved down there to Brooks and then I sent down a two-star to be the head of all that. I called down personally one day to talk to this fellow and the person on the other end of the phone said "Air Force Surgeon General South." I said, "What?" "Air Force Surgeon General South." I said, "There is only one Air Force Surgeon General. He is in Washington, DC. Now change that the next time I call. I'm going to give you five minutes and call you back." So we quickly got rid of that AFSG North and South. It was tough to make that split work, but we made it work. It wasn't easy, but now things are turning around again and those elements will move back to Washington.

N: In moving out of DC, before going to Bolling AFB, there was a possibility of going to Andrews AFB. Is that correct?

Myers: Yes, but that wasn't entertained too seriously. The Surgeon General's office used to be the office of the top cop, the Head of the Security Police. That was his office, over there in that building... what is the name of that building?

N: At Bolling?

Myers: Yes.

N: The R.V. Maisey building.

Myers: Maisey Building. I didn't think I would ever forget that name. Well, I went over there when the cop was still there. I said, "I'm just coming over to look at your office, because I've been told that's where I'm going." We had a nice chat and it was a great office, because I could look over across the river and see the Capitol. Then they put up

that DIA building, which blocked the view. That was not bad. The difficulty driving was driving back and forth to the Pentagon. That was hazardous. I did it every day. Then I finally said, "Well, we got to have an office over here." So they gave me a little closet on the fourth floor where I could put my brief case down and spend a little quiet time.

N: The quarters of the Surgeon General at that time, were they at Bolling then, in the 70s?

Myers: Yes, it had been there I think since those quarters had been established. Among the people who sit there at Bolling, who live at Bolling, the Vice Chief is the senior officer on the base. He is the only four-star. Then all of the deputies on the Air Staff live there.

That was another thing that helped, because your next door neighbor might be an a two-star action officer over there in the Deputy Chief of Staff for Personnel office. On a Sunday afternoon, maybe, the two of you are sitting out back sharing a beer and could get a lot done.

READINESS INITIATIVES, 1978-1982

N: Readiness became an issue almost as soon as you arrived. I don't see much evidence that readiness really was a front page issue when you were still down here at Wilford Hall. Apparently something took place in the planning community. One briefing I have suggested it had something to do with increased casualty estimates because of reassessment of war fighting technologies. Do you have any memory of exactly what these planning changes were? Who was responsible for those planning changes that produced a change in the casualties estimates?

Myers: Yes. I can give you some conceptual information. The emphasis on readiness intensified prior to the Reagan administration towards the end of the Carter administration. The Assistant Secretary of Defense for Health Affairs was a man named Jack Moxley. He was appointed under President Carter. The Reagan administration failed to make an appointment for a long period, many months, and Moxley stayed on into the Reagan administration and carried the intensity of his concern over. The were always working two scenarios. The first was made of this NATO versus Warsaw Pact on the plains of Europe, similar to World War I and World War II, weapons technology changing. As our people under General Swindell, in the operations area became more aware of that through intelligence sources, the estimation for casualties begin to climb. And then when Jack Moxley testified before a Congressional Committee and made the announcement that we only had the capability to take care of one in ten, that hit the headlines. We had been, though, aware of the problem before he made that announcement and were seeking ways to intensify our capability for casualty management. There isn't anything like realistic training. My association with General Dixon had been very close of the years. Under his direction at the Tactical Air Command, we used Russian aircraft that had been diverted, one way or another, and we got enough

information from Russian pilots who had fled their own system to understand what their battle plans were. General Dixon put together a thing called Red Flag, and it matched the US fighter pilots against Russian air crafts in the Southwest, going through the training exercise on how they would wage war on the plains of Europe. The second scenario, by the way, was some conflict in the Pacific basin, more than likely an invasion of South Korea by North Korea. That was realistic training. Then General Dixon instituted a thing called Operation Maple Leaf, which was a realistic training exercise with the Canadian government, our fighter force against their fighter force, the threat over the Pole. We were looking at what we were going to do also of course with the tremendous number of nuclear casualties that might occur, from both tactical nuclear weapons as well as strategic weapons. We had to look again very carefully at what the concept would be for casualty from the management, what happened from the moment of injury on the field? How are we going to take care of a combat wounded person? For the first time it became very clear that the Russians had developed a capability to strike air bases in Europe for the simple reason that to be successful on the ground they had to have air superiority.

What better way than to gain air superiority than by dropping individuals who would attack air bases, bomb runways, put the airplanes out of order, put the people out of order. That meant that we were going to have casualties for the first time in our experience on air bases. No longer were they sitting way behind line with total protection. We had never had a problem with our airbases except for Clark and Hickam, which was an un-announced strike at the start of World War II. We never had any problems in World War II in having our air bases under attack. In the south Pacific on some of the Islands in the early years, yes. But not in Europe. So all of a sudden all of this begins to come together. We got to take care of casualties on our bases, we got to protect the people that are going to be operational to maintain air superiority on the plains of Europe. Same thing in Southeast Asia. How are we going to do this? As that whole concept begin to come together, I have forgotten how I did it one time. I don't know whether I was just musing in a quiet moment one night or whatever, but the thought came to me that if General Dixon can do with pilots we can do it with medical care. So we're going to develop a combat casualty care program that will require training and that will be our readiness effort.

We had that moving before Moxley made his pronouncement. Well, you have to start simply because it takes a lot of dollars to do something like that. We began by saying that the first assistance that can be given to a combat casualties is by his buddy, simple care: stop the bleeding, help him breathe, make him comfortable. His buddy needs to know how to do that. We started right here at Lackland in the basic training program, teaching the young airman how to take care of the guy next door. It was very fundamental, the basics. Out of that grew the concept of the echelons of care, go through four echelons with eventual evacuation to the United States. But we had to keep in mind also that you need to get back to the commander as many people as possible after they had been injured. So there has got to be a screening process, and what was the echelon of care? A re-establishment of the old triage programs took place. We decided the way to do that was realistically and we developed the Red Flag exercises, which meant setting up a field hospital, a casualty care station, an airevac simulation: bring the casualties in, handle

them, move them out, and take our medics and put them in combat uniforms and make them live under those conditions. Then we did a big one with the German Air Force in Europe in 1981, and we did one in Southeast Asia independently. So we began to do these; every medical center did a Red Flag exercise. That made us combat ready in a hurry. Besides that, we developed a program that would call for enough funds to give us moveable combat hospitals, a hundred of them. We also sought in-country agreements, particularly in Germany and Luxembourg. Some of the things went on very quietly. I don't know whether this is still sensitive but we were making arrangements with the Israelis and the Egyptians and the French, even though the French were not overly friendly. So that we would have facilities there to move people in. All of that just came together and began moving with intensity. We put something like $170 million into this readiness program. It turned out to be the very best thing the Air Force every did.

I want to give credit where credit is due, because when we were looking at echelons of care and how we were going to develop that, what the training would be, I gave them the general concept of the Red Flag. But General Swindell sent about six or seven young officers to that underground retreat out in Maryland, for use in event of a nuclear attack, to determine what the training would be.

We put these young people out there for almost two weeks, under a mountain in the wilds of Maryland, told them to brainstorm this issue. They came back with a very workable plan. That was the basis for all the details. General Swindell should get the major credit for all that. He implemented the concept.

N: So what you're saying is that the Air Force was out head of Army and Navy and any JCS element?

Myers: I think we were just working that issue everyday, and we got in the ball game earlier, as I remember. Yes. Of course, General Swindell was working hat and glove with the JCS people. We kept them aware. I remember how difficult it was to try to get tri-service cooperation. There would be a need, all of us agreed, for a tertiary capability in Great Britain if we were going to be fighting on the mainland of Europe. That would be the quickest first place you could get people airevaced to. Once they had been stabilized, gotten reasonable definitive care, we wanted to get them into Great Britain where you would begin to do some of the real serious stuff. I remember sitting with my colleagues and Jack Moxley at the end of the table on an afternoon over there at Fort McNair. I said it doesn't make sense to me, Dr. Moxley, for the Air Force to have a 5000-bed hospital and the Army to have a 5,000-bed hospital and the Navy to have a 5000-bed hospital. Let's put 20,000 beds in Great Britain and staff them, the three of us. Dead Silence, dead silence from my colleagues in uniform. That's where we were. I don't want that public [laughs].

N: The only other joint group I can think of you might be able to give some credit to is USUHS. Were they involved in any of these readiness initiatives.

Myers: No, no, not at that point. We were flying on our own. One thing that came out of that which was very positive was the Combat Casualty Care Course, out at Camp Bliss. That was a tri-service function and we tried to send every medical officer to that combat casualty care course. That was realistic training. So in addition to the Red Flags, we were bringing that along so that we could have all services participating in that training. That was a good, good cooperative effort on the part of three services.

N: I am surprised when you say that this official Moxley from Health Affairs was pressing this. I wasn't aware that Health Affairs was that interested in readiness issues, at least at that time. Was his an isolated response?

Myers: Well, he was the lead. He was the one who took the brunt of the Congressional vehemence about his announcement that we could care for only one out of ten casualties in Europe. He was forced into getting things moving. A lot of the activity intensified, but we were in the business. General Bralliar was the surgeon in Europe and General Ord before him. General Ord took the lead when we intensified the Red Flag program and made sure that we began to develop our capabilities for combat casualty care in Europe. He did a great job. General Bralliar made a major contribution to increasing the assets that were available, particularly the arrangements with host nations.

N: In reading through the Surgeon General's history for 1980, I saw that a new approach to wartime CONUS support went into effect in October of 1980 and the history says this involved a switch from the notion that CONUS facilities would all expand to receive casualties to the concept that only selected facilities would expand to receive casualties, while others would basically revert to active duty care, shutting out dependents and retirees. Could you comment on that?

Myers: Yes. There were several issues that we were addressing at that time.

One was that having taken the people out of the centers and providing red flag training to them, with the basic operational unit being a field hospital maintained by the tactical Air Force, the Tactical Air Command would get that hospital out and we would take medical center personnel and staff it. We could go anywhere in a hurry. Now that plan is a big logistic experience because no combat commander wants to commit airplanes to be carrying that kind of materials into a battle zone. He wants ammunition, he wants people, parts. So working the logistics of that airlift out was important.

What kind of a hospital did we need to deploy.? The Army was using these blow up things; you pump them up, fill them full of air like a balloon. The Army took a lot of heat on the development of what kind of a unit they should have. We in the Air Force just took tents and went. Then we got large boxes that we could air condition. You put them up not unlike a Gilbert erector set. That was the next concept. Move the boxes out and put them up. Those were great.

We were talking about how we were going to handle these casualties. You took all these training people out of the centers and they had taken the combat casualty course. Now

you bring in the backfill, all your reservists. They come into the centers and take care of the operation of the centers. Now if our casualties begin to fill the center, we got to divert that patient load of dependents and retirees elsewhere. So we got to make arrangements now with downtown people to handle that. We did that. We put that into effect. We also wanted to put into effect the fact that we were going overload our own facilities and we needed more beds. When the whistle blew there were designated hospitals in every community that would give up a certain number of beds to take what our overflow was. Outside of the regular peacetime load; these would be casualty care people. All of that was going on simultaneously, and I remember going around briefing and talking to local hospital staffs around the country saying we want to enlist your support in this concept. That came out of Health Affairs, that concept to get the civilian hospital to do two things: first, accept a given number of casualties, give us a certain percentage of you beds when we ask for them; second, take our overflow when our beds are full and taking care of those dependents and retirees. Does that answer your question?

N: Yes. I'm thinking of the Gulf War when suddenly DoD finds itself in the position of having to say we're going to take care of everybody. We aren't going to miss a step. Even if we have large casualties coming back here, we're going to keep providing care to dependents and retirees. It sounds as though you're saying in the periods when you were working, also, there was an assumption that you simply could not do that except by putting these people downtown. How would that work?

Myers: CHAMPUS was part of the solution. But when we were looking at the whole readiness issue, it became very clear because of the numbers that were being projected that we couldn't handle it with the bed capability that we had. So we had to get more beds. We put a plan into effect and some civilian hospitals signed an agreement with us. We also arranged to get more people to staff our facilities. That was known as the backfill. Third, we had some responsibility for those people who wouldn't be able to take care of when our beds were full. We would move then on out into the civilian world with CHAMPUS. I don't remember any more details.

We have always said that we have a very simplistic kind of arrangement in the Air Force Medical Service. The commander of the facility has the responsibility, the sole authority for determining who it is he is going to take care of. His job is to take care of the uniformed person first, the dependent of the uniformed person second, the retiree third, and the dependent of the retiree fourth. And depending upon what his assets are at the moment, he decides. If he can't handle it, he has got to go downtown and make some arrangements.

N: That sounds reasonable.

Myers: It is. If you stop and think about it, it's basically very simple. The Surgeon General could never tell the commander of Wilford Hall who he can put in this hospital and who must be rejected. He could give a hell of a lot of advice and guidance, but the commander was the one that made the determination depending what he saw from day to day. I think that gives the Air Force, in its operation of its medical service, having the

four-star control all the medical assets in his command, a wonderful advantage. It's proven that its worth over and over again.

I want to just say that all of that training that took place in the 70s and 80s paid huge dividends in our experience in the Gulf War. Our people just right went in there.

N: That's true. Our basic approaches to the Gulf War came out of the readiness initiatives in the early 80s.

Myers: Including he acquisition of the equipment, the authorization and the appropriation of that material.

When I look back at my tenure as Surgeon General and wonder what contributions I made, that is what I take the greatest pride in.

DOD HEALTH AFFAIRS -- THE PUSH FOR INTEGRATION

N: When you were Surgeon General did you perceive that DoD Health Affairs was pushing for greater medical integration among the services?

Myers: Oh, yes. I had that awareness even before, when I was commander here and had the opportunity to visit and participate in meetings called by the Assistant Secretary of Defense for Health Affairs. Even prior to that time, after I became a general officer, and we in the uniform felt that if one of our kind had to take an assignment over in DoD Health Affairs, that was the kiss of death. I think I say this with great objectivity, because it's absolutely true. We thought that you got brainwashed, you began to lose sight of you own particular service and got into the purple suit frame of mind. Their weren't very many I think who willing ever went over there to work, because they knew what it was all about.

Then as my experience as a general officer continued, when I reached Washington, this feeling intensified. It was always felt that the evil figure in the whole operation was Vernon MacKenzie.

N: Who was he?

Myers: Well, he was a deputy. He would be kind of the DoD Health Affairs Chief of Staff, principal activator, motivator. He was an Army MSC retired officer. He was the one that always seemed to be considered the bad one, the black hat guy.

N: Was there any medical element in the JCS that exerting any pressure in that direction?

Myers: I never had much in the way of business with the Joint Chiefs group. When I was SG, General Swindell handled most of that. I never heard him mention any one in particular. To be very honest with you the role of the joint chiefs in some of the planning confused me a little bit. I couldn't quite understand just where they coming from.

N: Wartime plans?

Myers: Yes. I didn't feel that I was getting all that I really needed to know. It was probably my own fault, I didn't ask anyone. But it seemed that there were people in that DoD Health Affairs office who felt that the Services were not capable, that each service was incapable of managing its own affairs. Of course they just grabbed that [Dr. William] Stanford blowup, because they said, "Here is the classic example. If we'd been running the show that wouldn't have happened." Now I thought Jack Moxley was pretty objective. I thought he was pretty damned good. He listened to the Surgeons General. He really did. I think Bob Smith was another good one.

N: I'm sure you know that Dwight Eisenhower recommended a single military medical agency in 1949?

Myers: Yes.

N: I've heard some Air Force medical officers say their impression is that the Army is always been more sympathetic to purple suit solutions and integration than the Navy and the Air Force.

Myers: That's because the Army would be lead agency. They wouldn't lose any prestige in that.

N: Why is that?

Myers: Well, I think the Army would just step in the role of being the leadership, DOD medical leadership. On the other hand, in defense of the Army, they might lose a great deal because it would mean a lot of civilian control at the top that would be in DoD. The Army might lose of their autonomy, so maybe that's not a fair comment.

I would invite, though, those who say we should have one service, to read what's happened in Great Britain and talk to their people, because they have an airman in charge of their RAF medical service. Although they share some facilities with their army and navy, the RAF still has its own. They speak to the fact that integration won't work.

The Canadians don't like it one bit. I had a lot of discourse with my colleagues in Canada when I was on active duty. We were very close.

N: That is a perspective that often gets lost, as you can see in the fact that pressures for amalgamation have resurfaced many times since 1949. Almost every time the past has not been consulted and other countries are not consulted.

Myers: Well, if I were given the responsibility to revamp the military medical service, the first thing I would do is echo the words of Bob Rand, who ran the Rand Corporation. He said, after studying the military medical model, "this duality of responsibility provides a very convoluted logic train." Those words are just right on target. It is very difficult.

Peacetime is one thing; you could see integration working beautiful in peacetime. In wartime, no! In wartime the medic has got to be subservient to his commander in the field. Now you could have all kinds of stateside cooperation once the casualty reached stateside; that's no problem. But not in combat. There have to be separate roles in combat.

N: In your earlier interview you discussed the loss of the Air Force Veterinary Service and how that was interpreted as a step towards the purple suit medical service. Why? Because the Army took over all those functions?

Myers: Yes. That was a very definite step and it reminded me at the time it was happening about the old story about the young bull and the old bull who were standing at the foot of the hill and up the side of the hill was a whole herd of cows. The young bull said "Hey, what do you say we run up the hill, jump over the fence and get one of those cows." The old bull said "No, we're going to amble up the hill, we're going to roll under the fence, and we'll take the whole herd." Well, the old bull philosophy wasn't holding at that time. They couldn't get the whole herd. So they jumped the fence and took one cow. They took the Veterinary Service. [laughs]

Yes, that was a definite move and I can remember our people mashing their teeth and saying "Ah! that's the first step, we're going down the road now toward purple suit. If they can do it now, they can do it again." On the other hand, on reflection, with the changing role of veterinarian in today's world. Yes, that is a scenario where they could well be some integration.

I keep thinking back, Jim, that you and I came into this world and were educated in what was known as the black and white world: the Ford/ Chevrolet, the vanilla/chocolate, up/down, left/right, go/no; but that's not the world of today. The world of today is just a series of grays, all of which are just different shades. We have got to work in a more coordinated and integrated manner. We need to do these things with a degree of intelligence. One formula isn't going to fit everything.

N: In some areas integration makes more sense than others?

Myers: Yes, precisely. Let's take a very simple supposition. I don't know whether this is true or not, but let's make an assumption that Wilford Hall has a huge laundry contract with somebody in town and Brooke Army Medical Center had a laundry contract with somebody else. Why not combine that function and put a cheaper bid on it? Maybe it's being done. I don't know about that.

OPERATING PROCEDURES AND KEY ISSUES AS SURGEON GENERAL

N: As Surgeon General did you have occasion to talk to the other Services' Surgeon General one on one, face to face, or over the phone? Was there a regular meeting established?

Myers: We had a regular meeting with the Assistant Secretary of Defense for Health Affairs. When I first went up the Army and Navy Surgeons General and I had a very warm and open relationship. I wouldn't hesitate for a moment when I got a call from the Navy SGO asking for help. He would call and say, "Can you come over and have lunch with me today or can I meet with you about three o'clock this afternoon? I got an issue that is bothering me and it may effect you; let me just get your thoughts on it." I said, "I'll be right there." We did a lot of back and forth among ourselves, and that was excellent, just very wonderful. I don't know whether that existed before or whether it occurred after; but, boy, it was sure wonderful when we had that group together.

N: You mentioned that physicians' pay was a key issue. Were there any others?

Myers: Pay and retention were two major issues. Readiness was the number one issue. Then came modernization of facilities, upgrading our Air Force facilities. The next priority was our people issues, and the major people issues were retention and pay. We have discussed readiness at some length.

On facility modernization, Don Wagner was my Chief of the Medical Service Corps. By the way, you might look at this historically, but to the best of my knowledge since the Air Force Medical Service was created, he was the only general that we ever had that headed the Medical Service Corps. The Army traditionally has always had a flag officer as head of its Medical Service Corps, but we had only one, Don Wagner. He was mine. We were able to get him promoted.

Don worked intimately with the man who handled resources at the Air Staff level and the three star. We put together a facility modernization plan that was to take place over about a five year period. Melvin Laird had talked about that when he had been Secretary Defense: we had to modernize our health facilities. We made some progress. We got the new Travis hospital obviously on the books. We got Wilford Hall done. We had a new clinic made at Brooks. We upgraded a number of facilities; but we never totally succeeded in our efforts, I don't believe.

The major people issues were retention and pay, one tied to the other. The biggest issue for pay the most highly trained professionals: physicians and dentists. Congressmen Bill Nicholas from Alabama, who had lost a leg at the Battle of the Bulge in World War II, was very concerned about military pay. He was on the House Armed Service's Committee's subcommittee on pay and benefits, and he was very sympathetic. His staffer and I worked together to put together the first bill that was really generous in providing added pay for medical officers. The Air Force prior to that time had used flight pay as an incentive. If you could get on flying status, that gave you an extra two hundred and twenty-one dollars a month. Everybody was trying to get on flight pay. Now you can imagine how difficult it was to justify having the Chief of Neurology at Wilford Hall being on flying status. Eventually, the Air Force got around to taking them off. Well, the minute he was taken off flying status, the professional tended to just say "So long." We had to bring the pay up to a somewhat acceptable level. But we were always dealing with

the mentality among the physicians that said, "I need to have an income that will provide me with the lifestyle that I think I deserve as a physician." We couldn't do that.

But here is an interesting story. I've got hundreds of them. The one I tell repeatedly is about we had a man here who was the Chief of Orthopedics. He got dissatisfied with the salary, with the way that we appropriated funds. We never gave him what he thought he needed in the way of equipment. We couldn't get the right people for him. He said, "I'm leaving. I'm going to go and be the professor of Orthopedics at the University of Arkansas." I saw him some time later and said, "How are you? Are things going well?" He said, "Terrible. I left the University and I'm in private practice." I asked, "Well, why did you leave the University?" He said, "The legislature never game me enough money to operate. I couldn't get along with the Dean. I couldn't get enough people. They never bought me the equipment in a timely way." I said, "That's the song you sang in the Air Force, same verse, same words." "Yeah, I know. I know." I saw him a few years after that and said, "How do you like private practice?" "I quit." "Why?" "Can't get reliable help. People are always cheating you. You get somebody who works very well in the office and they get pregnant and leave. People don't pay you. I'm sick and tired of insurance." I said, "What are you doing now?" He said, "Running a fishing camp."

So, there is a man who went through everyone of these environments and found that the same problem exists in all those worlds. You can't make a young physician understand that. He's got to go out and find that out on his own. One year we tracked young people who left the Air Force for something else. At the end of the first year there was a significantly small percentage who were still in the first job they took when they left. Most had found that their first choice wasn't exactly what it was that they wanted at all, and they had made a major change.

But pay has become somewhat equated. As the years go by it's going to be more equated, because physician incomes are dropping with cost containment. Yes, there has been some overcrowding in specialties. For example, a Hispanic neurosurgeon down in Laredo, Texas, recently left and went back to his native Puerto Rico because he could make a go of it. Gradually, I think that pay differential will change. The pay now is pretty darn good. A young LTC or Col physician or dentist who's drawing that extra pay is doing very well. In the service, though, in the military, the question was "Should Col so and so who is Chief of Surgery at Wilford Hall be making more than the Chief of Staff of the Air Force?" That's not the parallel to draw. We should ask, "Should the Chief of Orthopedics at the University Medical Center be making as much as the Head of the NBC bank element here?" The answer is, "Certainly." So it's a little different. That was another accomplishment, that we were able to put down a great deal of unhappiness by getting that bill passed.

N: How did you handle dealing with Congress? Did you leave most of that to experts like Pat Bragg? I know you had to go up there in the spring to testify, but apart from that yearly ritual, what were the mechanisms you used to reach Congress? How much personal contact was there with staffers and individual congressmen?

Myers: I could take about ten minutes to go through that whole litany. If I started with the mindset that said people who have been elected to the House and the Senate are really outstanding people, knowledgeable, thoughtful, considerate, working for the betterment of the country...if I started with that precept, it soon changed. The people on the Hill are like anybody else; they fall on the bell curve. There are some truly outstanding members of Congress; there are some bums. The vast majority fall in the middle. I could look with pride with some of the relationships that I had. I thought they were very warm, very sincere and they believed what I said and I believed what they said. Gradually, however, Congressional staffs got to be bigger than we did. The law was if the Congress makes an inquiry you got to get back to that person in X number of hours. They had jillions of questions and jillions of people asking them and their staff grew, while ours were being reduced. We were never an even match.

I found some Congressional staffers to be absolutely tramps, who were working from the seat of their pants, and didn't know beans from shineola. They were very difficult to get along with. One of them, in his attempts to try to manipulate cost control, was working off a very shaky base. He really didn't have the numbers right, and what's more, he wouldn't listen to you or try to have some comprehension about your numbers.

Anecdote: I hadn't been Surgeon General for more than six weeks and John Stennis was chairman of the Senate Armed Services Committee, a venerable old man from Mississippi. We had a pulmonary specialist who had been through the Air Force Academy. We had sent him to medical school. We had trained him as a pulmonary specialist and he had served about a year and a half. On leave to his home, a small town in Mississippi, he happened to take care of a good friend and strong supporter of John Stennis. And this man said, "We got to have that doctor in this community." So John Stennis called me and said, "Now general, I would like very much for you to let that man out of the service." I said, "Senator, we've given him this and this and this, and the guy has only paid back a year and half. I can't." He said, "We've got to have that boy; that's all there is to it." I said, "Senator, if he went to a bank and borrowed ten thousand dollars and only paid back fifteen hundred, he'd still owe the bank, wouldn't he?" "Well, yeah, but he ain't a banker." Then he sat there, leaned back in his chair and said, "Now, general, I understand you're going to come up with some ambitious plans to modernize some of your facilities. Is that right?" I said, "Yes, indeed, Senator." He said, "I think that boy ought to go back to Mississippi. Don't you?" I got the message. The guy went out of the service and went back to Mississippi. That's a true story.

Bill Nichols, and people like Bill Nichols were great. Bob Krueger never was a political success but I found him to be a straight arrow. People talked disparagingly about Henry B. Gonzalez. When this whole Stanford thing broke, Gonzalez stood up on the floor of the House and fully supported me. I never let anybody in my presence speak ill of him. There were some good ones, but again I say it was a very difficult time because I most often found myself trying to defend a position where the staffer had already made up his mind. Then I found a guy, a real major player, whom I thought we had convinced strongly that we were on the right track. We even had him out to one of our Red Flags in

Washington. He was enthusiastic when he spoke to me, "Boy you are just doing great," and when push came to shove, he just turned turtle on me. I never understood that.

I think a lot our testimony before the Congress is sham. The questions are pre-prepared; you pre-prepare the answer that has to clear through OMB. You got to be espousing the party line, the administration line. They always tried to catch you. They'd say, "Well, now let's assume you have taken your uniform off; tell me what you are really thinking." They put you in a most unenviable position.

Then you have people like Patricia Schroeder from Colorado for year and years. She's terrible. And here's a story about Talmadge Smith, a representative from Ohio, serving on appropriations I think. When I went in talk to him about Wilford Hall, here he is sitting up there on his lofty perch as they do, and all the time I was testifying he was sitting there zipping and unzipping the zipper on his trousers. That wasn't the world I came from. [laughs]

N: I suspect you wondered, at times, why you didn't stay at Wilford Hall.

Myers: I will say this: I learned through General Schafer how to do it on the Hill, because General Jones set the mark. He prepared himself, he did his homework, he never used a book. He never took a big stack of papers with him. He went in and looked the Congressmen right in the eye and answered the question, one after the other. He never asked for anybody's else's opinion. I did the same thing. I would never read the statement. I said, "I have a written statement here and would be happy to give it to you, but let me just summarize it in these words." I tried to say as little as possible about as much as possible in the shortest period of time and not refer back to it, keeping eye contact. They got to appreciate that. They know where you're coming from. It doesn't take them long.

THE STANFORD CASE

N: Could you comment on certain larger historical and medical trends in the 1960s and 1970s that may help explain the Stanford case? Can you relate the unique, biographical aspects of the case to history?

Myers: I think I understand what you are asking. I guess the best way to deal with the structure of this whole subject is to just take some blocks first and see where they all fit. What were those blocks? Number one, just looking at the quality control in the military medical system, in comparison with the civilian world. When you talk about the civilian world at that time, we are talking about morbidity and mortality conferences, particularly related to a surgical service. All deaths were reviewed, all infections were reviewed, all poor results were reviewed. That was done in an open forum conducted by the chairman of the department. That was the academic methodology. In a not-for-profit, non-academic institution those conferences were held by all the attending people who held appointments at that hospital. They were usually well attended; very few ever failed to come to those because it was that important. That was one way to look at whether or not

people were producing the kinds of results that were expected of them and to raise issues if they weren't meeting what was considered then to be the standard.

There were chart reviews that were done also every month in both kinds of institutions, academic and non-academic. You would sit down and review all of the charts. In the academic environment that meant that the Chief or Vice-Chief of the service would sit down with resident staff and go through every record of every patient that had been discharged during the previous month. To make sure that the record was complete, that there were no missing parts, that the operative notes were included, that there were plenty of adequate progress notes, adequate laboratory reports were filed. It was really just an audit of the documents. That was another way to find out if there had been some kind of therapeutic mishap. We did that with regularity and with conscious effort in the military as well.

In the civilian world there were other interval kinds of exposures to quality control. Those were conducted by the Joint Commission on Accreditation of Hospitals. Those people came, as I remember, every two years. Now the military was as subject to that kind of review as was anybody else. That group would come in and you'd pay them a fee. So the Joint Commission would also look at the records and see whether there were any unusual trends.

There was still another review process and that was the residency review. If you had a institution in which there were people training, the residency review committees would come in and spend several days looking at the activities of that given service. Looking at what was being done, again selecting out the surgical service. What kinds of operations were being done? What were the results? Who's doing them? What were the residents doing? Who was allowed to do what at each level of training? What went on the first year, second year, third year, etc.? The residency review committee also would interview the residents and ask them of their opinion of the training they were getting and, indeed, what did they think about the quality of the teaching and the quality of the surgical procedures. That was a chance for the residents to give the residency review committee a good bit of insight into the activities of that particular service. If you were successfully reviewed, then your residency would be approved again for the next month.

The military had two additional kinds of oversight. Now, this is all before the quality control issue came into play. On of those was a system of national and local Air Force consultants. There was a national consultant to the Surgeon General in every single medical specialty. They would make periodic visits. Those people were to be used to come in and help unscramble any unusual problems; that's part of what was dictated and spoken to in a particular regulation, I think Air Force Regulation 35-4.

But we still had another control that the civilian world did not have, and that was the inspector general system, the Air Force medical IG. There was always a medical general on the IG team out at Norton AFB who would come in here with a team and spend a week or more, looking at every facet of the operation. When that IG was here, there was an open invitation to anybody on the staff who felt that there was something that needed

to be said to the IG. That was a opportunity for people to step forward and say "Hey! I've noticed that there is something medically amiss." There were all of those precautions.

I'll never forget when General Bob Dixon invited me as the Wilford Hall Commander to go to TAC and speak at one of his TAC commanders' conferences and present my views. And I gave a presentation that had to deal with the trends in America medicine and how they were affecting the Air Force. When I opened it up to questions, sitting in the very front row next to General Dixon was the Commander of the Strategic Air Command, two four-stars sitting down there. General Dixon looked to his colleagues and smiled a little bit and asked the following question, and I knew I was being set up. He said, "Well, doctor, we have as you know an inspector general system and you've explained about all the reviews that are done by outside agencies. If there are that are many being done by the outside agencies, what is the rationale for continuing with medical inspection within the Air Force through the Inspector General system? That's overkill isn't it?" I knew that they were just waiting, hoping perhaps that I would say, "Yeah! That's a good idea; we ought to do away with the medical IG." I thoroughly believed in the IG system, so I spoke with utter conviction when I answered by saying "No, that's a requirement because the same standard that is being imposed on other aspects of other Air Force operations by the use of IG to make sure those standards are being met needs to be imposed on the medical people. They should have exactly the same kind of exposure. There should be no relief from that. It is a good system that needs to stay in place." That was an honest conviction. I wasn't just saying those words because if I didn't I was going to lose my head, literally. Obviously, it was the right answer, what they wanted to hear. They asked because they wanted the line commanders to hear that the medical people were anxious to toe the mark to the same tough Air Force standards that the line was being required to meet.

We had a lot of those things in place and working. Having said all of that now, in the two-year period prior to the accusations made about the incompetence of the given surgeon, that never surfaced, by anybody who came through to look at us; in fact, we were told by a two-year review report that we had an exceptionally fine service. The controversial surgeon himself, Dr. Stanford, had a national reputation. He was recognized among his peers as being a very capable individual. So it came as a shock to me when I heard the question,...I forget whether it had come from the inspector general's office or whether it came through Dr. Cooper's queries of me... "Did you ever here that Stanford was known as the Porter Loring professor of thoracic surgery?" I said, "I've never heard that before." Well, Porter Loring is the leading local mortician here in San Antonio. I'd never heard of that. Nobody had ever come to me with the slightest suspicion, questioning this man's confidence. As I pointed out earlier there was a problem with Dr. Stanford: his personality was such that he was extraordinarily dictatorial in attitudes; but a huge ego is not an unusual finding in anybody who is doing a lot of high risk surgery.

N: I've heard that.

Myers: That's well known, and in my own particular specialty we've always looked at awe at some of the leading figures of America neurosurgery. My own chief was an

absolute tyrant in the operating room. That was just a way of life -- profanity, explosive behavior, instrument throwing, and knuckle-rapping. Knuckle-rapping is taking an instrument and rapping the knuckles of your assistants who weren't doing well. There are some incredible stories, embellished over the years obviously, about some of these people and their behavior. But at Wilford Hall we were having enormous problems in trying to run the same volume of work through an organization that was being severely taxed because of operating room deficiencies, not only in size, but staff, air conditioning problems, and what not.

The result of the whole Stanford investigation was a real boost and implemented the quality control measures that all of American medicine was experiencing. I think it speeded the process, and in the end it was a good thing like many other things that occur as a result of reflex reaction to some kind of critical situation. There was probably more done in quality control that needed to be done. It took a while for it to settle back and find its rightful place, and I think that's in effect now.

In the 1970s there were many incidents that made for media involvement -- they just all seemed to fall at one time. There was the business scandal at Walter Reed with the Chief of Anesthesia. There was the cardiothoracic surgeon at the National Navy Medical Center, who had severe difficulties with his vision, and was felt to be incompetent. It was just a field day for the media to pick up on all of these things, and try to prove incompetence.

But then that isn't unusual; the military has always been subject to severe media criticism and congressional criticism. It's there, and we are a favorite institution to pick on. We had alleged cost overruns in weapon development, for instance. We were just fair game.

Within the media in the 1970s there was a remarkable revival in investigative reporting. That seemed to be the name of the game, led certainly by the CBS "60 Minutes" crew. That became a very popular kind of method, and it always smacked of William Randolph Heart yellow journalism to me -- take a piece of information out of context and make it look terrible by only telling part of the story.

Then -- if I may for just a moment digress -- I guess one of the reasons I think this all happened is summed up in a phrase I heard applied to this whole process -- "information float time." That means, How long does it take for a piece of information to get to form point A to point B? Well, here's a classic anecdotal example. When Abraham Lincoln was assassinated, the Manchester Guardian got the story about ten days afterwards. It took that long, perhaps even longer. When Ronald Reagan was shot, the editor of the Manchester Guardian phoned his Washington correspondents and said "Tell me about the attempted assassination of President Reagan," and the man in Washington said, "What attempt?" Meaning that the information float time was now measured in microseconds; that the editor overseas knew about it long before the fellow who was on the local scene knew about it. That's in contrast to the time it took for the information to reach him at the time of Lincoln's shooting.

The point of that whole story is in that today's world the information float time is so brief that when something breaks, the media goes and gets what it can in a very short period of time, without any opportunity to really find out what the facts are. It gets in the paper because if it doesn't or it gets on television, they've lost money, because they are not going to sell as many newspapers. That brief information float time precipitates this kind of reporting, in my personal opinion. That's terrible, because if the information is incorrect then you can't go back and reshoot it with any degree of creditability. The damage is done, and that's precisely what happened.

N: Earlier you referred to professional credentials review committees that were being set up through the Air Force. This sounds like a new initiative.

Myers: Yes. In addition to the credentialing process, which was in effect at that time, that was new -- reviewing an individual's credentials and determining what it is that they could and could not do. What was their training? What was their experience? What was their capability? The credentialing review committee would determine whether or not that person had the privileges to do x, y, z.

This other process was really an assessment of the individual's results, and the main criticism that I had of the data that was initially released to the media was that they took a forty-three percent mortality rate that had been calculated over a very brief period of time. It did not reflect a year or two or three or four or five, which it should have. It was a snapshot of a very narrow window. My old professor of neurosurgery, I can recall vividly, Dr. Campbell, lost three or four patients in a row who had an especially difficult tumor on their spinal nerve. I can remember him being utterly dejected and depressed, saying "I will never operate on one of these people again. I just will not do it; it's just terrible. These are unacceptable results and I'm just not going to do it anymore." Of course, all the ten years prior to that and in the following years after he had just had one success after another. You cannot take a snapshot over a brief period of time and use that as a standard of incompetence.

N: This is why I raised the question, because it's clear that the various studies and data sets that were presented early on were all based on different methods, different snapshots. Was the field of professional review really in that much flux at the time so that there was no agreed methodology?

Myers: That's correct. We had five separate sets of data presented to me, none of which matched. They were all different because nobody was using the same formula. It became very obvious then that we needed some standard. What we had was one fellow using a yardstick and another was using a metric rule, somebody else was using a piece of string with no marks on it all. It never was subjected to a good solid statistical analysis. What we needed to do was find the right formula and do it in a statistically objective way to measure results. That was the reason for this move to create that capability.

N: Was this the quality assurance movement that developed after all this was over?

Myers: We began developing it during that period of time. Actually, when I became Surgeon General that whole process was already being developed, if my memory serves me correctly, but the process became accelerated when this Stanford case broke several years later. It's in place today; in fact it's all over.

You see, there were many good things that came of this controversy. It made the states look at licensing; it made them look harder. It provoked requirements among the board and the state licensing bureau to ensure that individuals who are practicing medicine were spending time in continuing education programs, that those had been requirements. It provoked on the part of many specialty boards the requirement to take an examination at intervals to make sure that you were staying with the whole program, that you were technically up on the racer's edge. It provoked an exchange of information between states on credentialing and licensing, and if somebody was found to be incompetent or what we call in a "disadvantaged position" because of alcohol and substance abuse of some kind and was denied licensure, it ensured that he couldn't go to the state next door and get a license, that that information was being exchanged. It provoked a number of very positive things. That was the good part. The bad part was that it became media circus, initially. I have mentioned that it was at a time when investigative reporting was reaching its zenith. All younger journalists, perhaps I would include middle age as well, were out to see if they could win a Pulitzer prize by uncovering something that was of great magnitude and they would be recognized, etc.

N: You've mentioned that certain individuals seemed to be disruptive here at Wilford Hall; certain individuals who were involved in some of these accusations had a history of being disruptive in various ways. Do you think that they reflecting for some reason a lack of respect for authority? It was growing in the United States at that time.

Myers: Well, I don't think that there was any doubt on the part of some individuals. That was very true. We had some unique individuals who were wearing the uniform. Particularly in the medical centers it was in the late 60s and 70s. You had those people coming out of a dedicated education, many of them liberally oriented and now suddenly thrust into a highly structured, very well disciplined organization -- the military, where there was conformity. To see how much of a problem we had, all you had to do was to look at one symptom. We required haircuts that conformed to military regulations, and we had constant problems with getting people to conform to the haircut regulations, not only among the officers but among the enlisted personnel as well. We had a very famous case here, when I was a commander, of a man, a blood blank technician, who wore a wig. When that was discovered the matter got to me. He wore a wig which conformed to the regulations, while his long hair was tucked underneath the wig. He was in my office and I ordered him to remove his wig, so I could examine his hair, and he refused to take the wig off. We wrestled with that thing for a long time.

Oddly enough, there is a follow-up on that story. About 2 or 3 years ago a fellow approached me at a golf course locally here and he said, "My name is so and so, and you won't remember me by looking at me, but I'm the guy that was wearing the wig." He was very well groomed and he looked like he was quite successful. He had obviously left the

service and he said "I want to share something with you, General. You know, I was real bad guy in those days. Over the years I've just come to respect you for the stand you were taking. Obviously, I was just a damn rebel and I realize the error, but it took me a long time to understand that." I thought, "Gee, at least we've got a contributing citizen here." [laughs]

N: Better late than never.

Myers: Yes, better late than never. But the Air Force Medical Service was not well received here in those days. The training instructors there on the other side of Lackland, who were involved in the training of basics, were always complaining to their superiors how the medics were getting away with murder. They didn't wear their uniform right. They didn't know how to salute. They didn't get a haircut. They didn't shine their shoes.

I remember going over and in an auditorium over on the other side, in a theater facing hundreds of these instructors and also the center commander, a two star general. I explained to them that we had a harder program for our officers and enlisted personnel than they did. They altered their perception. We had a whole lot of kitchen workers who wore white, and many of them were Hispanic civilians, and anybody the instructors saw in white was automatically a medic.

But non-conformity was a problem we wrestled with regularly, specifically among the young people who were coming in to do a short two-year tour. They knew they were only here for two years. They had come many of them from very sophisticated training programs. They were highly skilled. They were anxious to demonstrate their capabilities, and when they ran up against somebody who was their senior who had to wear two hats, one a professional hat as the physician/surgeon and the other as a superior officer, the young person could handle one but not the other. They could handle the professional side reasonably well, but they officer they couldn't.

N: One other way to look at the accusations that were made against Dr. Stanford is to see it as an instance of what you call being "these horrible conflicts of personality" that are always going to exist, something in human nature. In the medical world, how often did you see this kind of conflict in your career? Have you seen a lot of this hostility among professionals?

Myers: I don't know that it was any more frequent or infrequent than among a group of engineers, a group of chemists, any group of highly trained individuals who are somewhat egomaniacal. But in my own professional life I have seen remarkable hostility. In the civilian community I've seen it. On one occasion I can remember it literally destroyed a man, this incredible hostility between two individuals, both of whom were surgeons. Then I saw a lot of it just in the Medical Service. It occurred at high levels at times. It occurred at low levels. Wherever there is an issue that can become polarized, the ability to communicate breaks down and there's just abject hostility between the individuals representing those two extreme positions.

Have I painted enough of a background mural?

N: Yes, certainly. I think that all of that it does put the whole Stanford case in context of how it developed, when you consider the larger picture, the big picture.

Myers: It was a reflection of the times. There's no question about it.

N: How did this affect you and your last year as Surgeon General?

Myers: Well, it was personally devastating to read in the press the vehement comments that I till this day feel were absolutely unjustified. I don't think that in any way, shape, or form it degraded any performance that was required of me in the carrying out of my responsibilities, other than to cause an inroad on whatever time was available. But from the very beginning when the thing first broke, I went directly without invitation to the Air Force Inspector General and related to him the entire story and also briefed the Chief.

The part that disturbed me so greatly, too, was the accusation of a cover-up. The record clearly shows that this was discussed with General Schafer, the Surgeon General, and he in turn informed General McBride who was the Vice Chief of Staff. I had gone to the Inspector General and told him about it. I don't know where this cover-up business originated, except perhaps that it was conjured up in the mind of an investigative reporter. As I pointed out in the material that you already read, to this day I have great difficulty understanding why it was that the Atlanta Constitution as a newspaper took this on. Why were they so intrigued with this, and why did they send two reporters to the court room in Milwaukee? And you know the connections. The connections were that the anesthesiologist in the case went to Emory University, number one, and number two, Sam Nunn was on the Senate Armed Services Committee and he was from Georgia.

N: Sir, when I look at all the investigations the only criticism against you that continued to persuade some well-informed people, such as the DOD Cooper investigation, was that you did not take strong enough management action to resolve this crisis early on. The implication of the final Congressional report is that you should have been stronger in removing Dr. Stanford from responsibility and more quickly accepting the accusations against Dr. Stanford. Could you comment on that?

As an alternative approach, could you have, once you got the report from Dr. Ebert, just announced that the accusations were unproven and everyone should just get back to work? I wonder what your thought process was right there when you received Dr. Ebert's report? Did it occur to you that maybe you should just do nothing at this point and just get back to normal?

Myers: No, that wasn't a possibility.

Let's just go back a minute and talk about the criticism about not taking definitive action. That is also untrue. First of all, when the data was brought to me, the initial data, I said to Beckman "Go back, and do this again more carefully with greater precision." We were

struggling with this so-called executive committee that I mentioned and trying to determine what options we had to exercise. Meanwhile, I put into effect some fourteen constraints, right then and there. You noticed that I called my former commander, who was then Secretary of the American Board of Surgery, General Humphreys, and I asked his advice early on. His advice was rather non-committal. I think, if I remember rightly, he spoke to getting the consultant in Dr. Ebert, and Dr. Ebert just couldn't come at the time. He couldn't come until September, and this was May. Meanwhile, other reports were coming in, some five. So I had insufficient data really at that point, but the restrictions that I imposed stood, and indeed Stanford voluntarily stepped aside. A commander, like the captain of the ship, has to be very careful that when somebody's pointing a finger at someone else, that you do not reflexively overreact, because that is destructive to the individual who's being accused.

I mentioned in many remarks that I have made since that I still think that the premise of this nation is that legally you're innocent until proven guilty. Knowing Dr. Stanford's reputation, having been associated with him for years, having never heard anything detrimental prior to this, I wanted to be sure I did not destroy a human being by overreacting. If I was going to act, I was going to act on hard data. Meanwhile, I felt that we should constrain Dr. Stanford to some degree, but Dr. Ebert's letter came and he said "Gosh! I don't see a problem. You ought to do some kind of selection of cases." When I went to the cardiologists with this recommendation, they said they didn't want to do that. So I told General Schafer we had clearance, and General Schafer went the Vice Chief of Staff and said, "Hey, we are OK; we're on track." That was when Dr. Stanford said, "I'd like to go and do a sabbatical," and it came to my mind "Hey, that is a good idea."

N: He initiated it?

Myers: Yes, and I said, "I subscribe to that, that's a good idea." For the simple reason that it would give me an opportunity to have someone else outside the military, his peers if you will, actually watch him at the operating room table. That would be really worthwhile. He went to Milwaukee, and I got these glowing letters from those people.

N: If he had said "I want to stay here at Wilford Hall," would that have caused a problem with the cardiologists, since they were the ones who...?

Myers: I probably would have reassigned him to something else. We discussed that in the review. We talked about another assignment for him. Those were options that I was leaving open. I also wrote a letter, and it's strange indeed that that letter disappeared from my file; it's never been found. I wrote him a personal letter before he returned and I said that Dr. Knauf, who was acting Chief, was going to review all cases that you elect to in the operating suite, and before they are done he is to determine whether they should be done or not and is to watch and monitor the procedure. Stanford agreed to that, reluctantly, but he agreed to it.

N: So you had some consideration, some concern that lingered after the Ebert report?

Myers: It's because I kept hearing these sayings that I never heard before like the "Porter Loring professor of surgery" from my own staff. Stanford was kind of rough, and I just wanted to be absolutely certain for the patients' benefit. That's all I was ever trying to protect, the patients. I thought these things ought to be seriously considered.

That concern never appeared anywhere in this Cooper review: all those constraints were done in spite of the fact that Ebert said we didn't have a problem. That was never ever considered.

N: When you became aware of the details of the trial in Milwaukee, did you think Dr. Stanford was again being unjustly accused?

Myers: There were many elements in that trial.

One, it was getting an incredible amount of publicity through the Atlanta Constitution, which was reporting on it everyday. Two, the judge was extremely anti-military; he was unbelievable. I've been courtroom many times, and I never saw anybody as biased as that man was. In fact, he delivered a scathing denunciation Dr. Stanford personally. It was unbelievable the way he took Dr. Stanford down as a human being, and treated him as a criminal. He talked about his arrogance, and he went on and on about it. The plaintiff's attorney was really an outstanding lawyer. He was really good. He was very provocative, and he knew he had me when he got me mad, when he got me angry. So that reduced the effectiveness, I think, of my testimony. I know in retrospect that we didn't have the world's best government attorneys either. They could have been a lot more effective in their presentation.

Can you imagine this transpiring in ultra-liberal Milwaukee, Wisconsin, with all of us showing up in uniforms. We were the bad guys, and we didn't have a prayer. We were before the hanging judge, that's all there was to it. The case was about a terrible, terrible error, and certainly the plaintiffs deserved some compensation; there's no doubt about that. But in the environment and the climate in which this all took place, you just knew what the outcome was going to be.

N: It's really ironical that it really did not directly concern Dr. Stanford's own skill as a surgeon per se.

Myers: Yes, that's right. You've made an excellent point. This has absolutely nothing to do with his manual dexterity, nothing. But the problem got lumped into what is called "surgical competence."

N: Later on, when OSD became involved in this issue, Dr. John F. Beary III, Acting Assistant Secretary of Defense for Health Affairs, testified before Congress that he had received some threats. I haven't seen the text of the testimony. Am I correct that that was a Congressional testimony and that he received some kind of threat?

Myers: I wasn't aware that he had any threats until that appeared in the paper.

N: I never saw a follow-up on that.

Myers: Yes, the article was on the front page of the Washington Times. Here is a copy of it. It says that Dr. Beary testified before a Congressional subcommittee that he had been threatened.

I don't know by whom. I have no idea, but I was told by General Leaf... I don't know whether that appears in any of the documentation you've looked through...but when this thing was all over, General Leaf said to me, "There is reason to believe..." and I don't know who his source was "...that there was a conspiracy developed against you." That was from the Inspector General himself.

So when Dr. Beary talks about being threatened, the other side of that coin is that the Air Force Inspector General himself felt that there was a conspiracy that had been put together to get me.

N: I don't remember seeing General Leaf's statement.

Myers: We never ever were able to determine anything about this alleged threat. I couldn't understand Dr. Berry's position. Here was a very young inexperienced individual who has been the number two guy under Moxley. He suddenly is thrust in as acting deputy.

I remember telling him in detail about this whole thing. I also remember telling him specifically (I went over one day to his office), "Dr. Beary, I know how difficult it must be for you to serve in this acting role, and I just wanted to tell you that I, as the Surgeon General of Air Force, have great appreciation for the good work you're doing." He was very grateful about it, we shook hands, and I left. The next thing I knew Berry was in league with Caspar Weinberger to hang me from the nearest yardarm. Weinberger had his mind made up. I think Carlucci had his mind made up.

But Mr. Vernon Orr, the Secretary of the Air Force, wrote Mr. Weinberger a letter and showed it to me. It was one of the strongest pieces of correspondence I have ever seen. It said that if they forced me to retire as major general rather than lieutenant general it would be a gross injustice. I think that carried the day over at the White House, no doubt about it. The former Chief, Lew Allen, was incensed. A general officer policy letter that was distributed among the generals when General Gabriel became commander had the entire issue devoted to this subject. The conclusion was that "We're behind our Surgeon General 100 percent." Those things never came out later on, either.

N: That's all I have of a broad nature on that topic.

Myers: I don't know whether you knew, but "60 Minutes" was to do a piece a few years ago on Dr. Michael Carey, a former Air Force doctor who was practicing in New Orleans. Mike Wallace [of CBS, who made the original accusations against General Myers on public television] called me and said, "60 Minutes" wants to talk to you about a

show. The producer of the show is in San Antonio." I said, "Well I'll tell you what. You guys killed me, and my resentment is very high, and I'm not sure I want to talk to you. But I'll tell you what I'll do. I'm got a friend, a respected member of the media, formerly the president of the NBC television outlet in San Antonio, If you want to come talk to me in his office, in his presence, and I record the whole conversation I'll do it, and we'll lay the groundwork on what to talk about." This CBS producer came down and I thought he was very honest and above board. I said "I'd like to speak in Dr. Carey's defense, but I want a guarantee from you all that you aren't going to make any reference to the previous program in which you killed me. I don't want this distorted in any way and I want to review the tape before it is shown. I want those guarantees." He said, "I think we can do that, but I'm not too sure."

So he went back to New York and he called me on the phone and he said, "I got the OK from the higher-ups. I'll send you a letter confirming that." So I said OK, and the next call I had was from Mike Wallace himself. He said, "I want to meet you in New Orleans to talk to you." I responded, "I'm still kind of waffling a little; I'll have to let you know. Because of what you did to me, I don't trust you." He said he really wanted to talk to me. I said, "Well, I'll close one more loop. I'll go to the president of the American Association of Neurological Surgeons and ask his advice." I wanted to know what he would think, what the folks in that huge neurosurgical association would think. When I asked them, the answer was, "Don't trust Mike Wallace any farther than you can throw him." So I called Wallace back and called it off. He pleaded with me again, and I said, "No way, you can't be trusted."

So I did have some interface with those guys years afterwards. It was very difficult for me to even talk to them. I felt real sorry for the producer of that new show, however, because I thought he had been pretty straight forward.

N: Did it make you think a lot about the state of the American libel law and what you can do and cannot do as a public official?

Myers: Oh, yes. I went to one of the more notorious attorneys in San Antonio, and I said I want to go after CBS. He said, "You got a million dollars?" I said, "Of course I haven't. I've worked for the federal government all my life. I haven't got two nickels. Can you take it on a contingency basis?" He said no. I was ready to do battle.

N: I have some documents you might like to read.

[Dr. Myers reads documents on the Stanford case provided by Dr. Nanney. General Myers decides to read his reactions into the taperecorder.]

Myers: This a continuation of an interview that I've had with Dr. Jim Nanney, the chief historian in the Surgeon General's Office, on the 12 April 1995. We have covered a great deal of my professional activities in the Air Force, particularly as Commander of Wilford Hall and Surgeon General. As one might expect, some time was given over to the

Stanford case, the infamous events that occurred in 1978. They were brought to life through a CBS "60 Minutes" program that aired in 1982.

What Dr. Nanney has shown me today are some documents that were turned over to him by the Air Force's Judge Advocate Office and that I had never seen before. Some of them are very, very interesting. Not the least concerns the infamous OER [officer efficiency rating] that appeared on the front page of the Atlanta Constitution, which was an evaluation of Dr. Stanford. Both Dr. Sparks and Dr. Buckley -- who were the chiefs of hospital services and surgery at the time -- denied ever signing it. The OSI [Office of Special Investigations] report implies very strongly that there was deception in testimony provided. I recall that the secretary to Dr. Buckley refused to any statement of any kind. What comes out of the OSI investigation is that there was some degree of involvement by the two secretaries and by the Chief of Surgery. That's information that I was not privy to before today. The OSI document has no implication that I had anything to do with that OER preparation.

There are other documents which came from the Air Force Inspector General's office. There is also an overview report pointing out that the [Col. Russell, U.S. Army] Zaichek report and the report by the Society for Thoracic Surgeons disclosed Dr. Stanford's mortality rates to be at 19 or 20 percent, nowhere near the 45 percent that was alleged by Dr. Akins and publicized through the "60 Minutes" presentation. There is also an unsigned report by one of the investigators, the "chief investigator" from General Leaf's office, who clearly supports the position that I had taken at the time. This conclusion was reached after an extensive investigation in which some two thousands pages of testimony were taken.

There are two copies of two letters signed by then Secretary of the Air Force, Mr. Vernon Orr, one written to Senator John Tower in July of 1983, saying that Dr. Orr fully supported my position and recommended my retirement in the highest grade held. The other was a memorandum dated January 5, 1983, which is a memorandum for the President of the United States. This memorandum accompanied a memorandum from Secretary Weinberger, which said that I should be punished by retirement in the permanent grade of major general. To quote directly for Mr. Orr's letter to the President:

> "This is a recommendation with which I most strongly disagree. The disagreement is shared by the present and former chiefs of staff of the Air Force. "

It goes on to say that Secretary Weinberger has generously permitted me to convey to you our reasons for disagreement. This is a very supportive letter recommending that I be retired as lieutenant general. In the last paragraph, however, it says, "In view of his [General Myers'] lack of more prompt action, an announcement could be made that various procedures have been undertaken in the Air Force medical branch to ensure that such situations do not occur again." (I might say, parenthetically, that reforms were made.)

The letter also says that "the officer [General Myers] has been reprimanded for not taking more prompt action, but that his judgment in this case is not considered to be sufficiently faulty to warrant the extreme punishment of failure to retire him at the highest grade which he reached."

To set the record straight, I was never, ever reprimanded by anybody. So I really don't know what the reference is here where it says the officer has been reprimanded. If by that it's meant that maybe Mr. Orr or somebody said, "Gee, you could have done it differently" -- if that's what 's being said, I guess that did take place. But nobody put the long, bony finger on my nose and said "You've been bad."

N: I have one final question about the IG document you were looking at this morning, the memorandum of 2 September 1982 from the Chief Investigator to General Leaf. It says:

> I'm convinced that in his mind that at that time Gen. Myers felt that question of surgical competency was resolved in Stanford's favor. He was also convinced that Dr. Stanford had to go for other reasons. How was the only question.

Does that summarize your state of mind at that time?

Myers: I don't think that is accurate, no. Now, my retrospectoscope is a little blurred since that was along time ago. But I think really what I was trying to say at the time was that Dr. Ebert had solved for me the question of excessive mortality rates. What lingered, however, was [a doubt about] the overall competency [of Dr. Stanford]. Enough had been raised in discussion with the staff that I needed to take some kind of action which would show the staff that I was sensitive to what they were saying. But I was also somewhat protective of Dr. Stanford, and that's why I recommended that he go on do the sabbatical and that he come back and have a trial of observation to firmly establish in their minds that he was capable and competent, and that that would put the matter to rest forever. I thought that if I did anything less than that, there would be lingering doubts.

N: It sounds as if quite a few members of the staff were aware of the...

Myers: As soon as the accusation was made, some of the rumblings begin to appear and people felt a little more courageous in what they were saying -- "Oh yeah, I knew that," and so on.

The sabbatical also was a way to try to see if we couldn't find some other solution to the problem of Stanford being dictatorial, abrasive, and so on, and to get that surgical problem resolved. I really didn't know how to do that.

N: So you had two concerns even after the mortality rates were disposed of -- about the overall surgical capability and also the issue of officer efficiency ratings?

Myers: What I was shooting for was the very thing that I was accused of not doing in the management world. I wanted to do two things: a) to make certain that this kind of issue didn't come up again in relation to Dr. Stanford, and that there would be resurgence of confidence in his capability; and b) I wanted to also do what I could to protect Dr Stanford, even though it wasn't perceived by him as being a protective action. He thought that I was overcontrolling him, and there was no need for that; and yet he had asked for the sabbatical himself. We could have -- if the unfortunate mishap in Milwaukee had not happened -- have taken the letters that had been sent to me by the people out there, with whom he had been training, and presented those to the senior staff here, and said "Here, look, we'll put an end to this right now; here are the reports."

It also in retrospect would have provided a precedent for anything like that ever came up in the future: To review that whole process and see how we could enhance it, improve it, taking logical steps. It's the old business of decision-making. As you know, there are three major types of decision. First, the generic decision, for which there is some kind of protocol, because the problem has come up so many times you have figured out a way to handle it. You can just look it up in the reference and find out how to solve it. Second, there is the unique decision, which doesn't quite fit that pattern, and requires alittle more thought and discernment. Third, and finally, there is the unusual problem, and that's where leadership comes in, because the thing has never come up before and you have to make some kind of decision that you have no precedent for. I was thinking that the sabbatical would give us an opportunity to have a reference frame for anything like that in the future.

So this summary is not accurate. I wasn't terribly convinced that Dr. Stanford had to go.

Let's make some assumptions. If he had come back from the sabbatical, if the accident in Milwaukee had not occurred, if he had become abrasive and disruptive, I did not want him on my staff. I would have moved him, like I would have moved anybody else of that ilk. On the other hand, if he had come back and they [in Milwuakee] had said, "He just doesn't cut it. He just shouldn't be in this business," then he would have to go. But that didn't happen either.

By the way, I have read what I said earlier on the Stanford case in my interview with Dr. [Raymond] Crawford [USAF, MC], and I don't think I would change a word of that. It's still exactly as I remember it, even after the interval of time that has taken place since then. Anything I have said here in no way conflicts with what is in there.

N: Thank you very much, sir.