

## **Walter Reed National Military Medical Center (B)**

### **Integrating Army and Navy Cultures at the New Walter Reed**

In the summer of 2011, two historic military hospitals in Washington, D.C., merged. The Walter Reed Army Medical Center closed its century-old campus in northern Washington and joined the National Naval Medical Center at its longtime base five miles away in Bethesda, Maryland. The combined facility was renamed the Walter Reed National Military Medical Center (WRNMMC). Intended to help rein in the Pentagon's steadily rising health care costs, this consolidation was the centerpiece of a 2005 congressionally mandated reorganization of the U.S. military's medical activities in the region.<sup>1</sup> Prior to the merger, each military service—the Army, Navy and Air Force—ran its own medical system, creating redundancies and expensive overhead. Although Walter Reed and Bethesda Naval had been the premier medical institutions of their services, many in the Pentagon and Congress saw their proximity to one another as an especially glaring example of waste in the military health system. The 2005 legislation combining Walter Reed and Bethesda Naval into one “joint” hospital was unprecedented in both scope and scale. The projected cost of the reforms was \$829 million. In the end, the capital region's medical reorganization would cost more than \$3 billion and constitute one of the largest single investments in the history of the Department of Defense.

From the beginning, the plan was fraught with difficulty. There was no clear leader to oversee the reorganization. Instead, the legislation called on the Army and Navy to rise above their entrenched service loyalties and cooperate in a spirit of “jointness.” As a result, the first two years of the merger were characterized by confusion, competition and stalling. Adding to the political and logistical struggles was the fact that the merger had been ordered in a time of war. With a high number of casualties flowing in from Iraq and Afghanistan, there were deepening concerns about whether the plan would diminish the quality of care to patients. Then, in 2007, Walter Reed was embroiled in a scandal over the dilapidated state of its outpatient residential facilities. The resulting scrutiny from Congress and the press distracted military medical officials from the hospital merger and drove up costs. Finally, a joint task force created to take control of the merger in the wake of the Walter Reed scandal met significant bureaucratic hurdles in achieving that task.\* The three-star admiral appointed to lead the joint task force spent more than two years just trying to secure the proper authorities to make decisions concerning everything from governance structures to allocating construction funds to the placement of personnel.

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\* See Case (A): VADM John Mateczun and JTF CapMed.

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Controversy dogged the merger of Walter Reed and Bethesda Naval throughout the six years it took to complete. Almost all of the disputes that arose between the merger's supporters and detractors had to do in some way with the problem of integrating the hospitals' cultures. On the surface, Walter Reed and Bethesda Naval were two military hospitals, five miles apart, delivering essentially the same medical treatment to thousands of military personnel and their families. Indeed, the Base Realignment and Closure Commission (BRAC), the congressionally empowered body that meets every few years to cut down on expensive, underused or redundant military real estate, and that recommended the merger in the first place, viewed the hospitals just that way. The hope was that the consolidation would be a straightforward process of finding and exploiting efficiencies. But to treat the hospitals' realignment as a merger of equals was to ignore the idiosyncrasies and the basic cultural gulf between the two services that in many ways made Army and Navy provisions of health care more different than alike. For the merger of Walter Reed and Bethesda Naval to be successful ultimately required a full accounting of and appreciation for the two hospitals' prevailing cultures.

### **Differences in Army and Navy Culture**

The BRAC-mandated merger required the collaboration of thousands of members of the Army and Navy, the military's two largest services. The Army and Navy are almost incomprehensibly complex organizations, and ascribing individual traits to institutions with millions of members can be problematic.<sup>2</sup> Nevertheless, each service is identifiable by its unique mission, history, procedures and language—in short, its culture, or what Carl Builder, in his book *The Masks of War*, calls “service personality.”<sup>3</sup>

First and foremost, the Army and Navy differ in the principles they revere and the ideals they cherish. Over the centuries, the Navy has clung to its traditions, characterized in part by the rigid professionalism the service inherited from the Royal Navy and evident today in virtually every Navy action. Among the most important of Navy traditions is the idea of the independent command at sea.<sup>4</sup> Before reliable worldwide communications through radio, ship captains, cut off from the watchful eye of superior commanders or friendly forces that might rescue them in an emergency, were solely responsible for the sailors and equipment under their commands. This helps explain why today's Navy tends to bristle at intrusions in its affairs from Washington, particularly regarding command and control.<sup>5</sup> By contrast, the Army has historically been able to communicate along all levels of command and maintain synchronous action among its units. Naval command is reserved for truly independent organizations such as ships, and command is often not obtained until 15 years of service and achieving the rank of Commander. The Army begins command at the Company level, an organization generally too small to independently supply itself. A Company commander is an officer with as few as 4 years of service, and the more junior rank of Captain. This leads to an Army view of command that involves interdependence, teamwork, and synchronicity of action. Sebastian Juenger provides a salient example of this thinking in his book *War*, stating “The reason First Platoon did not get wiped out...was because the men reacted not as individuals but as a unit. Stripped to its essence...[combat is] much more like football... The unit that choreographs their actions best usually wins. They might take casualties, but they win.”<sup>6</sup>

Second, the Army and Navy differ in how they interpret and respond to changes in the respective size of their services.<sup>7</sup> The Army's most salient measure of strength is the number of people in the force, and it will usually

advocate for more soldiers not fewer. But the Army is often unruffled by decreases in this most basic resource, accustomed as it has become over time to the expansion and contraction of the force as the demands of national security change.<sup>8</sup> The Navy, on the other hand, constantly worries about any reduction in the size of its fleet.<sup>9</sup> There are both technological and historical reasons for this difference. The time needed to manufacture an aircraft carrier (6 years for the USS George H.W. Bush, the newest Nimitz-class supercarrier) is considerably longer than that needed to train an infantryman; indeed, it is longer than many wars. Article 1, Section 8 of the US Constitution speaks to the fluctuating size of the Army and constant size of the Navy, stating that Congress has the power “To raise and support armies, but no appropriation of money to that use shall be for a longer term than two years” but simply “To provide and maintain a navy”.

Third, the Army and Navy diverge in where their systems place value. While people in the Army tend to take their greatest pride in the skills of soldiering, Navy personnel are more likely to be proudest of their loyalty to the Navy as an institution.<sup>10</sup> The Navy retains highly stratified distinctions among its personnel, creating rigid hierarchies and divisions<sup>11</sup>—surface ships versus submarines, sea- versus land-based aviators, etc. In the Army, though, the distinct branches—infantry, artillery, armor (tanks)—are more about bragging rights and identity than explicit markers of future promotion and power.<sup>12</sup>

Finally, while the Navy has fretted about its relevance since the advent of air power and the atomic bomb, the Army remains supremely confident in its role as the military’s one indispensable service: Army leaders believe there will always be a need for boots on the ground, regardless of the nature of specific military operations.<sup>13</sup>

### **Differences in Service Medical Systems**

These distinct “personalities” of the Army and Navy are evident in the design and management of their medical systems. Although Walter Reed and Bethesda Naval were the most famous medical centers in the Army and Navy, they were only two of dozens of hospitals across the globe governed and funded by either the Army Medical Department (AMEDD) or the Navy’s Bureau of Medicine and Surgery (BUMED).

The AMEDD and the BUMED are the ultimate medical authorities in the military,<sup>†</sup> doing everything from managing medical appropriations to credentialing doctors to publishing safety standards. Doctors and administrators operate within these systems in a hierarchy of responsibility called a chain of command with each service’s Surgeon General, a three-star medical officer, at the top, overseeing all medical affairs. The Surgeons General have command authority and answer to each service’s top officer: the Army Chief of Staff and the Chief of Naval Operations. (Unlike in the Army and Navy medical systems, the Air Force Surgeon General does not have command over hospitals and clinics but does exercise policy oversight.)

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<sup>†</sup> The AMEDD and the BUMED make up only a part of the wider military health system, a confederated system of care with the primary mission to keep troops medically ready to serve in the nation’s defense. This system provides coverage to active duty personnel, retirees and their families—including everything from basic primary care to complex neurosurgery—through the Defense Department’s insurance program, known as TRICARE. With a rapidly growing budget of more than \$50 billion and a beneficiary pool of almost 10 million people, the military health system is one of the largest medical systems in the United States.

The AMEDD is as old as the Army itself, even though its name has changed over the years. It was founded as the “Army Hospital” in 1775 to coordinate the care of soldiers in Washington’s Continental Army. (Benjamin Rush, a prominent Philadelphia physician and signer of the Declaration of Independence, wrote the first American preventive medicine guidelines for the Army’s doctors.) The size and scope of the AMEDD have grown significantly since the American Revolution, as the nature of war itself has changed, but its basic mission of providing medical care for soldiers has remained the same. Today the AMEDD coordinates the activities of six “special branches”: the Medical, Nurse, Dental, Veterinary, Medical Service and Medical Specialist Corps. The Surgeon General who commands the AMEDD comes from one of the six Corps and is usually a physician.

The BUMED, created by an Act of Congress in 1842, was meant to serve as one of five pillars in a modernizing American Navy, the others being the Bureaus of Naval Yards and Docks; Construction, Equipment and Repairs; Provisions and Clothing; and Ordnance and Hydrography.<sup>14</sup> The Navy’s bureaus resemble the highly specialized functions assigned to various officers on a ship and remain the foundational structure of America’s sea service. Like in the AMEDD, the BUMED’s Surgeon General is a three-star admiral—usually a doctor—who has risen through the Navy medical ranks.

The merger would require the unprecedented colocation and cooperation of hundreds of doctors, nurses and civilian staff from the AMEDD and the BUMED.

## **Two Historic Hospitals**

Walter Reed and Bethesda Naval were the preeminent medical institutions of the Army and Navy. Their cultures reflected those of their parent services, and their structures conformed to the standards and cultures of the AMEDD and the BUMED. But they were also iconic institutions in their own right, boasting reputations for medical excellence. Merging the two meant integrating all of these various cultures, standards and traditions.

Walter Reed Army Medical Center, founded in 1909 and named for the Army physician whose groundbreaking work attributed yellow fever transmission to mosquitoes,<sup>15</sup> was the crown jewel of Army medicine. From its Georgia Avenue location five miles north of downtown Washington, Walter Reed had always provided top-quality care to soldiers, retirees and their families as well as elected government officials—President Eisenhower spent his final days there in 1969. By the end of the 20<sup>th</sup> century, the hospital had gained worldwide name recognition.

In 2005, Walter Reed was a 2.8 million square-foot, 294-bed hospital with a patient load of 189 people per day. It was also a teaching hospital and a research facility. As one of the military’s largest hospitals, it was a worldwide referral center for every kind of patient in the Army’s medical network. But it was in “warrior care”—the treatment of troops wounded in battle—that Walter Reed most excelled. The medical center had recently become known as the best facility on the planet for cutting-edge prosthetics research and amputee rehabilitation, making it invaluable as the Iraq and Afghanistan wars wore on.<sup>16</sup>

Bethesda Naval was the flagship of Navy medicine. The hospital was the largest facility in the Navy’s smaller, more decentralized medical system. Although it was the Navy’s most visible medical facility, it was not a referral center. It served instead as a community hospital focusing on family and patient care for naval personnel in the

national capital region.<sup>17</sup> In 2005, Bethesda was half the size of Walter Reed, covering 1.4 million square feet; it hosted two-thirds as many beds (196) and saw only 60 percent of Walter Reed’s daily patient load (113).

Founded in 1940 by President Franklin Roosevelt, Bethesda Naval had a devoted workforce, proud of its long history of providing care to sailors and Marines. The hospital is a famous landmark in the Washington DC region, with a tall central tower which from the air resembles a giant map pin. Another source of pride for its employees was Bethesda Naval’s status as the “President’s Hospital,” treating all the Commanders in Chief since its founding. Even today, almost an entire floor of the main tower is a highly secure suite where the sitting president receives all medical care. Because of its location on the medical evacuation route from Iraq and Afghanistan, since 2001, Bethesda Naval also became an evacuation center for wounded Marines, although it saw fewer casualties than Walter Reed.

### *Need for a Merger*

Because the medical activities of the Army and Navy operate independently of one another and rely on their “parent” services for funding, capabilities are inevitably duplicated, from the Surgeons General of each facility on down. Army and Navy heart surgeons perform the same types of clinical procedures in their separate hospitals, Army and Navy nurses are indistinguishable but for their uniforms, and so on. For decades, studies have questioned the need for this duplication. The issue rose to the forefront as military health care costs ballooned.<sup>‡</sup>

To address the issue, Pentagon officials revived a debate almost as old as the Defense Department: how to reorganize the confederated military health system. One idea that had emerged in previous attempts at reform—consolidating Army, Navy and Air Force medical systems into a “unified medical command,” resourced from the very top—gained new support at the Pentagon. This scheme had never been popular among the services, which preferred to keep their own medical systems. The services’ brass argued that each of their medical activities had unique skills and requirements that were valuable on the battlefield and would be undermined by combining their efforts.<sup>18</sup>

Nevertheless, in 2005 the Pentagon saw an opportunity to test whether the military might be ready for a more streamlined arrangement. It looked to its own backyard as an opportune place to conduct an experiment. The Washington area contained an enormous patient pool of more than half a million members of the military, retirees and their families—not to mention members of Congress, federal judges and even the President of the United States.<sup>19</sup>

### *Base Realignment and Closure Commission (BRAC)*

In November 2005, the Defense Department recommended—and Congress enacted into law—the closure of Walter Reed and its realignment with Bethesda Naval. The merger’s deadline was set for September 2011. The six-year plan, unprecedented in size and expense, originated in the Base Realignment and Closure Commission (BRAC) that met every few years to scuttle underused or overpriced military real estate.

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<sup>‡</sup> Between 2001 and 2011, military medical spending rose from \$24 billion to \$52 billion, a faster growth rate than Medicaid and Medicare.

The BRAC's plan left many details fuzzy. But the core decision to close down Walter Reed while preserving Bethesda Naval seemed unfair to many Army employees at Walter Reed, particularly to the civilians who had worked at Walter Reed for years. The hospitals, which had operated for decades in the spirit of healthy competition, were ordered to combine their campuses to form a new "joint" center at Bethesda. As one officer said, "It was like learning that Harvard would close and join Yale in New Haven."<sup>20</sup>

The BRAC considerations were based on practical grounds. "The BRAC is a very analytical process," said Gordon England, Secretary of the Navy during the BRAC's evaluations. "It's not about people."<sup>21</sup> The Walter Reed campus was almost a century old, and its buildings were in need of major restoration.<sup>22</sup> It was also difficult for patients to get to. Nestled between Georgia Avenue and 16<sup>th</sup> St. NW at the northern tip of the diamond that forms the boundaries of Washington, D.C., the campus no longer enjoyed the geographic isolation it did when it was founded in 1909. The city had literally grown up around the campus, making it an anachronistic oasis in Washington's congested urban sprawl. The National Naval Medical Center was 30 years younger than Walter Reed, and its location in the affluent suburb of Bethesda, Maryland, some 10 miles north of Washington, D.C., close to the highway and sharing a Metro stop with the National Institutes of Health, made it easier to access. Moreover, there was more land available on the Bethesda campus, with room to expand the facilities.<sup>23</sup>

### *Fusing Service Cultures through "Jointness"*

The BRAC's decision to combine Walter Reed and Bethesda Naval was made primarily to cut medical costs. But it was also done in the spirit of "jointness," a military-wide strategy for operational cooperation among the services that had gained favor since the 1980s.<sup>24</sup> Conventional Army and Navy line officers had grown accustomed to working together on tactical missions and had become familiar with each other's systems and processes. However, the military's medical officers had been specifically exempted from the new "joint" policy.<sup>25</sup> Facing the prospect of creating a new "joint" hospital, the Navy's well-known resistance to any change that might weaken its power or influence quickly resurfaced, and it hunkered down for a fight. The Army, after a period of stunned disbelief, eventually let go of its attachment to the deteriorating facilities at Walter Reed and prepared for the next chapter.

### **Problems Integrating**

The November 2005 decision to close Walter Reed sent shock waves through the entire military. The profound sense of disbelief that descended on the hospital reverberated throughout the wider Army. The thousands of medical personnel who had spent their formative professional years at Walter Reed experienced something akin to the loss and grief of a death in the family. Down the road in Bethesda, however, the mood was jubilant. Personnel welcomed the news with a mix of relief and triumph. There were fist-pumps and backslapping all around. "It was like a Hail Mary at a football game," one administrator present during the announcement said.<sup>26</sup> It was a reaction that perhaps ignored the fact that Walter Reed was not going away, but rather that room would have to be made at Bethesda to absorb it—doctors, patients and all.

The iconic status of Walter Reed and Bethesda Naval, the pride their respective services took in them and the loyalty and dedication of the medical officers and the thousands of doctors, nurses, medics, Corpsmen and

administrators—uniformed and civilian—who had learned and honed their craft at the facilities meant that the two cultures clashed over the merger in ways large and small. There were three main areas of contention: choosing a name for the new institution, integrating the workforce and deciding how the new hospital would be governed.

### **The Name “Walter Reed”**

From the moment the BRAC’s decision was announced, nothing produced more acrimony than the hospital’s new name. The law decreed that the newly merged hospital at Bethesda would be called “Walter Reed National Military Medical Center,” a name strikingly close to the name of the Army’s current campus (“Walter Reed National Army Medical Center”). This touched off huge controversy. “An enormous amount of energy was expended on this issue,” said Colonel Charles Callahan, an Army physician and administrator at both Walter Reed and Bethesda Naval who was intimately involved in the merger.<sup>27</sup>

Losing the Walter Reed campus was traumatic for the Army, and preserving its name in the newly merged hospital at Bethesda was supposed to be a small but important consolation. Many powerful people in Washington shared that feeling, including the President. “On a visit to Walter Reed in 2006, President Bush pulled me aside,” Callahan recalled. “He asked me, ‘Are you gonna keep the name? It’s really important.’ And I’m thinking to myself, ‘Yes sir, it’s in the law.’”<sup>28</sup>

Proponents of the Walter Reed name pointed out that it already enjoyed worldwide name recognition. “I had a resident who spent a month on the Ugandan-Kenyan border,” said Lieutenant General Eric Schoomaker, a former Army Surgeon General who once commanded Walter Reed Hospital. “[She was] out a day’s trip in a Land Rover, where no roads were, and came to a village on the frontier.... They spoke no English, but they knew the name Walter Reed Hospital.”

Not surprisingly, the Navy saw things differently. The Navy felt that the Walter Reed name had been inserted into the BRAC’s legislation without any public discussion and despite its strong opposition. Indeed, officials at Bethesda Naval interpreted the proposed name as an indication of the Army’s plans to take over. At the time, Bethesda Naval’s campus had all the trappings of a Navy hospital—a large anchor in front of the famous tower, the brass-ringed lobby entrance to the facility; even the hospital commander’s office was decorated to look like a ship captain’s quarters. But taking on the old Army name would have a more powerful impact than any anchor statue. The Walter Reed name would give the Army a victory in the battle over branding.<sup>29</sup> “It was a direct and personal and emotional threat [to the Navy],” said one staffer.<sup>30</sup>

The fight carried on for years. Employees at both Walter Reed and Bethesda Naval coined their own competing nicknames for the facilities, like the “New Bethesda on Wisconsin Avenue” or the “New Walter Reed on Wisconsin Avenue.”<sup>31</sup> (As late as 2010, Colonel Callahan and another merger-friendly Navy officer tried without success to break the cycle by going out of their way to refer to the future hospital as “Walter Reed – Bethesda,” “WRB” or even the clumsy acronym of WRNMMC-B. Even proposals for a new hospital logo pitted the services against one another. An impasse over its design, which leaders at Bethesda Naval wanted to include an image of

the hospital tower in exchange for the Walter Reed name, was never resolved. “Symbols matter; they become the core artifacts of culture,” Callahan said.<sup>32</sup>

## **Merging the Workforce**

The most formidable challenge in consolidating the two cultures was in finding common ground for the hospitals’ combined workforce of more than 7,000 doctors, nurses, medical and support staff after the merger. They had grown up in two distinct systems with separate policies and procedures. With thousands of severely wounded patients arriving from Iraq and Afghanistan, it was imperative that the staff be able to function at the highest and most effective levels.

There were three major obstacles: overcoming the prejudices each hospital’s workers held about their counterparts in the opposite service, harmonizing operational procedures in a way that would be acceptable to both services, and finally the logistical strain of moving Walter Reed’s workforce into Bethesda Naval’s facilities.

### *Overcoming Cultural Biases*

Since operating in a spirit of “jointness” had never been asked of the military medical community, service parochialism at Walter Reed and Bethesda Naval remained ingrained. Personnel at each hospital harbored suspicions about the other’s command culture and operations based on generalizations about Army and Navy culture that bordered on caricature. But these stereotypes were not entirely unfounded.

Army personnel tend to approach problems as battlefields, where “controlled anarchy” and chaos are accepted features that commanders factor into mission planning. Their instinct is to throw more resources into the fight: more troops, more weapons, more ammunition, more “stuff.” Battlefield commanders are delegated relatively wide latitude to improvise as situations evolve.<sup>33</sup> As a result, it is often more effective—and more virtuous for a commander to follow a higher commander’s intent, rather than the strict dictates of an order. A clever, resourceful general is preferable to an overly obedient one. Flexibility trumps procedure.<sup>34</sup>

The Navy, by contrast, sees adherence to procedure and process as essential qualities in its leaders. A ship at sea is a closed system that lacks the ability to absorb mistakes the way a well-supplied ground force can. Anarchy and mutiny are the ultimate enemies. On a battleship, there is no room for more people and stuff, so risks are mitigated and problems solved through the implementation—and modification when necessary—of scrupulous procedures and processes.<sup>35</sup> This aversion to risk also influences notions of command in the Navy. The captain of a ship disappearing over the horizon is “God on Earth,”<sup>36</sup> exercising a degree of autonomous power over his sailors that is unparalleled elsewhere in the military. In an environment where small mistakes can have catastrophic consequences, minor infractions are often severely punished.

These antithetical images—the enterprising commander on a smoke-filled battlefield versus the authoritarian ship captain with no tolerance for miscalculation—permeate the culture at every level of the Army and Navy, including their medical systems. In the years leading up to the 2005 BRAC decision there had been little cross-facility collaboration between Walter Reed and Bethesda Hospitals. Forced to merge their operations, leaders at each hospital viewed their counterparts with suspicion and resentment.

Officers on each side used bellicose language to describe their predictions of how the other side would approach the merger. “Don’t give up the ship! Fight her till she sinks!”<sup>37</sup> said Callahan, conjuring the famous dying command of an American ship captain in the War of 1812 to illustrate a common Army view of the Navy’s position. To Bethesda Naval, Walter Reed was a Trojan Horse: once the Army made it through its gates on Wisconsin Avenue, the proud Navy hospital would be irreparably transformed.

“The Army is an acquisition force,” said Vice Admiral Matthew Nathan, Commander of Bethesda Naval during the latter half of the consolidation.

It fights by acquiring. It takes the hill, and then it takes the next hill, then it takes the next hill. It sets up in a place, and it stays for a long time. They call their bases forts. And they’re logistically intensive because they’re going to create an occupational zone that’s going to stay for a while and push the bad guy off their own field of play.

Nathan continued:

So when people would come to me and they would say, “Walter Reed just seems like it kind of wants to take this land over,” I’d say, “Well, yeah, that’s what the Army does.” I mean, that’s how they succeed. It’s not malevolence.... It’s just simply their cultural ethos.<sup>38</sup>

How long it would take to overcome these ingrained perceptions—whether exaggerated or not—was anyone’s guess. At best, it might just take a readjustment period as each side became comfortable working in proximity. At worst, it would take a generation or more until all the pre-merger officials had moved on.

#### *Adapting to Unfamiliar Policies and Procedures*

Walter Reed and Bethesda adhered to different policies and procedures in the day-to-day delivery of care—a situation that at times undermined leaders’ sincere efforts at team building.

The clinical rounds performed by Army medics and Navy Corpsmen provide one example. Medics and Corpsmen hold virtually the same positions in the Army and Navy: they are enlisted personnel trained to provide the first level of care to the wounded in tactical environments or, in a domestic hospital setting, to perform basic medical functions in support of doctors and nurses—checking in patients, drawing blood, taking vitals, etc. However, working alongside one another on the clinic floor revealed the nuanced discrepancies in their roles. Corpsmen had greater practice privileges than medics. Navy medical policy authorized them to hang intravenous drip bags, for instance, a procedure denied to medics by Army rules.

Making matters more awkward, hospital-based Corpsmen generally had far less experience than medics, who tended to spend their first years out in “the force” among tactical units and then show up in clinical settings when they were non-commissioned officers. Ironically, a land-based hospital was often a Corpsman’s first ship. “The Corpsmen had to be treated as first-term sailors, but medics were sort of grizzled,” Callahan said. “What you had was young inexperienced Corpsmen with a lot of privileges and older, more experienced medics with fewer

privileges. If that isn't a formula for resentment I don't know what is." (The eventual solution was a unique training and privileging process for Army medics that gave them all the authorizations Corpsmen enjoyed).<sup>39</sup>

Even high-ranking officers like Callahan had trouble adjusting to the new joint environment. Once, in a disciplinary proceeding for a sailor who tested positive for marijuana in a drug test, Callahan invoked his discretion as an Army officer to grant leniency to the remorseful young man (part of the sailor's pay would be withheld and he would lose rank). Callahan told him that if he learned from this mistake, he would have a bright future in the Navy. But other naval officers standing behind the sailor were appalled. In the Navy, drug use is punishable by automatic discharge from the service - no exceptions. "He was out of the Navy within 10 days," Callahan said. "If members of the three different services commit the same infraction, they are punished in three different ways."<sup>40</sup>

### *Wall Hangings, Chairs, and Rumors*

In the final months before the September 2011 merger, employees at Walter Reed and Bethesda Naval dug in. At Walter Reed, the prospect of moving to Bethesda Naval cast a pall of uncertainty over the workforce.

Years of poor communication about how the transition and integration of hospital staffs would proceed produced a vacuum in which misinformation flourished. "There was a rumor that shuttles to other facilities in the NCR, which were very useful, would be ended," said Colonel John Gaal, Deputy Commander for Administration at Walter Reed during its final years. "I checked up on this. There was never any intent to stop them." Gaal held weekly meetings with officials at Bethesda to identify the most outrageous rumors and collect evidence to refute them. Rumors included: "Bethesda did not give out Blackberries. Bethesda did not have laptops. Bethesda did not use e-mail." All were untrue.<sup>41</sup> Walter Reed personnel were nevertheless convinced that as newcomers to Bethesda Naval they would be short-changed, with the Navy grabbing all the best amenities. "Every staff member wanted to know *exactly* where they were going to work at Bethesda," Gaal said. "There was so much uncertainty. 'I don't know where I'm gonna sit,' they would say. I kept asking people at Bethesda for that information, but I was told not to worry about it."

Army personnel tried to cling to the physical remnants of their time at Walter Reed. Many would have brought every brick if they could have. "We might need this," was a frequent refrain.<sup>42</sup> Chairs were of particular sentimental value. A delay in the delivery of new chairs to outfit the refurbished Bethesda Naval opened a window for Walter Reed staff to make the case for bringing along their old chairs. Some claimed doctor-ordered "accommodations" that required use of their current chair. Gaal had to track down these claims. "In some extreme cases, the chairs were broken, with wheels and arms missing. I realized that chairs were the one thing people could control, and we were taking them away" Gaal said. "That's when people figured out the move was real."

It wasn't just chairs. Virtually everyone at Walter Reed with a desk printer insisted on bringing it to the new office spaces, Gaal remembered. Desk printers were sometimes easier to use than communal LAN printers, especially if a doctor had to get up and leave a patient to retrieve a printout, but security and contract issues made the desk printers problematic. "The drama over not having a printer was so great, for the people I let bring one I became a hero."<sup>43</sup>

Parking was another headache. Rumor was the parking at Bethesda was bad and likely to get worse; the Navy would snatch up all the good spots. “They just wanted to be angry with the Navy facility,” Gaal said, adding that parking at Walter Reed wasn’t so great either. Other complaints (such as the sprawling layout of Bethesda Naval or the fact that its buildings had numbers— instead of names like the Army’s) —added to the growing list of gripes.<sup>44</sup> Right before the merger deadline, emotions boiled over. One of Gaal’s subordinate officers came to him panic-stricken that the hospital was not inventorying all equipment before the move, some of it decades old and remaining behind. “You just don’t understand!” she pleaded through tears.<sup>45</sup>

While Walter Reed’s workforce prepared for their big move, Bethesda Naval’s workforce girded for the merger like a ship about to be boarded by pirates, relying on established policies and procedures to guide them through it.<sup>46</sup> Sincere efforts to peacefully welcome their Army counterparts were made, but Navy discipline was heavily tested. At one point during the move, for example, a policy about hanging items on the wall brought the Bethesda Naval staff close to mutiny.

Before the arrival of Walter Reed staff, Navy personnel had been allowed to move into some of the new office spaces, provided they did not make themselves permanent. That meant no hanging pictures or anything else on the walls since workspaces would inevitably be compressed when the Army got there, and it was simply too difficult to keep patching up the walls. However, because the order made its way down from the command suite with little context, Navy personnel took it to mean that hanging pictures would never be allowed. When the Army showed up and began hanging pictures in defiance of the order, the obedient Navy staff simmered over the outrage until Gaal finally clarified the policy as only temporary. Even so, one long-retired Army doctor still working at Walter Reed was so angered by the policy that he hung his many framed accolades from the ceiling tiles by strings.<sup>47</sup>

## **Governance**

The BRAC’s decision to merge Walter Reed and Bethesda Naval brought the Army and Navy to loggerheads over how the new Walter Reed hospital (and other clinical facilities in the Washington region) would be governed, a controversy that played out on two levels. First, there was the question of how much autonomy the Navy would retain in managing its medical activities after a joint task force had been established in 2007 to “take control” of the merger. At a lower level, hospital officials struggled to redesign the administrative structures of Army and Navy hospitals into a hybrid system that each service could adapt to.

### *Governance from on High: Walter Reed Scandal and JTF CapMed*

During the first two years after the merger was announced, Army and Navy medical officers allowed themselves the hope that Walter Reed would not actually close. And even if it did, the expectation, particularly in the Navy, was that things at Bethesda Naval would not change all that much.

Then, in 2007, a series of exposés in the *Washington Post* revealed that wounded warriors in Walter Reed’s outpatient residential facilities were dwelling in moldy, filthy, and dangerously under-maintained buildings.<sup>48</sup> Though the revelations did not center on the quality of medical care, the crisis turned into a full-blown scandal that

shook Army medicine to the core. The national media descended on the hospital for weeks. Congress launched investigations. The Secretary of the Army, the Army Surgeon General and Walter Reed's commander were all fired.

Spurred by the nation-wide call for action, the Pentagon sped up plans for the establishment of a coordinating command called Joint Task Force National Capital Region-Medical (JTF CapMed) that would make decisions about the merger, resolve disputes among Army and Navy hospital leaders and prevent something like the Walter Reed scandal from happening again. John Mateczun, a two-star Navy admiral and psychiatrist nearing the end of his career, was appointed as JTF CapMed's commander – with a direct reporting line to the Deputy Secretary of Defense.

The mission of JTF CapMed was to ensure the timely and successful merger of Walter Reed with Bethesda Naval by the 2011 deadline and to oversee the consolidated medical activities at the new Walter Reed and other clinical facilities in the national capital region thereafter, although for just how long remained unclear. Mateczun immediately focused on the big challenges, particularly designing a new governance structure for the military's medical activities in Washington. The model he chose designated Walter Reed as a fully "joint" hospital run by neither the Army nor the Navy. Instead, future commanders of the merged hospital would alternate between Army and Navy officers, leading a mixed workforce of soldiers, sailors and Marines. Most controversially, the commanders would report to JTF CapMed, not to the medical chain of command in their own services.

However, since JTF CapMed's lifespan and authorities were vague, subordinate hospital commands like those at Walter Reed and Bethesda Naval had some latitude to resist Mateczun's efforts. The Army was generally compliant with the new governance plan. In a way they were forced to accept it: Walter Reed was shutting down, and the powers that be had decided they would move in with the Navy at Bethesda. The Navy, on the other hand, pushed back against the notion that they would answer to anyone other than the Navy Surgeon General, much less allow Bethesda to run like something other than a Navy hospital, no matter what the BRAC had decided to call it.

In addition, the cloud of the Walter Reed scandal polluted the atmosphere at Bethesda Naval. There was worry that Army medicine's tarnished brand might threaten its reputation or, worse, bring down its quality of care. Though the Army hospital's problems had been infrastructural, not medical, and Walter Reed's fate was written two years before the scandal, many in Bethesda Naval's workforce now took the view that the hospital was shutting down as a result of something it had done wrong. "We didn't get BRACed," was a phrase that Callahan, a fresh Army member of Bethesda Naval's command team, frequently overheard.<sup>49</sup>

Right up until the merger, the issue of who would govern the new Walter Reed—JTF CapMed, the Navy, or someone else—was a source of ongoing animosity.

### *Redesigning Internal Hospital Governance*

The other governance challenge in merging Walter Reed and Bethesda Naval concerned the hospitals' internal structures, at the clinical and administrative level. Close to two centuries of independent operation had produced systems that were more different than alike in critical ways. For example, each service has its own criteria to certify and evaluate physicians.<sup>50</sup> In terms of basic organization and governance, the two flagship hospitals each followed the distinctive models of their respective services.

The governance of a large Army hospital is comparable to that of an Army division, a fundamental tactical unit of modern armies. The commander enjoys overall authority and responsibility for all the facility's operations and is supported during his or her term by an administrative staff and "deputy commanders" who oversee and report on clinical services, administration, nursing, and other activities. Because, like in the rest of the Army, the turnover for these command positions is high (approximately every 3 years) the center of gravity of governance for the hospitals usually rests with "clinical department chiefs" — for surgery, OBGYN, pediatrics, etc.— who tend to serve in those positions for many years. This lower echelon of management is where institutional knowledge resides.<sup>51</sup>

The governance of a Navy hospital, by contrast, again resembles the organization of a Navy ship at sea. The command structure is hierarchical. The commanding officer is at the helm, aided by an executive officer, an enlisted command master chief and the deputy commander. Unlike deputy commanders in an Army hospital, this deputy commander serves primarily as the hospital's chief operating officer and is regarded as a protégé to the top officer—a commander-in-training. The hospital is broken up into highly compartmentalized directorates like nursing, dentistry, surgery, medicine, and behavioral health, echoing the sharp divisions of labor on ships. The directorates answer to deputy commanders, who answer to the hospital's chief of staff, who answers to the commander. The Navy's deputy commanders have greater access to and sway with their hospital commanders than in the Army, if less institutional heft.<sup>52</sup>

Both the Army and Navy hospital governance systems were vaguely familiar to officers at the opposing facilities, but not enough to forestall the confusion in trying to integrate them. One problem was vocabulary. Officers at Walter Reed and Bethesda shared familiarity with the language of military hospital governance, but remained ignorant of the different meanings each side ascribed to the same words. Terms like "commander," "chief," "department," "deputy," and "executive" were mutable and interchangeable. For example the "center of gravity" for both Bethesda Naval and Walter Reed was the "chief," but the word implied a different position in an Army hospital than in a Navy one.<sup>53</sup> The communication breakdown led to confusion about title, position, rank and status, a huge source of anxiety.

Addressing these misunderstandings fell to the Deputy Commanders for Integration and Transition, new positions at Walter Reed and Bethesda Naval that were created to merge the hospital's governance structures into a hybrid framework. The task required reverse engineering each hospital's structure, analyzing their component parts, assessing their utility and then patching them together in a coherent, efficient and fair way. At Bethesda Naval the position was filled by an officer brought in from Walter Reed. At Walter Reed, Navy doctor Captain Lou Damiano, was assigned to fill the same role.

After learning Walter Reed's systems from an Army colonel assigned as his assistant,<sup>54</sup> Damiano set about designing an altogether new command and administrative structure. This brought intense scrutiny from entrenched constituencies within each hospital. "Integrations don't come with a map," Damiano said. "They come with guiding principles. I spent a lot of time trying to find out intent."<sup>55</sup> (An option to simply select either the Army's or the Navy's governance structure was quickly dismissed as too politically volatile.) Callahan later wrote about the initiative in the *Naval War College Review*:

The practical governance structure and system for the new hospital had to be developed to allow adequate authority to rest with the deputy commanders while still allowing scope for the influence and leadership of the new integrated clinical department chiefs, many of whom had served in these roles for many years at [Walter Reed].<sup>56</sup>

Damiano knew that the structural imbalances between the two institutions meant any solution was bound to create winners and losers. He toiled for months, mapping the functions of commanders, administrators, physicians and other staff at each facility in an effort to synchronize the centers of power at each hospital. There were the hundreds of clinical jobs that, thanks to the stove piping between the AMEDD and the BUMED, had evolved incompatible coding, pay scales and qualifications for otherwise identical positions. “It was a very complicated matrix, and I was trying to keep everybody happy,” Damiano said. In an effort to be fair, he came up with a rule of thumb. “The Phone Call Test is whether I can pick up the phone from here and find my counterpart there. If that could not happen, then something was not working.” In the end, Damiano had to elevate the official titles of some workers and demote others. It was an unavoidable outcome that he tried to minimize. “I didn’t want to castrate everybody,” he said.<sup>57</sup>

The hybrid structure of the new Walter Reed would not be an Army system or a Navy one, but something new, combining elements of both. The management org chart would be flatter than a Navy hospital’s but more hierarchical than an Army one. The center of power would be vested in integrated service chiefs, positions that would be open to clinical leaders from Walter Reed and Bethesda after the merger deadline. Those chiefs would report to a hospital chief of staff, with authorities similar to those of deputy commander in a Navy hospital.

## **Final Result**

By late 2010, anxiety over the merger turned to panic as signs of change appeared everywhere at Bethesda Naval. Heavy machinery hammered away at several construction sites—more clinical space, offices and parking would be needed to absorb the influx of new hospital staff. More Army camouflage appeared around base, with doctors and administrators from Walter Reed beginning to filter in. Fear set in that an invasion of Army personnel would create a culture not of synergy and cooperation, but of scarcity and competition. The Walter Reed name continued to be particularly painful for the Navy to accept. Once, during a discussion with a Navy captain about the merger, Callahan was stunned when the captain shouted at him, “We gave you the goddamn name! What else do you want?”<sup>58</sup>

Bethesda Naval’s commander at the time, Admiral Matthew Nathan, worked hard to foster a climate of acceptance among the hospital personnel. To that end, he invited Callahan and a handful of other Army officers to occupy top posts on his staff in advance of the merger deadline, a decision that chafed even the Navy Surgeon General. Nathan also worked to manage anxiety in the ranks.

I had to be a cheerleader. I had to make sure that everybody understood that as a leader, I embraced service culture. So whenever I talked in a forum, I always made sure that I said a couple of things. I always made sure [to say] that I expected each service to

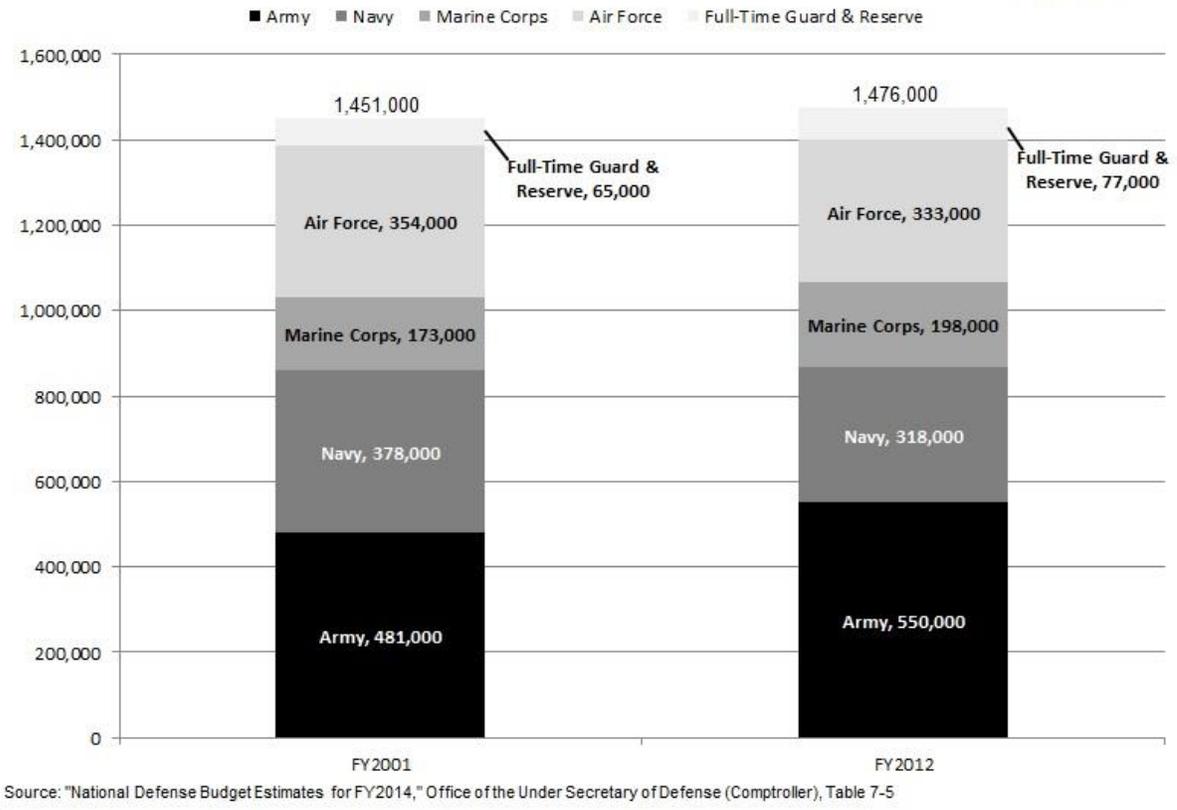
retain their traditions and their heraldry, that we weren't going to give those up, that Army should be proud of all those things that make it Army.... I also said to people, "If you want to be a dinosaur that dies in a tar pit, that's fine. We'll step over your body and move on as you fossilize and disappear, but the rest of us are going to move and build something that the nation's never seen before" .... And you try to go after their worst nightmare. What's their worst nightmare? Their loss of their beloved icons and heraldry.<sup>59</sup>

On Sept. 15, 2011, the old Walter Reed closed forever, and the new Walter Reed National Military Medical Center at Bethesda was born. The merger deadline had been met, but it was clear to everyone that the envisioned "joint service" facility would still take time to congeal. In the first year after the merger, the hospital seemed in some ways more like an Army and Navy hospital clumsily layered on top of one another, like two radio broadcasts competing on the same frequency. Finding a sharper signal would take time.

The recriminations and trauma of the previous six years continued to rankle among the Army and Navy staffs. It would take time for those wounds to heal. "We were creating a new culture, and that takes time," said an Army two-star general involved in the merger. "We didn't have the luxury of an open-ended timeline to force this change."<sup>60</sup> Questions lingered about whether the controversial hospital merger would withstand political pressure from naysayers in Congress and the Defense Department, who were never sold on the idea of a purely joint hospital. Would they try to roll back some of the features of integration to recapture the autonomy each service lost in consolidating?

# Active Duty Military Personnel

## EXHIBIT 1



# Military Service Advertising Campaigns Exhibit 2



Source: Military Service Recruiting Websites

Base Realignment and Closure Actions					Exhibit 3		
Service	Action	1988	1991	1993	1995	2005	Total
Army	Close	76	9	2	28	12	127
	Realign	9	15	6	10	6	46
Navy	Close	6	15	105	35	5	166
	Realign	1	19	26	6	12	64
Marine Corps	Close	0	1	5	0	0	6
	Realign	0	0	4	0	1	5
Air Force	Close	5	12	8	7	5	37
	Realign	0	5	3	6	12	26
Defense-Wide	Close	2	1	16	8	0	27
	Realign	0	0	2	2	2	6
"Minor Closures & Realignments"		n.a.	n.a.	n.a.	n.a.	685	685
<b>Total</b>		<b>99</b>	<b>77</b>	<b>177</b>	<b>102</b>	<b>740</b>	<b>1195</b>

Sources

1988 - 1995 Data: *Final Report of the Defense Base Closure and Realignment Commission, Appendix F*

2005 Data: *2005 Defense Base Closure and Realignment Commission Process Briefing*, 06 Oct 2005.

Supplementary Information: 1988, 1993, & 1995 BRAC Commission Final Reports

Notes

"Relocate" actions are categorized as "realign."

"Disestablish" actions are categorized as "close."

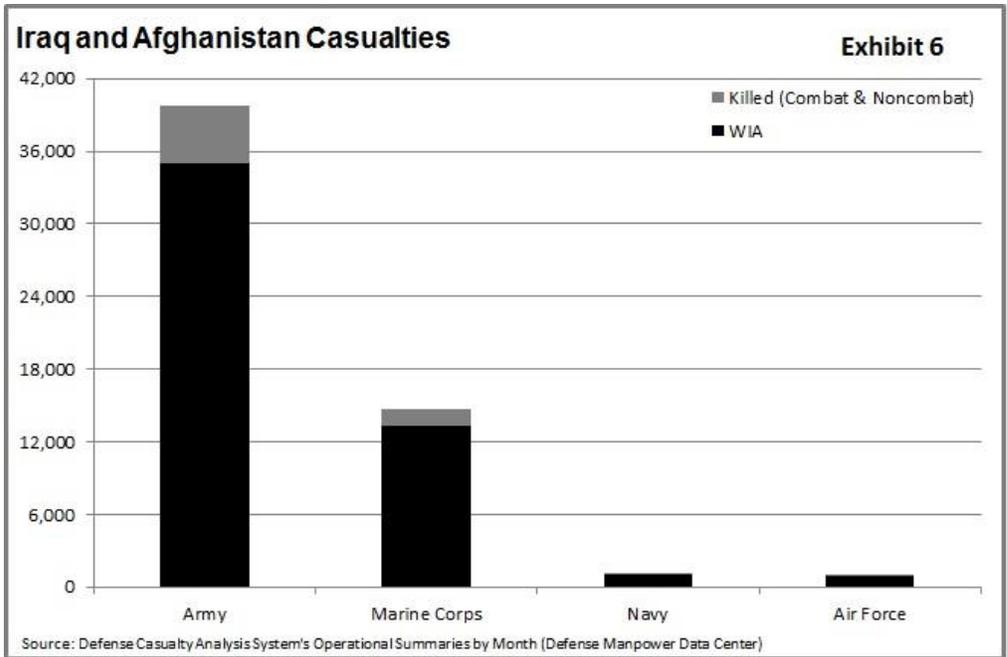
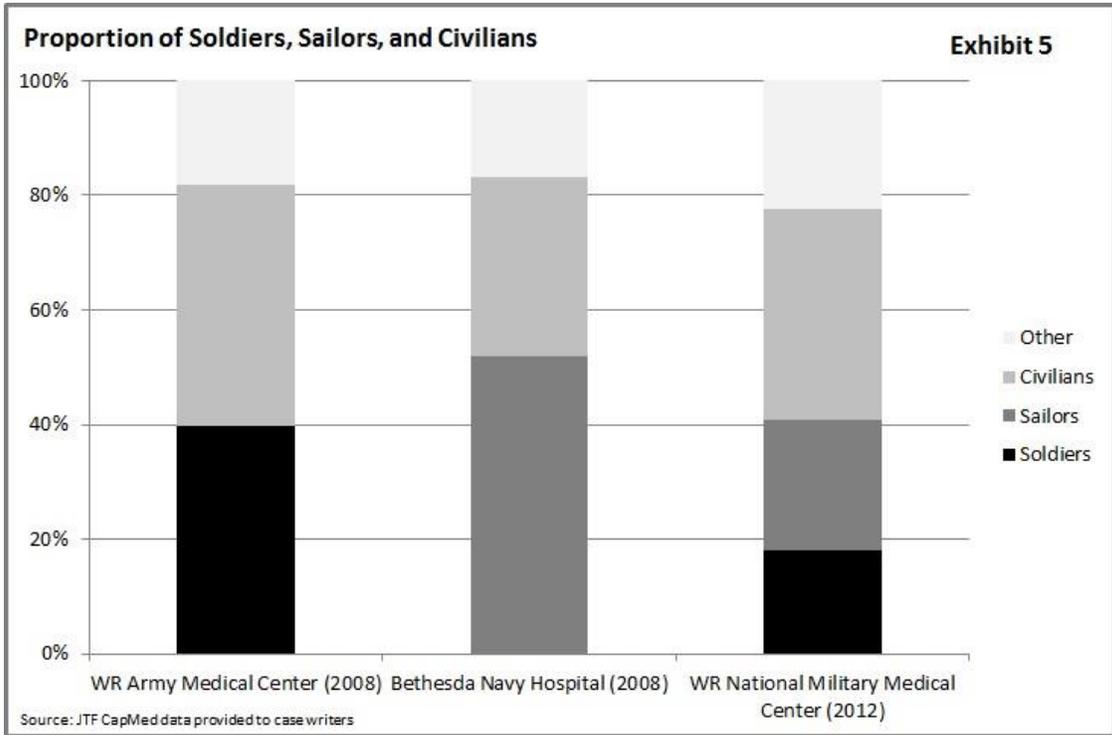
"Redirect" actions are Redirects excluded

2005 is the only year in which some actions are summarized as "minor closures and realignments."

	Facility and Personnel Infrastructure		Exhibit 4
	WR Army Medical Center (2008)*	Bethesda Navy Hospital (2008)*	WR National Military Medical Center (2012)*
Beds	242	216	345
Total Inpatient Admissions	9,880	9,727	12,212
Total Outpatient Encounters	744,973	561,751	1,125,407
Total ER Encounters	17,293	19,607	26,739
Physicians	736	555	1,227
Nurses	912	592	1,161
Square Footage*	2,800,000	1,400,000	2,900,000

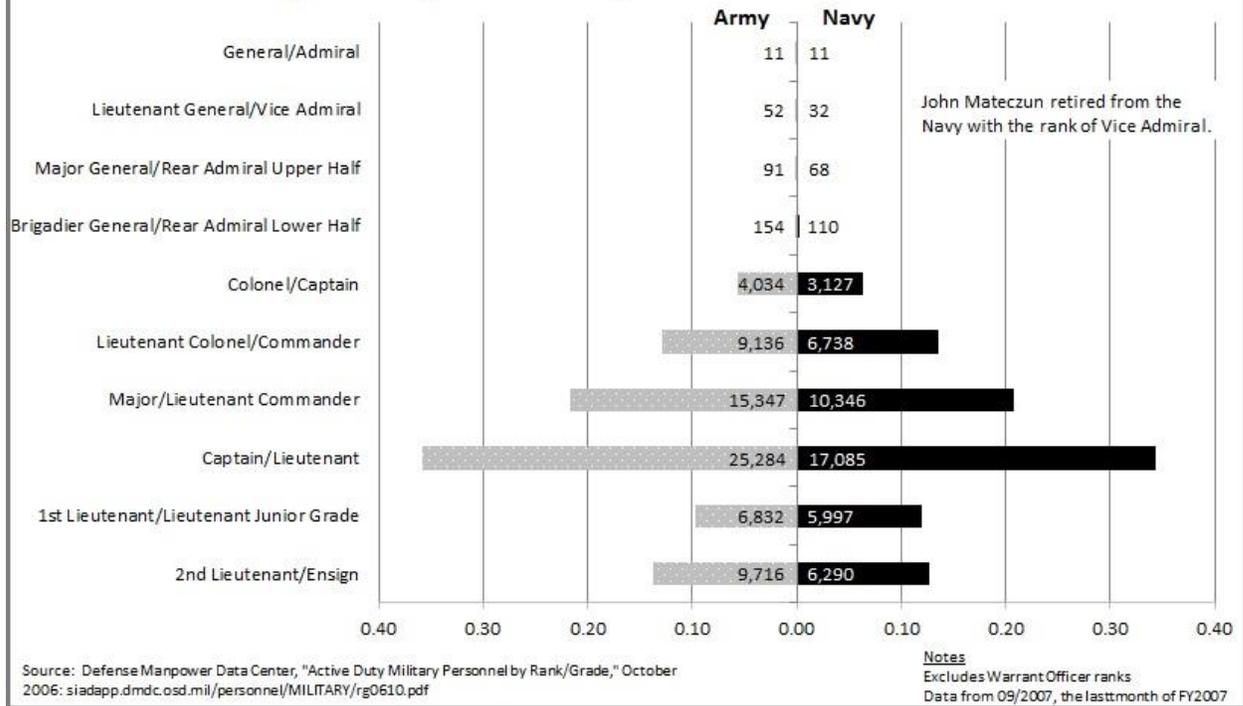
Source: JTF CapMed data provided to case writers

\* Note: WRAMC and Bethesda Navy Hospital square footage figures are from 2004 rather than 2008. WRNMMC square footage includes warrior transition center.



### Army and Navy Officer Ranks, FY2007

### Exhibit 7



### Exhibit 8 Iraq & Afghanistan Casualties by Year, Service, and Type\*

	Death (Combat and Noncombat)				Combat Wounded			
	Army	Navy	Marines	Air Force	Army	Navy	Marines	Air Force
2001	6	4	0	1	24	0	1	8
2002	28	5	10	6	63	1	1	9
2003	413	14	85	19	2,169	14	303	34
2004	555	19	316	8	4,662	205	3,239	113
2005	667	29	239	7	4,285	119	1,729	79
2006	631	24	252	11	4,351	192	2,190	81
2007	862	27	112	19	5,627	91	1,039	110
2008	381	18	60	9	2,357	48	363	74
2009	344	15	85	15	2,103	54	617	50
2010	361	15	166	17	3,289	115	2,113	122
2011	335	34	79	20	3,930	99	1,296	113
2012	221	25	60	10	2,379	61	445	78
<b>Total</b>	<b>4,804</b>	<b>229</b>	<b>1,464</b>	<b>142</b>	<b>35,239</b>	<b>999</b>	<b>13,336</b>	<b>871</b>

Source: Defense Casualty Analysis System (Defense Manpower Data Center)

**\*Notes**

Data represents Iraq and Afghanistan figures through CY2012, as updated through 08 Oct 2013. This data source excludes personnel wounded, injured, or contracting disease outside of combat circumstances while deployed.

As of Jan. 2013, the VA has treated more than 850,000 Iraq and Afghanistan veterans for conditions incurred while on active duty. (Bilmes, 4/13)

## **Exhibit 9: Cast of Characters**

### **Vice Admiral John Mateczun** *Commander, JTF CapMed, September 2007 to February 2012*

A Navy psychiatrist, Mateczun was appointed as the first commander of JTF CapMed, an organization created to guide execution of the congressionally mandated consolidation of military hospitals in the national capital region. Mateczun was selected for the job in part for his familiarity with “joint” military operations and doctrine, an unusual distinction for a military medical officer. Mateczun began his military service as an enlisted Army bomb diffuser in Vietnam.

### **The Honorable Gordon England** *U.S. Deputy Secretary of Defense, January 2006 to February 2009*

A businessman and former Secretary of the Navy under President George W. Bush, England rose to be the DoD’s number two official, a post he held for four years. It was during England’s tenure as DepSecDef that he helped conceive, establish and implement JTF CapMed, a new kind of military medical unit that adopted the structure and philosophy of tactical joint task forces that had been in use among combatant commands since the late 1980s. In creating JTF CapMed, England made the decision of making its commander answer only to his own office.

### **The Honorable William Lynn** *U.S. Deputy Secretary of Defense, February 2009 to October 2011*

Lynn replaced England as DepSecDef when President Barack Obama came into office. Lynn had made a career in Defense policy circles and served under President Clinton as the Pentagon’s Comptroller. Lynn served as DepSecDef at a time of increased focus on the war in Afghanistan and the drawdown in Iraq.

### **Vice Admiral Adam Robinson** *U.S. Navy Surgeon General, 2007 to 2011*

A career colorectal surgeon and the first African-American to become Surgeon General of the Navy, Robinson was opposed to the plan to make Bethesda Naval a joint military hospital. Robinson commanded Bethesda Naval during and after the BRAC announcement and saw it as an embodiment of Navy medicine’s unique culture. He cited the Army’s Walter Reed scandal and the potential or disruption to patient care as his primary reasons for urging caution in the hospital merger.

### **Rear Admiral Matthew Nathan** *Commander, NNMC–Bethesda, August 2008 to September 2011*

A career Navy internist, Nathan commanded Bethesda Naval during the critical years of the BRAC hospital consolidation and over the last three years of Mateczun’s leadership of JTF CapMed. Initially a supporter of plans to integrate Walter Reed with his own hospital, Bethesda Naval, Nathan differed fundamentally from Mateczun on the reasons for which JTF CapMed was created. Nathan viewed JTF CapMed as a temporary entity, not a fully empowered military command.

**Colonel Charles Callahan** served as the Deputy Commander for Clinical Services at Walter Reed Army Medical Center, Commander of DeWitt Army Community Hospital, National Naval Medical Center Chief of Staff, Walter Reed National Military Medical Center Chief of Staff, and Director of Belvoir Hospital. Callahan is the only military officer to serve in five leadership positions within the National Capital Region Medical Directorate. He held key leadership positions at both Walter Reed and National Naval Medical Center, serving as a critical link during the transition to the new Walter Reed National Military Medical Center.

## Endnotes

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<sup>2</sup> Carl Builder, *The Masks of War*, Baltimore: Johns Hopkins University Press, 1989, p. 8.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid., p. 18.

<sup>5</sup> Ibid., p. 19.

<sup>6</sup> Sebastian Juenger, *War*, New York: Hachette Book Group, 2010, p. 120.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid., p. 22.

<sup>9</sup> Ibid., p. 21.

<sup>10</sup> Ibid., p. 24.

<sup>11</sup> Ibid., p. 25.

<sup>12</sup> Ibid., p. 26.

<sup>13</sup> Ibid., p. 30.

<sup>14</sup> "About BUMED – The Bureau of Medicine and Surgery (BUMED)—A Brief History," available from <http://www.med.navy.mil/bumed/Pages/Default.aspx>.

<sup>15</sup> "History," *Walter Reed Society, Inc.*, available from [http://www.walterreedsociety.org/legacy\\_of\\_walter\\_reed/history.aspx](http://www.walterreedsociety.org/legacy_of_walter_reed/history.aspx).

<sup>16</sup> Fred W. Baker, "New Amputee Care Center Opens at Walter Reed," American Forces Press Service, September 13, 2007, <http://www.defense.gov/News/NewsArticle.aspx?ID=47432>.

<sup>17</sup> Matthew L. Nathan, Vice Admiral, U.S. Navy, Personal interview, U.S. Navy Bureau of Medicine and Surgery, Falls Church, Virginia, December 3, 2012. (Audio recording.)

<sup>18</sup> "Defense Health Care: Issues and Challenges Confronting Military Medicine: GAO/HEHS-95-104," Government Accountability Office, March 22, 1995, p. 30.

<sup>19</sup> "Fiscal Year 2009 Budget Estimates: Personnel Summary (PB11A)," Defense Health Program, February 2008, [http://comptroller.defense.gov/defbudget/fy2009/budget\\_justification/pdfs/09\\_Defense\\_Health\\_Program/VOL\\_1/Vol\\_1\\_Sec\\_6\\_-\\_B\\_PB-11A\\_PERSONNEL\\_09PB\\_DHP.pdf](http://comptroller.defense.gov/defbudget/fy2009/budget_justification/pdfs/09_Defense_Health_Program/VOL_1/Vol_1_Sec_6_-_B_PB-11A_PERSONNEL_09PB_DHP.pdf).

<sup>20</sup> Philip Perdue, Captain, U.S. Navy, Personal interview, Walter Reed National Military Medical Center, Bethesda, Maryland, December 4, 2012. (Written notes.)

<sup>21</sup> Gordon R. England, Deputy Secretary of Defense (Ret.), Personal interview, Cosmos Club, Washington, D.C., December 16, 2012. (Written notes.)

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<sup>22</sup> Anne Hull and Dana Priest, "Soldiers Face Neglect, Frustration At Army's Top Medical Facility," *The Washington Post*, February 18, 2007, available from: <http://www.washingtonpost.com/wp-dyn/content/article/2007/02/17/AR2007021701172.html>.

<sup>23</sup> Matthew L. Nathan, Vice Admiral, U.S. Navy, Personal interview, U.S. Navy Bureau of Medicine and Surgery, Falls Church, Virginia, December 3, 2012. (Audio recording.)

<sup>24</sup> Rumsfeld, Donald, Secretary of Defense (Ret.), Memo: "Transformation through Base Realignment and Closure," The Pentagon, Washington, D.C., November 15, 2002, available from: <http://cdn.govexec.com/interstitial.html?rf=http%3A%2F%2Fwww.govexec.com%2Fdefense%2F2002%2F11%2Fdefense-secretary-donald-rumsfelds-memo-on-military-base-closings-in-2005%2F12964%2F>.

"A primary objective of BRAC 2005, in addition to realigning our base structure to meet our post– Cold War force structure, is to examine and implement opportunities for greater joint activity. Prior BRAC analyses considered all functions on a service-by-service basis and, therefore, did not result in the joint examination of functions that cross services. While some unique functions may exist, those functions that are common across the Services must be analyzed on a joint basis."

<sup>25</sup> John M. Mateczun, Vice Admiral (Ret.), U.S. Navy, Personal interview, Cosmos Club, Washington, D.C., September 18, 2012. (Audio recording.)

<sup>26</sup> Focus group, Conducted by the case-writers, Walter Reed National Military Medical Center, Bethesda, Maryland, October 18, 2012. (Written notes.)

<sup>27</sup> Charles T. Callahan, Colonel, U.S. Army, Commander, Fort Belvoir Community Hospital, Telephone interview, September 3, 2013. (Written notes.)

<sup>28</sup> Ibid.

<sup>29</sup> Charles W. Callahan, Colonel, U.S. Army, Personal interview, Fort Belvoir Community Hospital, Fort Belvoir, Virginia, September 4, 2012. (Audio recording.)

<sup>30</sup> Vincent Musashe, Telephone interview, October 9, 2012. (Audio recording.)

<sup>31</sup> Charles T. Callahan, Colonel, U.S. Army, Commander, Fort Belvoir Community Hospital, Telephone interview, September 3, 2013. (Written notes.)

<sup>32</sup> Focus group, Conducted by the case-writers, Fort Belvoir Community Hospital, Fort Belvoir, Virginia, Bethesda, Maryland, March 20, 2012. (Written notes.)

<sup>33</sup> Charles W. Callahan, M.D., Colonel, U.S. Army, "Stowaway Soldier, Camouflage in a Khaki World: Creating a Single Culture of Trust from Distinct Service Cultures," *Naval War College Review*, Summer 2013, Vol. 66, No. 3, p. 141.

<sup>34</sup> Boris Groysberg, Andrew Hill and Toby Johnson, "Which of These People Is Your Future CEO?: The Different Ways Military Experience Prepares Managers for Leadership." *Harvard Business Review*, November 2010, p. 2.

<sup>35</sup> Charles W. Callahan, M.D., Colonel, U.S. Army, "Stowaway Soldier, Camouflage in a Khaki World: Creating a Single Culture of Trust from Distinct Service Cultures," *Naval War College Review*, Summer 2013, Vol. 66, No. 3, p. 141.

<sup>36</sup> Vincent Musashe, Telephone interview, October 9, 2012. (Audio recording.)

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<sup>39</sup> Charles T. Callahan, Colonel, U.S. Army, Commander, Fort Belvoir Community Hospital, Telephone interview, September 3, 2013. (Written notes.)

<sup>40</sup> Ibid.

<sup>41</sup> John Gaal, Colonel, U.S. Army, Personal interview, Walter Reed National Military Medical Center, Bethesda, Maryland, December 4, 2012. (Audio recording.)

<sup>42</sup> Charles T. Callahan, Colonel, U.S. Army, Commander, Fort Belvoir Community Hospital, Telephone interview, September 3, 2013. (Written notes.)

<sup>43</sup> John Gaal, Colonel, U.S. Army, Personal interview, Walter Reed National Military Medical Center, Bethesda, Maryland, December 4, 2012. (Audio recording.)

<sup>44</sup> Ibid.

<sup>45</sup> Ibid.

<sup>46</sup> Charles T. Callahan, Colonel, U.S. Army, Commander, Fort Belvoir Community Hospital, Telephone interview, September 3, 2013. (Written notes.)

<sup>47</sup> John Gaal, Colonel, U.S. Army, Personal interview, Walter Reed National Military Medical Center, Bethesda, Maryland, December 4, 2012. (Audio recording.)

<sup>48</sup> Anne Hull and Dana Priest, "Soldiers Face Neglect, Frustration At Army's Top Medical Facility," *The Washington Post*, February 18, 2007, available from:  
<http://www.washingtonpost.com/wpdyn/content/article/2007/02/17/AR2007021701172.html>.

<sup>49</sup> Charles W. Callahan, Colonel, U.S. Army, Personal interview, Fort Belvoir Community Hospital, Fort Belvoir, Virginia, September 4, 2012. (Audio recording.)

<sup>50</sup> Ibid.

<sup>51</sup> Charles W. Callahan, M.D., Colonel, U.S. Army, "Stowaway Soldier, Camouflage in a Khaki World: Creating a Single Culture of Trust from Distinct Service Cultures," *Naval War College Review*, Summer 2013, Vol. 66, No. 3, p. 142.

<sup>52</sup> Ibid., p. 143.

<sup>53</sup> Ibid., p. 144.

<sup>54</sup> Rosemarie Edinger, Colonel, U.S. Army, Telephone interview, September 25, 2012. (Audio Recording.)

<sup>55</sup> Louis Damiano, Captain(Ret), U.S. Navy, Personal interview, Walter Reed National Military Medical Center, Bethesda, Maryland, November 15, 2012. (Written notes.)

<sup>56</sup> Charles W. Callahan, M.D., Colonel, U.S. Army, "Stowaway Soldier, Camouflage in a Khaki World: Creating a Single Culture of Trust from Distinct Service Cultures," *Naval War College Review*, Summer 2013, Vol. 66, No. 3, p. 143.

<sup>57</sup> Louis Damiano, Captain(Ret), U.S. Navy, Personal interview, Walter Reed National Military Medical Center, Bethesda, Maryland, November 15, 2012. (Written notes.)

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<sup>59</sup> Matthew L. Nathan, Vice Admiral, U.S. Navy, Personal interview, U.S. Navy Bureau of Medicine and Surgery, Falls Church, Virginia, December 3, 2012. (Audio recording.)

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<sup>60</sup> Philip Volpe, Major General, U.S. Army, Telephone interview, October 3, 2012. (Audio recording.)