Chapter Six
Force Reductions, 1992–1995

"The concept of having a strong, mission ready reserve unit does not happen overnight. This unit took years to develop… that, with a stroke of a pen was taken out… all of the experience that formed the foundation of the unit is now gone."

Col. Randy Schwallie, U.S. Army Reserve (USAR)[1]

All was not quiet in the Persian Gulf region, as the huge allied forces returned to their home nations. Emboldened by the decisive defeat of the Iraqi forces, dissident groups such as the Shia in southern Iraq and the Kurds in the north began to rebel against Saddam Hussein. Fearing such a development, he had withheld some of his forces from the fight in the south to deal with any threat. The Shia were first. In March and April 1991, Iraqi infantry and helicopter gunships brutally smashed them. Some escaped into territory held by coalition forces. As noted earlier, MEDEVAC helicopter units evacuated many of them.

Operations

Operation PROVIDE COMFORT

Then Hussein turned on the Kurds in the north. When he attacked them, they feared a repeat of the brutal and indiscriminate slaughter perpetrated on them in 1988, and more than 450,000 fled to the north and assembled in the mountains along the Turkish border. Smaller numbers of Turcomans, Assyrian Christians, Chaldeans, and other Iraqi citizens fleeing for political reasons joined them. The harsh conditions created a critical and immediate need for water, food, sanitation, medical care, shelter, and security. To avert a humanitarian disaster, in early April, U.S. and allied forces—with Turkish permission—moved into the area to provide needed assistance as part of Operation PROVIDE COMFORT.[2]

U.S. Air Force and special operations forces from Europe initially led the force. They were well familiar with the area, having operated from the region against Iraq during DESERT STORM. Dealing with the magnitude of the refugees, however, required a larger effort. A combined task force with personnel from 13 nations was formed, which eventually included 21,000 personnel. They were sequestered in a security area centered on the city of Zahko, approximately 150 kilometers by 40 kilometers, with 43 separate clusters or camps. The combined task force was also augmented with numerous nongovernmental organizations. One of the major components of the combined task force was a large aviation task force composed of elements from several nations and services. In it was a U.S. Army flight detachment of 52 helicopters including a detachment of six UH-60s from the 159th Med Co (AA), which was actually located in the security zone.

Maj. Pauline Lockard now commanded the 159th. After her tour with the 54th at Fort Lewis, Washington, she transferred to Europe where she initially served on the inspector general team with the 7th Medical Command and then moved over to the 421st Medical Battalion (Evacuation) as the assistant S-3 until selected to take over the 159th. This afforded her the opportunity to return to the cockpit, and she went through a very intense checkout program with the unit instructor pilots, even getting fully qualified to use night vision goggles.[3]

Working with the medical units from almost all of the participating countries, Lockard and the troops from the 159th provided medical care to the refugees and the coalition forces until the operation was terminated in September, when Iraqi forces in the area backed away, and the majority of the refugees felt safe enough to return to their homes. Then the 159th aircraft and crews joined their unit detachment in Saudi Arabia, and eventually Kuwait, where Army MEDEVAC helicopters have maintained a presence ever since.

After-action reports from PROVIDE COMFORT indicated that the need for MEDEVAC was not identified early in the planning process and the deployment of MEDEVAC assets lagged the rest of the force flow. The main challenge for MEDEVAC was the coordination and centralization of control of all coalition assets to handle the myriad problems encountered. Civilian aid workers and medics were too quick to call for a MEDEVAC pickup when the needs of the patient did not necessarily require evacuation by air.[4]

Lessons Learned to Force XXI

In the months following their return from the Persian Gulf, all commands wrote after-action reports and lessons learned for DESERT SHIELD/STORM. More than 1,350 observations were filed on medical issues, with more than 100 directed in some form at MEDEVAC. They covered a gamut of issues including the adequacy of ground and air ambulance vehicles, Table of Organization and Equipment (TO&E) unit structures, the efficacy of the evacuation battalion, the challenges of long-range communications, challenges to operational and logistical support to MEDEVAC units, and medical equipage onboard MEDEVAC helicopters and their use to carry noncombatants.

Col. Jerry Foust, the commander of the 44th Medical Brigade, directed the collection of observations and lessons learned for his command. Several addressed MEDEVAC issues. The findings showed that Foust's medical forces were prepared to support the XVIII Airborne Corps by being able to evacuate and treat 1,600 allied casualties a day. Most of their patients were Iraqi enemy prisoners of war. Foust also saw how the long distances covered by the combat forces stretched his MEDEVAC units beyond their limits. Communication was a problem, as well as logistical support. Accordingly, he supported and encouraged assigning—where possible—MEDEVAC units to ground maneuver units, and then locating them with the aviation elements. He remembered:

> We lashed them [MEDEVAC units] up with aviation brigades. [They] had the comms. They had the involvement with the planning. That is where I see where we really, really changed because of the distances involved and because of our lack of communications. We had to depend on those aviation brigades for Intel[ligence], Ops, comms, and some maintenance, weather.[5]

As an old MEDEVAC pilot himself, he also made sure that within the 44th launch authority rested within the medical chain. He stated:

> Our job was release authority. Our job is to take care of patient. [The] individual pilot, the ops officer and the commander had release authority. …we had to release it so that the pilots and crewmembers could get enough information where the mission would be inherently safe. We didn't have the comms.[6]

The General Accounting Office did an overall effectiveness study examining the efficacy of the large medical force deployed to the Persian Gulf. The report included data from the Office of The Surgeon General and the U.S. Army Health Services Command and Academy of Health Services, both at Fort Sam Houston, Texas. The study included recommendations for improving medical effectiveness.

The report found that out of a concern for massive casualties potentially caused by modern warfare and the possible widespread use of chemical weapons, the U.S. Army deployed 23,000 medical personnel for all components and organized into 198 medical units, in addition to those units directly assigned to the maneuver forces. The deployment occurred in two phases: the first consisting of primarily active duty forces to support the defensive mission of protecting Saudi Arabia, and the second consisting of units from Europe and the Reserve Components to support offensive operations to eject the Iraqis from Kuwait.

Many deficiencies were noted including incomplete or out-of-date personnel information systems. Many personnel were nondeployable for a variety of reasons including a lack of training for wartime missions. Unit status reporting was not accurate. Some hospital units were never fully equipped or supplied. Medical supply centers in the theater could not adequately respond to the demands of in-theater units for various reasons. Some hospital units lacked the mobility to stay up with rapidly moving maneuver formations.[7]

Noting that "A prompt and well planned patient evacuation process is a key factor in saving the lives of those who suffer battlefield casualties," the report pointed out that "The Army's ability to effectively and quickly evacuate casualties from

the battlefield was impeded due to rugged terrain, distances between the hospitals and the front lines, poor communications, and the lack of navigational equipment and repair parts."[8]

Several specific lessons learned for MEDEVAC were offered:

1. Ground ambulances were ineffective because of rugged terrain, a lack of navigational equipment, communication difficulties, and the long distance between units and medical treatment facilities.
2. Desert conditions degraded air ambulance capabilities. The UH-1 Huey legacy aircraft was inadequate because it lacked proper navigation capability and instrumentation for flight in bad weather and low visibility conditions; its lift capability was limited by the hot weather; its overall usefulness was limited by its low speed, short range, and maintenance requirements; and it also had trouble meeting its requirement to perform backhaul and hospital transfers because of the distances involved and lack of refueling points.
3. Communication and navigation shortfalls impeded patient evacuation and regulation. Units were severely limited because radio communication was limited in range to only 15 miles or less by the altitudes at which they flew for protection and the harshness of the desert. Before combat, the 44th Medical Brigade had reported this radio deficiency and had requested FM radio repeaters for emplacement in the desert, but did not receive them. Some air ambulance units deployed without secure radio capability, forcing them to make all calls "in the clear," thus violating Operations Security guidance.
4. Ambulance units also had difficulty getting modern navigational gear on their aircraft. Global positioning system units and LORAN were slow to arrive.
5. A lack of spare parts also affected overall aircraft sustainability.[9]

The report recommended that the Secretary of the Army should take steps to ensure that the doctrine for using ambulance units was consistent with the battlefield of the future and that these units were sufficiently resourced with equipment and support to accomplish their missions.

The Department of Defense, in its review of the findings, concurred with the assessment, and indicated that the development of new air and ground ambulance doctrine was another element of Medical Force 2000 (MF2K). However, overall Army priorities and fiscal constraints determined the upgrade of the fleet from older UH-1s to UH-60s.[10]

These noted deficiencies, the increasing sophistication of modern aircraft, and the availability of and need for advanced navigation, instrumentation, and communication gear indicated that the MEDEVAC units needed to be more closely aligned with aviation units from which they could get more constant intelligence and Army Airspace Command and Control, weather, supply, logistics, and maintenance support.

The MEDEVAC community's lessons learned collection was a part of the inclusive medical collections for the conflict. In turn, they were a part of the overall

Army process. Assuming the position of the 32d Army Chief of Staff in June 1991, Gen. Gordon Sullivan directed several boards and study groups to analyze the data and suggest force structure changes to better prepare the Army for the fast changing world. In a series of experiments and exercises called the Louisiana Maneuvers, the collected groups scoped out a plan for change called Force XXI. It took advantage of evolving technologies to develop lighter but no less lethal and strategically mobile forces capable of fighting as part of inevitable joint and/or combined task forces for almost any mission from humanitarian assistance to conventional war. One suggested approach proposed modular units or forces that would craft organizations from discrete elements with different capabilities in combination to produce a functional military unit. These ideas developed in future years.[11]

Hurricane Andrew

The next challenge for the MEDEVAC forces occurred within the United States. The hurricane season in 1992 started off very quietly. The first named storm did not form until August, but it more than made up for its lateness by becoming a monster that slammed into Florida just south of Miami on 24 August. It was named Andrew and would forever be remembered as one of the worst storms of the century.

The storm, which first formed as a tropical depression on 17 August, steadily gained strength and was declared a hurricane on 22 August. It crossed the Bahamas the next day as a Category 4 storm and headed directly for south Florida.

Hurricane warnings were posted for the southern portion of the state and more than a million persons evacuated north. The storm came ashore near Homestead at 0500 on 24 August with peak winds of 150 knots and traversed the state in four hours. The resulting storm surge, thunderstorms, tornadoes, and heavy rain left a path of utter devastation. It then proceeded across the Gulf of Mexico and turned north into the generally less-populated areas of western Louisiana, finally dissipating over the southeast United States.[12]

Early warning of the storm allowed Florida state agencies, local governments, and National Guard units to mobilize and pre-position. However, massive federal help was also needed, and President George H.W. Bush declared Broward, Dade, and Monroe counties as major disaster areas and ordered federal assistance to include military forces.

While military units across the nation deployed, local units sprang into action. Coast Guard helicopters were airborne as soon as the winds died down, as well as helicopters from the Homestead-based 301st Rescue Squadron, U.S. Air Force Reserve. Several Florida Army National Guard (ARNG) helicopter units sent aircraft and equipment that were organized into Task Force 50. The 347th Med Det (RA) of the USAR was based in Miami and its personnel were personally affected. The pilots flew the aircraft out of the path of the storm. As soon as it was safe, they flew them back, providing opportune help to people

they could see en route who could flag them down. Upon returning to home station, they volunteered their services to the Florida ARNG, but were not utilized. Then they asked their parent Army Reserve command to activate them. When they did, the unit began flight operations, eventually as the core of a larger Army Reserve task force designated Task Force 3220, which also received some augmentation from the 348th Med Det (RA) from Orlando, Florida.[13]

At first, these operations were rescue and damage survey operations. Capt. Pete Webb was still the active duty advisor to the 348th and participated in the Andrew response. He recalled:

> We were called up for Hurricane Andrew. About 80% of the people in the unit had their houses damaged or facilities damaged and we were ordered by our Army Reserve Command out of Atlanta, Georgia, the 81st ARCOM, to scramble three ships and crews and go to Hurricane Andrew and do anything we could do to assist humanitarian wise with anything we saw or happened on to. We were sent there for approximately two weeks. It was quite an amazing scene as part of the most dangerous environment I have even flown in just because there was no air structure. VORs [aviation navigational aids] were out of commission. There was every branch of service, every civilian counterpart, every type of aircraft you could think of out there flying and no one knew how to talk to anybody…. It was kind of crazy, a lot of near misses.[14]

The XVIII Airborne Corps deployed for hurricane relief. It formed Joint Task Force (JTF) Andrew, which included an aviation task force. That task force supported the 57th Med Det (RG) from Fort Bragg, North Carolina, which was commanded by the 55th Medical Group of the 44th Medical Brigade, both of whom also deployed units.

The elements of the aviation task force and medical units were in southern Florida in strength by 28 August. The aviation task force immediately commenced a much larger operation, with the earlier task forces remaining separate, but coordinating all of their actions with JTF Andrew. Within days more than 120 helicopters supported the operation.

JTF Andrew provided critical command and control to the overall operation. Within a few days, its staff put together an overall plan consisting of three phases: (1) relief, (2) recovery, and (3) reconstitution. The aviation task force also developed a rudimentary airspace control plan to coordinate the myriad operations ongoing.

Relief operations were terminated on 15 October. At that point the aviation task force dissolved and was replaced by the Aviation Brigade of the 10th Mountain Division, which continued the recovery and reconstitution support operations. Subordinate units returned to their home stations. Despite other hazards generated by the storm, occasional stormy weather, and low visibility operations, the aircraft of JTF Andrew and the other task forces logged 8,000 accident free hours. Partial records also show that they carried 6,279 passengers and 3.54 million pounds of cargo. Medical units treated more than 20,000 patients and uncounted animals, and also replenished local medical facilities so that they could operate. No specific number of MEDEVAC missions or patients carried was reported, but the two units involved provided 12 aircraft and crews, or 10% of the fleet. Hurricane Andrew was the worst natural disaster to hit the United States up to that point. The cost of rebuilding was estimated at $25 billion.[15]

Postevent lessons learned highlighted two areas of concern to MEDEVAC:

1. Joint aeromedical operations needed to be better coordinated.
2. Medical units lack adequate communications capabilities.[16]

The deficiencies in communications capabilities were a repeat complaint from the experiences in DESERT SHIELD/STORM.

Hurricane Iniki

One month later, as the cleanup for Hurricane Andrew proceeded, Hurricane Iniki struck Hawaii. The response was similar to that dispatched for Andrew, although on a smaller scale, and included Army active and Reserve Component units. For two weeks, JTF Hawaii deployed more than 5,000 troops to the island of Kauai. As part of the medical element, the 68th Med Det (RA) provided helicopters and crews that flew 41 immediate life-saving missions and transported medical personnel and supplies to many isolated locations until the roads could reopen.[17]

Doctrine

FM 8-10, Health Service Support in a Theater of Operation, March 1991

Almost coincidental with the collecting and writing of the lessons learned for DESERT STORM, the Academy of Health Sciences at Fort Sam Houston published an updated version of Field Manual (FM) 8-10, dated 1 March 1991, which replaced the October 1978 version. Released to the Army literally as its forces concluded combat operations in the Persian Gulf, the rewrite—like FC 8-45—acknowledged AirLand Battle as the warfighting doctrine of the Army. It reaffirmed that the Army Medical Department (AMEDD) played a key role in developing and maintaining combat power by accomplishing its mission to maintain the health of the Army to conserve its fighting strength. Discussing the command and control relationships in the theater communications zone, it reaffirmed the formation of medical groups to provide command and control and administrative supervision of assigned or attached medical units. Paralleling lessons learned in DESERT STORM, this included the newly redesigned medical evacuation battalions. These battalions were also assigned to the medical brigades supporting the corps.[18]

The medical evacuation battalions provided command and control, supervision of operations, training, and administration of a combination of three to seven air ambulance companies of either the 25-ship (TOE 08-137H200) or new MF2K 15-ship (TOE 08-447L100 or L200) variety, ground ambulance units, or the older six-ship medical detachments (TOE 08-660H0) with either the UH-1s or UH-60s. The basis of allocation was one battalion for three or four air or ground ambulance companies.

The battalion also provided medical supply support and limited Echelon I health service support (HSS).[19]

FM 8-10-6, Medical Evacuation in a Theater of Operations, Tactics, Techniques, and Procedures, October 1991

Published eight months later, a new manual, FM 8-10-6, was released. It devolved from the new FM 8-10, but was a more expansive and updated rewrite of the 1983 version of FM 8-35. It took the philosophy and doctrine of that FM and applied it specifically to medical evacuation in a theater of operations. Acknowledging again that evacuation is a critical link in the continuum of care, it then explained the structure and function of the evacuation battalion and subordinate 15-ship air ambulance companies and six-ship medical detachments.[20]

The manual also explained in significant detail how the medical battalion functioned to include the following:

1. A combined S2/S3 for properly coordinating MEDEVAC operations into combat operations.
2. Coordination with the Army Airspace Command and Control system.[21]

The 15-ship air ambulance companies were allotted on the basis of one in direct support per division or .33 per separate brigade or armored cavalry regiment, and one assigned in general support to a corps for every two assigned divisions or fraction thereof. The company accomplished unit-level maintenance on aircraft and equipment (less medical), and organizational maintenance on all organic avionics equipment. The unit also provided air crash rescue support and the rescue of downed aircrews. However, the companies had to rely on higher commands for other personnel, supply and security items, and aviation intermediate maintenance support. The company was organized with three forward support MEDEVAC teams that were assigned to specific brigades and generally located with the forward support medical company in the brigade support area. The company also maintained a six-aircraft area support MEDEVAC section designed to provide area support or reinforce the forward support MEDEVAC teams.[22]

The legacy six-aircraft medical detachments were tasked similarly to the companies. Although they were also capable of 24-hour operations, they could only provide two three-ship sections and needed more maintenance (unit and intermediate level) personnel and administrative, supply, logistical, and security support.[23]

Perhaps in early response to lessons learned being developed for DESERT SHIELD/STORM/SABRE, the FM stated, "Evacuation support for offensive operations must be responsive to several essential characteristics. As operations achieve success, the areas of casualty density move away from the support facilities. This causes the routes of medical evacuation to lengthen."[24] That is exactly what happened in Kuwait and Iraq.

The FM also included chapters dedicated to a revision of the evacuation precedence codes, the nine-line request, and tactics, techniques, and procedures that were repetitive of the earlier FM 8-35 manuals but updated for the newer equipment available. In essence, the evacuation battalions balanced both medical and

aviation concerns to run an integrated evacuation system for the medical brigades supporting the corps.

A Contrary View

Serving as an observer/controller at the Joint Readiness Training Center at Fort Chaffee, Arkansas, Maj. Van Joy certainly was aware of the changes. His work required him to know the latest in doctrine and lessons learned to properly evaluate the MEDEVAC units coming through the center.

Joy had initially joined the Army as an enlisted soldier with the Nebraska Army National Guard in 1978. He had a college degree in environmental sciences, and the ARNG sponsored him for a commission and flight school. While at Fort Rucker, Alabama, he applied for active duty and was accepted and branched into the Medical Service Corps. Subsequent tours included the 247th Med Det (RG) at Fort Irwin, California, where he transitioned to the UH-60; Korea, where he served in the 377th Med CO (AA) with Maj. Bill Thresher, Capt. Dave MacDonald, and 2d Lt. Pete Smart; and Panama, where he served in the 214th Med Det (RG) from just after JUST CAUSE until August 1992, when he was posted to Fort Chaffee for this present job.[25]

Serving at Fort Chaffee until the summer of 1993, he evaluated numerous MEDEVAC units that deployed to the center to support brigades going through the training cycle. While serving in Panama with the 214th, Joy was impressed with the full support that the unit received from the aviation brigade. However, he noticed that most of the MEDEVAC units coming through Fort Chaffee did not receive the same degree of support he was used to seeing and their performance suffered in the exercises because of it. He remembered:

> I was the one at JRTC [Joint Readiness Training Center] when the MEDEVAC would come there and deploy with the rotational units. I saw that where they needed to be was up under the Aviation task force … The Medical community had no clue of where the MEDEVAC was on the battlefield at any one time; they never tracked them; they never did anything with them. They would a lot of times want to push them off to the Aviation brigade or the Aviation task force…But they had no control over them. We then pushed to say "When you deploy, you need to deploy up under the Aviation Task Force, not up under the Medical task force or that Charley Med out in the FSB." In doing that, in giving it up under the Aviation Task Force, now that Aviation Task Force commander has an inherent responsibility for them. He not only now has to worry about their training, but has to worry about their feeding, the fueling, the fixing: all of the life support…Doing it up under the Aviation brigade, now they are already in the predeployment training cycle there; they are rolled up there in everything. It is not an afterthought which MEDEVAC had always been—an afterthought for everything. They never were brought in from the very beginning for the planning all the way up through execution.[26]

Joy left Fort Chaffee in the summer of 1993, just as the Joint Readiness Training Center moved its entire operation to Fort Polk, Louisiana. His orders took him back to Panama for more duty in Central America. Regardless of how MEDEVAC doctrine was evolving, he left Fort Chaffee with a firm belief that MEDEVAC should be assigned to the aviation brigades. He would have occasion in a few years to again deal with that issue, but in a more definitive way.[27]

Reorganizing and Reducing the Forces

Organization

Active Duty

In April 1991, as the allied forces returned from the Persian Gulf, the North Atlantic Treaty Organization (NATO) Council met in Rome and formally declared that there was no longer an immediate threat of a Soviet Bloc invasion of western Europe. However, it did identify regional political instability in eastern Europe and the Balkans region as new threats to the general peace. The American people, however, were convinced that the cold war was over and wanted a "Peace Dividend," which would be paid for with large military force reductions.[28]

In the United States, calls for force cuts actually started as early as 1987, and they only accelerated with subsequent events. Some unit inactivations were planned to take place during DESERT SHIELD/STORM, but they were delayed until the units returned from the war, with many inactivating as they returned home. At one point, Secretary of Defense Dick Cheney proposed reducing the Army from 28 to 18 divisions, with commensurate cuts in the ARNG and U.S. Army Reserve (USAR), arguing that both components had grown with the active forces in response to needs and should now be so reduced. Between 1989 and 1994, total Army strength declined from 772,000 to 529,000.[29]

Other NATO nations also reduced their military forces. The alliance developed a new strategic concept based on smaller and more flexible and mobile forces. Subsequent restructuring led to the development of bi-national and multinational units and task forces that could be utilized for a variety of operations other than war.[30]

Reserve Components

Proportional reductions were also made in the two Reserve Components of the Army. Reflecting the guidance from Cheney, the Chairman of the Joint Chiefs of Staff, Army Gen. Colin Powell, pointed out that even though the Reserve Components were a robust part of the total Army, there was no longer a requirement for the current force levels. They—like the active Army—would need to be cut. Accordingly, the ARNG was reduced from 457,000 in 1989 to 375,000 in 1995, and the USAR was reduced from 319,000 in 1989 to 260,000 in 1994.[31]

No active Army MEDEVAC units were inactivated. However, the discussions of which Reserve Component units to inactivate became very heated and political, as various U.S. senators, representatives, and many veterans organizations weighed in on the issues. As the rancor built concerning the equitability of cuts between the two Reserve Components, the Army Chief of Staff, Gen. Gordon Sullivan, held an "off-site" working conference in October 1993, with the Chief of the Army Reserve, Maj. Gen. Roger Sandler, and the Director of the Army National Guard, Maj. Gen. John D'Araujo, Jr. No records exist of the discussions,

but at their conclusion, the Chief of Staff announced that 14,000 USAR positions would be "transferred" to the National Guard. These positions were primarily combat arms and aviation rotary-wing positions. In return, the National Guard transferred to the USAR about 12,000 medical, signal, military police, and transportation positions. These were position swaps, not unit movements. Those affected personnel who desired to remain in drilling positions had to find billets individually. This action generated personnel turbulence that was staggering to men and women who had just recently put civilian careers on hold proudly to serve in the Persian Gulf.[32]

The rotary-wing flying units of the USAR were the most dramatically affected by this action. Before the agreement, the USAR had 44 different aviation or aviation support units, including two MEDEVAC companies and 13 detachments. Most had been activated and deployed for DESERT SHIELD/STORM. As a result of the "off-site" agreement, the USAR would be left with just four flying units: lift and attack battalions. *All* of their MEDEVAC units would be inactivated within two years.[33]

The personnel in the affected organizations were devastated. Some quit and others scrambled to find jobs in other USAR or ARNG units. The competition was keen, and many had to cross-train to stay in uniform. Capt. Randy Schwallie found a position with the 429th Medical Battalion (Evacuation) in Savannah, Georgia. However, he would not fly again as a MEDEVAC aviator. Personally, he felt the loss and sensed it, too, in larger terms:

> The concept of having a strong, mission ready reserve unit does not happen overnight. This unit took years to develop a strong flight program that, with a stroke of a pen, was taken out of the hangar and put into the history books. Before any reserve unit is disbanded, the Army must be absolutely certain those assets will not need to regenerate quickly. Unfortunately, all of the experience that formed the foundation of the unit is now gone, too.[34]

As a result of that action, the USAR got completely out of the MEDEVAC business, and the Army lost about one-third of its entire MEDEVAC force.

Capt. Bill LaChance, then serving as an active duty advisor to the 321st Med Det (RA) USAR, at Salt Lake City, Utah, also witnessed the process. He was commissioned into the Medical Service Corps through the Reserve Officers' Training Corps program at the University of Rhode Island in 1988. He was interested in hospital finance, and his first tour was with a hospital unit. The commander was an old MEDEVAC pilot, Lt. Col. Bob Romines. He entertained the young officer with tales of MEDEVAC. LaChance had given some thought to flying, and within two years, he was at pilot training. Subsequently, he flew with the 36th Med Det (RA), at Fort Polk, and then attended the Medical Service Corps advanced course at Fort Sam Houston.

While in the course, he was offered the advisor job in Salt Lake City. LaChance had no idea if such an assignment would be good or bad for career advancement. Fortuitously, Col. Bob Romines was also assigned at Fort Sam Houston, and LaChance visited him to ask his advice. Romines knew that such service could be broadening, professionally rewarding, and even enjoyable and

counseled him to take the job. LaChance took the assignment and reported to the 321st in June 1994.

LaChance, who replaced someone who had been fired, fell in love with the unit and developed a deep respect for the dedication and professionalism of the reservists. As the only active duty soldier in the unit, he flew a lot, especially on mountain rescues, which was a unit specialty.

Sadly though, he was there at the unit when the announcement of the ARNG-USAR swap was released. Rumors abounded about the back room deals and sell-outs that must have occurred for such a bad decision to be made. The unit was devastated, and morale plummeted. Many of the reservists did not find slots with other units and gave up on many years of faithful service.

LaChance also found out that the unit soldiers had never received any awards for their service in DESERT SHIELD/STORM. On his own, he researched their tour in the conflict and then recreated all of the necessary paperwork for more than 70 individual awards for those reserve soldiers. They deeply appreciated his efforts. He left the unit in 1996 for a staff job at Landstuhl, Germany, just a few weeks before the unit inactivated.[35]

Active Duty Forces – MF2K

Whereas the active Army did not lose any MEDEVAC units, it did take steps to consolidate the continental United States based units under the MF2K initiative developed before DESERT SHIELD. Under a plan developed and disseminated by the U.S. Army Forces Command in April 1992, it realigned the current 25-ship companies and six-ship detachments into 15-ship companies and three residual detachments. The Delta Company of the 326th Medical Battalion assigned to the 101st Airborne Division remained as it was with 12 aircraft.

The plan dictated that the 498th Med Co (AA) at Fort Benning, Georgia, decrease to 15 aircraft and move to Fort Stewart, Georgia. The 57th Med Det (RG) at Fort Bragg gained nine aircraft and became a company. The detachments at Fort Drum, New York, Fort Polk, Louisiana, and Fort Irwin, California, remained as they were, as well as the 68th at Wheeler Army Airfield, Hawaii, and the 283d at Fort Wainwright, Alaska, both of which were assigned the U.S. Army Pacific. The 507th at Fort Hood, Texas, the 82d at Fort Riley, Kansas, the 571st at Fort Carson, Colorado, and the 54th at Fort Lewis, Washington, realigned as 15-aircraft equipped companies under the MF2K design. These units were assigned for C2 to the corps-assigned evacuation battalions also being created under the MF2K initiative and provided aeromedical support throughout the corps area.[36]

In the summer of 1993, the Army initiated the plan and took additional steps to consolidate some of the MEDEVAC units. The 237th Med Det (RG) at Fort Ord, California, was inactivated. Some of its personnel and assets were moved to the 54th Med Det (RG) at Fort Lewis, so it could grow to a company. The 431st Med Det (RA) at Fort Knox, Kentucky, was inactivated. The 57th Med Det (RG) at

Fort Bragg and the 571st Med Det (RA) at Fort Carson completed their transitions to Med Cos by absorbing aircraft and personnel from the inactivating MEDEVAC and some aviation units.[37]

Medical Reengineering Initiative

That same summer, the AMEDD initiated another force restructuring focused on medical units above the division level. The Medical Reengineering Initiative was designed to correct deficiencies in large medical units and hospitals that had been modified under the MF2K initiative but were too cumbersome for the post–cold war. It involved Combat Support Hospitals, area support medical units, forward surgical teams, ground evacuation units, and multifold support units. One of its goals was to push medical care forward. It also advocated enhancing the en route care available aboard the MEDEVAC helicopters by purchasing UH-60Q models as proposed by Brig. Gen. Foust and Col. Frank Novier at the Medical Evacuation Proponency Directorate (MEPD).[38]

Eagle Dustoff

At Fort Campbell, Kentucky, the 326th Medical Battalion, 101st Airborne Division, was directed to convert to the 626th Support Battalion (Forward) as part of a larger Army-wide restructuring of divisional support battalions occurring since the late 1980s. Under the restructuring, all divisional medical, supply, transportation, and maintenance battalions were combined and reorganized into a main and three forward support battalions. Most heavy divisions were converted before DESERT STORM; the 101st Airborne and 82d Airborne Divisions were converted after that conflict.

In this reorganization, the 326th lost its Delta Company MEDEVAC unit, which would be reassigned. Working with planners at Fort Campbell and Fort Sam Houston, Col. Jim Truscott, still the Assistant Commander for Force Integration at the AMEDD Center and School, Fort Sam Houston, convinced them to allow Delta Company to return to its original MEDEVAC heritage. Subsequently, Delta of the 326th was redesignated the 50th Med Co (AA) and assumed the heritage of the well-decorated 50th Med Det (HA/RA) from Korea and Vietnam. The commander at the time was Maj. Garry Atkins. For administrative purposes, it was assigned to the 8th Battalion, 101st Aviation Regiment, an aviation intermediate maintenance unit, also located at Fort Campbell. Truscott was proud of that small accomplishment, which was one of the last things that he did before he retired in 1992.[39]

Six months later the 50th was tasked under the Military Assistance to Safety and Traffic (MAST) program to support recovery efforts for communities in the vicinity of the Great Smoky Mountains National Park and the Appalachian regions of Tennessee and Kentucky in the aftermath of the "Blizzard of the Century," which dropped record amounts of snow and swept the area with severe

weather conditions. For two weeks, aircrews flew missions to rescue stranded hikers caught in the woods by the fast moving storm. More than 100 persons were hoisted or recovered from the deep snow and severe conditions.

A New Blackhawk

After DESERT STORM, Foust continued to command the 44th Medical Brigade until October 1991, when he was transferred back to Fort Sam Houston again, to serve now as the Deputy Chief of Staff for Operations at the Health Services Command. The next year, he was moved over to be the Commander of the Army Garrison. Shortly thereafter, he was selected for promotion to brigadier general and became the Chief of the Medical Service Corps, the first MEDEVAC pilot selected in that position. At that rank, he could no longer be the garrison commander, so he was transferred over to serve as the deputy commander of the AMEDD Center and School. In those twin capacities, he quickly became involved in a full regimen of issues including the structure of the basic and advanced courses, force restructuring based on lessons learned from DESERT STORM, and the Army-wide downsizing.

One item particularly captured his interest. He wanted to modernize the MEDEVAC helicopter fleet and pushed for an upgraded UH-60. He pulled funding from several sources to facilitate the development of the UH-60Q variant. Reflecting deficiencies identified and lessons learned in the recent conflicts and contingency operations, the new aircraft had an improved intercom system for communications between the pilots and crewmembers in the cabin, better long-range radios, and a global positioning navigational system. It could also carry forward looking infrared for better navigation at night or in bad weather.

For enhanced patient carrying capability and comfort, the "Q Bird"—as it was subsequently called—was also extensively modified. It was provided with a litter lift system, a hoist, improved cabin lighting, improved cabin heating and cooling, upgraded intravenous bag provisions, a suction system and secure waste collection unit, an oxygen generating system, defibrillator capability, and increased medical storage capacity.[40]

One of the officers who joined Foust in the UH-60Q effort was Col. Frank Novier. After returning from his DESERT STORM service with the 34th Medical Battalion, he remained in command until the unit was inactivated in 1992. He attended the Army War College and graduated in 1993. After the War College, he was selected for duty on the Joint Staff in the Pentagon. Instead, Foust asked him to be the head of the MEPD at Fort Rucker, because he needed an aggressive officer to do battle with the Aviation Center Staff there in the fight for the new Q model. Novier accepted the assignment.

After he was briefed on the new aircraft, he quickly gave it his full support and began to do battle with the Aviation Center Staff to get it funded for MEDEVAC. Such funding came through Aviation Procurement Army dollars—not AMEDD—planned for and requested through the Aviation Branch Program Objective Memorandum submission each year.[41]

At the time, the UH-60Q was low priority for Army Aviation. None was funded for the active duty. However, the Tennessee ARNG procured a line of funding through a congressional insert. Novier continued as director of the MEPD until the fall of 1995, when he was sent to Fort Hood, to command the 1st Medical Group.[42] Foust continued to champion the UH-60Q in every forum. However, he was unable to establish steady funding for the program before he retired in October 1996.[43]

Military Operations Other Than War

Operations

Somalia

The newspaper headlines explaining the humanitarian disaster in northern Iraq had barely faded when they were replaced by equally shocking pictures and stories of an unfolding horror in the arid and pitifully impoverished country of Somalia. The United States had some interest in the country because it was located on the Horn of Africa astride the entrance to the Red Sea and thence the Suez Canal. That interest grew when Somalia was struck in 1992 with a devastating drought that destroyed most crops and precipitated a famine. For survival, local clans attacked each other to steal food supplies. Social order broke down. International relief agencies tried to intervene. They were also put upon by the armed locals, and the international press was awash with troubling pictures of Somalis starving en masse.

In August 1992, President George H.W. Bush directed the initiation of Operation PROVIDE RELIEF, and U.S. Air Force cargo aircraft flew food and other relief supplies into Somalia from neighboring Kenya. Sensing opportunity, the local warlords immediately unleashed their thugs on those disbursing the food and material. They stole the well-intended supplies and then sold them to the locals. With practically no money, the people continued to starve.[44]

As the situation steadily deteriorated, President Bush, now supported with United Nations resolutions, ordered the initiation of Operation RESTORE HOPE, and in December 1992, dispatched 13,000 airmen, soldiers, sailors, marines, and Special Forces troops to staunch the violence and restore stability to the country. This force was reinforced by 25,000 more military personnel from 22 other nations. This combined force restrained the local militias so that relief organizations could disburse more than 40,000 tons of grain and other foodstuffs. Stores reopened, commerce resumed, and new crops were planted.

The Army component from the 10th Mountain Division also included a robust medical task force consisting of the 62d Medical Group from Fort Lewis, the 86th Evacuation Hospital from Fort Campbell, several smaller specialty units and detachments, and the 159th Med Co (AA) from Germany, equipped with 15 UH-60 aircraft and still commanded by Maj. Pauline Lockard.

The 159th was attached to a larger aviation package built around the 5th Battalion, 158th Aviation Regiment, sent by V Corps under U.S Army Europe. The Task Force members self-deployed to Livorno, Italy, where they boarded their equipment aboard a fast freighter, which then delivered it to Somalia in early January 1993.

The unit initially located its aircraft at Baledogle airfield, 25 miles north of the capital of Mogadishu, and brought a small tractor and trailer and a 10-ton forklift. They were the only ones in the task force and were in high demand by all units. Lockard also packed a goodly amount of sports gear and other "comfort" items for troop morale, welfare, and recreation. Given the very austere cultural environment, these items were also well sought after by the rest of the task force. Her unit helped build a small physical fitness facility—open to all—that was well utilized and offered a "free life membership." Working under the medical task force, Lockard had launch authority for her crews and supported almost of all the different national and international task forces working in the country.[45]

Also still serving with the 159th, Capt. Pete Smart deployed again as the maintenance platoon commander. As in previous deployments, he flew few actual MEDEVAC missions, but focused instead on keeping the fleet flying. He had an outstanding crew of noncommissioned officers and young soldiers, and he infused them with that sense of urgency for mission that Bill Thresher had instilled in him in Korea. He later said of them:

> They understand that they have a real world mission; it's not play; this is not a drill…You make a difference in someone's life every day and whether you are going out there and actually flying that mission or you are the guy who's fixing a broken airplane that needs to get fixed so it can be used for the next mission.
>
> I can remember nights when a bird would come flying in at 2 o'clock... It had a problem. And the guys would hear it come in. I didn't even have to get them out of the rack. We would hear the bird coming and we'd say, "Probably something wrong." So people would just get up on their own and head out to the flight line and wait for it to shut down and find out what was wrong.[46]

Like most of his fellow soldiers, Smart was shocked by what he saw in Somalia, remembering:

> It was a mess… At that point in time, it was such a huge humanitarian crisis, there was very little in-fighting going on. The militias had pretty much pulled back, established their lines; it was trench warfare going on in the city. There was just very little activity. The place was in very bad condition. I have never been in a place in the world that was in worse condition than what I saw in Mogadishu at that time. There wasn't a piece of glass that wasn't broken; the utility lines were all ripped out of the ground. Anything that was salvageable was torn down, ripped out. …That was the mission of the task force: to go in there and restore the supply lines, to get the food moving, because it was all being held up at the ports and being used as barter. There was no currency exchange; food was power.[47]

The U.S. Navy had several major ships off shore with extensive medical capability. Unfortunately, none of the 159th pilots was qualified to land aboard the ships. A quick training program solved that problem, and this deficiency was

A MEDEVAC helicopter from the 159th Med Co (AA) landing at the 86th Evacuation Hospital deployed to Somalia.
Source: Lt. Col. Rich Prior.

logged as a noted lessons learned for inclusion in postconflict doctrinal revision efforts. The MEDEVAC aircraft and crews were disbursed to four other fields for duty. Casualties were rare, and few actual MEDEVAC missions were needed.[48]

Operation RESTORE HOPE was terminated in May 1993 and replaced by a smaller United Nations operation labeled UNOSOM II. The initial medical task force was simultaneously replaced by a smaller force that consisted primarily of the 42d Field Hospital from Fort Knox, several smaller supporting units, and the 45th Med Co (AA) also from Germany, which replaced the 159th.[49]

The aircraft and crews of the 45th were also spread out over several locations to provide wider coverage. Although they were joined by helicopters and crews from France, Italy, Germany, and Malaysia, the crews of the 45th flew more than 75% of the total MEDEVAC missions. They all supported deployments of medical teams into villages to provide desperately needed medical support to the civilian populace. The 82d Med Co (AA) from Fort Riley, which deployed with six UH-1Vs, replaced the 45th at the end of August.[50]

However, the relief effort did not bring political and social stability. In June, a local clan leader, Muhammed Aideed, led a force that ambushed a United Nations Pakistani unit, killing 24 of their soldiers and causing 122 casualties overall. As the fighting increased, more MEDEVAC missions were requested.

The United States reacted to the increase in violence by dispatching a large special operations task force to capture Aideed and his supporters. In a series of hard-hitting raids in August through October of 1993, they slowly captured his troops. Unfortunately, the seventh raid failed when Aideed's supporters surrounded the raiding force and shot down two American helicopters. The ensuing

Maj. Pauline Lockard, commander of the 159th Med Co (AA) in Somalia, with President George H.W. Bush.
Source: Col. (ret) Pauline Lockard.

battle and rescue operation lasted into the next day before a relief column from the 10th Mountain Division recovered the force from the middle of the city. The 82d flew many missions recovering the wounded from this operation.[51]

As a result, the medical task force was reinforced with several specialist physicians and support personnel, and two more UH-1Vs from the 82d joined their unit in Somalia. However, the news of the horrible battle in Mogadishu shocked the American people. They thought that the mission to Somalia was a humanitarian effort and had not closely followed the steady rise in violence. When presented with scenes showing American bodies being dragged through the streets of Mogadishu, they quickly turned against the operation and demanded that American troops be brought home.

President Bill Clinton concurred and ordered American forces to return to their bases. They were out by the following March, with two 82d Med Co UH-1Vs and crews among the last to return home. The larger United Nations operation slowly withered away over the next year.[52]

Doctrine

The recent experience in Operations PROVIDE COMFORT and RESTORE HOPE in northern Iraq and Somalia reflected a changing philosophy in the United States concerning the use of military force for armed intervention both unilaterally and as part of a coalition. During the cold war, the United States had been only a minimal participant in such operations. As these two events showed, the nation was now prepared to consider the use of military forces in traditional peacekeeping missions, in particular, with others in broad-based coalitions or as party to existing international agreements to deal with lingering problems not dealt with while the world was engaged in the cold war.

FM 100-5, Operations, June 1993

These real world changes were reflected in the next rewrite of FM 100-5, as American troops sweltered in the blazing heat of Somalia. While reaffirming the basic tenets of AirLand Battle, it redefined thinking in a new strategic era. The cold war was over, and the threats had changed, driving a new strategy for the United States. That strategy now focused on stronger joint operations, as directed by the landmark *Goldwater-Nichols Act of 1986,* whereby Congress mandated integrated operations, and the Chairman of the Joint Chiefs of Staff was directed to publish doctrine for joint operations. AirLand Battle evolved into a series of choices for a battlefield framework and a wider interservice area and allowed for the increased incidence of combined operations, recognizing that Army forces could operate across the range of military operations. It became a manual offering a doctrine for full-dimension operations and focused more on the strategic versus operational level of war. In a chapter devoted to "operations other than war," commanders were encouraged to act to control the environment rather than let the environment control events and then have to devise imaginative methods of applying their resources as the circumstances changed.[53]

The Army would not fight alone. It integrated its operations within the theater commander's unified operations with the other services, other national agencies, and perhaps allied and coalition forces. In any given situation, HSS forces could be the first deployed into a contingency operation if they possessed the capabilities necessary to handle that unique situation. This was partly the case in Operation PROVIDE COMFORT in northern Iraq.[54]

The rewrite included an updated chapter on joint operations, pointing out that, "Army doctrine is compatible with and supports joint doctrine…." It also defined joint command relationships and the utilization of JTFs, and suggested a standard structure for a theater of war.[55]

A chapter dedicated to combined operations was also inserted. It discussed the inherent challenges of bringing together military units from different nations with different languages, organizational structures, and cultures to achieve common goals and objectives.[56]

The manual also included for the first time an inclusive section on HSS. While reiterating that the purpose of the HSS was to ensure a medical presence with the soldier and provide state-of-the-art medical and surgical treatment, it also stated:

> HSS requirements will surface in support of operations other than war. Typical operations will include disaster relief, nation assistance, support to domestic civil authorities, and peacekeeping activities…HSS is based on … standardized air and ground medical evacuation units using air evacuation as the primary means of medical evacuation; flexible and responsive hospitals …[57]

In a chapter defining and describing operations other than war, the manual explained that it may include a variety of operations that could generate a need for humanitarian assistance and/or disaster relief. These operations would "use DOD personnel, equipment, and supplies to promote human welfare, to reduce pain and suffering, to prevent loss of life or destruction of property from the aftermath of natural or man-made disasters… The Army's global reach, its ability to deploy rapidly, and its ability to operate in the most austere environments make it ideally suited for these missions."[58]

This was a dramatic change for FM 100-5, a manual classically designed to describe how the Army intended to *fight*. Now it was vastly broadening its scope and explicitly reaching out into missions beyond combat. While it reaffirmed the Army's primary focus was still to fight and win, it acknowledged a far more complex world where operations other than war would require Army services. They were services that the MEDEVAC force—as a key component of the HSS community—had been providing since its creation in Korea, domestically and overseas, in both war and peace. This suggested a larger mission for MEDEVAC, beyond the recovery of American soldiers, and possibly as a key instrument in operations other than war.

FM 8-55, Planning for Health Service Support, September 1994

As the actions in Somalia were winding down, medical staff officers were busy revising medical doctrine to reflect the changes presented in FM 100-5. In September 1994, they published an updated FM 8-55. It acknowledged the increased emphasis on operations other than war as an evolution, not a revolution. Such operations included missions such as disaster relief, nation-building assistance, security and advisory assistance, counter-drug operations, arms control, treaty verification, support to domestic civil authorities, and peacekeeping. They required an HSS that was flexible enough to support a diversity of operations.[59]

Reflecting the emphasis placed on joint operations in the new FM 100-5, this revision of FM 8-55 incorporated a section on joint HSS planning. It pointed out that joint force commanders could choose the capabilities they needed for any tasking from the air, land, sea, and special operations forces at their disposal. It also specified that the JTF surgeon could be directed to plan for civil-military, civic-action, or peacekeeping operations support.[60]

The manual included a discussion of the role that the medical evacuation battalions play in the HSS as the C2 headquarters for air and ground evacuation

companies. It listed the post-MF2K MEDEVAC companies, showing the same classic capabilities as in previous FMs, with allocation of one per division supported in direct support and one per two divisions supported in general support. Reflecting the recent events in Somalia, it also specifically directed that one company should be assigned to an active theater directly in support of hospital ships if they were deployed. However, no consideration was given to any larger patient group in terms of assignment of MEDEVAC companies. All allocations were still based on division sets.[61]

Joint Doctrine

As a result of the *Goldwater-Nichols Act of 1986,* the Chairman of the Joint Chiefs of Staff directed that the Joint Staff publish joint doctrine that would be applicable to all of the services. It would be specifically directive to commanders of combatant commands and subordinate components of those commands. The guidance provided was to be considered authoritative and to be followed except when—in the judgment of the commander—exceptional circumstances dictated otherwise.

Joint Publication 1 was published on 11 November 1991. As the initial and keystone document, the Chairman of the Joint Chiefs of Staff, Gen. Colin Powell signed it. The document was designed to guide the joint action of the Armed Forces of the United States so that they could fight as one joint team. Recognizing that individual service skills form the core of combat capability, it did not seek to lessen service traditions, expertise, or cohesion, but rather to present a common perspective from which to plan, operate, and fundamentally shape the way U.S. forces think about and train for war. All commanders were directed to integrate the values and concepts presented in this publication into the operations of the U.S. armed forces. From it would spring a full panoply of doctrine across the broad spectrum of military operations.[62]

Joint Publication 4-02, Doctrine for Health Service Support in Joint Operations, April 1995

The first joint medical doctrine was published in Joint Publication 4-02. Clearly structured similarly to the FM 8 series of manuals, it reiterated that the primary objective of HSS was to conserve the commander's fighting strength of land, sea, air, and special operations forces through continuous planning, coordination, and training to ensure a prompt, effective, and unified health care effort. It also reiterated the classic five echelon levels of care.[63]

The document highlighted the critical role that timely patient evacuation played in the design of the treatment sequence from front to rear. It also included a large section on military operations other than war, stating:

> Military operations other than war are usually joint operations, often performed in concert with other government agencies, nongovernmental organizations and private volunteer organizations. HSS policies during military operations for operations other than war may be substantially different from the policies associated with general war… Humanitarian and civic

> assistance (HCA) programs operate in conjunction with U.S. military operations or exercises. HCAs serve the local populace by furnishing assistance that the local government is not capable of providing. HSS is often provided within a larger military involvement. A significant number of humanitarian assistance programs involve disaster relief operations. The military can provide assistance to help ease the effects of natural disasters and manmade events.[64]

Within a combatant command, the joint force surgeon would have the responsibility of identifying HSS requirements and assigning cross-service support where practical. The surgeon was also responsible for identifying other medical factors that could affect operations and advising the joint force commander. All planning should be done through the Joint Operation Planning and Execution System. Timely patient evacuation was a key part of that plan. Patient estimates should be calculated for numbers distribution, areas of density, possible mass casualty events, and evacuation. These estimates should reflect the entire potential patient population at risk.[65]

This was potentially a dramatic change for MEDEVAC forces. The evolving doctrine seemed to suggest that while the allocation of MEDEVAC assets was based on a purely Army-designated ratio of MEDEVAC companies to combat divisions allocated to an operation, actual need could be driven by a potential patient base that—in a joint operation or operation other than war—could be much larger.

Operations

Disaster on the Green Ramp, Fort Bragg

On 23 March 1994, as the last few Americans were leaving Somalia, an F-16 and C-130 collided while trying to land at Pope Air Force Base, North Carolina. The C-130 landed safely. The F-16 crashed on the loading or "Green" ramp where more than 500 paratroopers were marshaled to board a C-141 for a training jump. Dozens of soldiers were immediately killed or severely burned by the wreckage and flaming aviation fuel.

As horrendous as the event was, its occurrence at such a high-density and high-training tempo base dictated that—fortuitously—significant medical assets and facilities were nearby. Based on well-written and rehearsed contingency plans, the men and women of the 44th Medical Brigade and its subordinate units sprang into action. The 57th Med Co (RG) located at the smaller helicopter airfield about four miles to the southeast had two aircraft on alert for MAST duty or base support, and both were immediately launched, arriving at the disaster site about 20 minutes after the F-16 crashed. They were rapidly loaded with wounded and took off for the Womack Army Medical Center at adjoining Fort Bragg.[66]

The 57th immediately generated six more crews and aircraft that then joined the recovery effort as other medical personnel from all base units responded. Ultimately, there were 130 casualties, of which 24 died. Later, in addressing the outstanding effort by all to care for those hurt, the commanding officer of the XVIII

Airborne Corps, Lt. Gen. Hugh Shelton, said of the responders, "No one shied away…It's the kind of phenomenal response that allowed us to get all the injured to the hospitals within 40 to 45 minutes."[67]

Haiti – Operation UPHOLD DEMOCRACY

The new Army strategy laid out in the latest iteration of FM 100-5 was put on vivid display a year later when a large Army task force consisting primarily of soldiers from the 10th Mountain Division landed at the Port-au-Prince Airport in Haiti in September 1994. They were part of a larger JTF whose objective was to reestablish a democratically elected government deposed by a military coup. During the cold war, such transgressions were—in many cases—ignored. However, the coup had disrupted the stability of Haitian society and generated a massive refugee migration. Thousands of Haitians fled on flimsy boats to brave the passage to the United States. For the most part, they were economic refugees. Democracy needed to be reestablished in that country so that the economy could revive and provide jobs for the disaffected. The United Nations initially tried to introduce a small task force of "blue hats" to resolve the issue. In response, the coup leaders called their thugs into the streets and blocked the arrival of the United Nations forces. When the Secretary General of the United Nations acknowledged the failure of a peaceful resolution of the dilemma and the General Assembly passed a resolution authorizing the "application of all necessary means to restore democracy to Haiti," President Bill Clinton directed the military to act.[68]

Troops from the 10th Mountain Division initially led the way, and then joined with a large U.S. Marine contingent to reestablish peace. A Special Forces task force of 1,200 who spread into the countryside augmented the division. There was some violence initially, but a show of strength by a Marine team, which killed 10 rebels and conducted active street patrolling by the 1,000 military police, quickly restored order among a very grateful populous.

Eventually, the force exceeded 20,000 with a battalion-size element supplied by other Caribbean nations. The 44th Medical Brigade from Fort Bragg deployed a supporting medical task force that included an element from the 56th Medical Battalion (Evacuation) and a combined package of six UH-60s, crews, and support personnel from the 57th Med Co (AA) and the 498th Med Co (AA). However, there was little business for them. Most patients were soldiers who were sickened with tropical diseases or civilians caught in sporadic violence. The crews had all been trained for shore-to-ship transfers and flew many sorties ferrying the patients out to the USNS *Comfort*.[69]

Serving with the 57th as a flight platoon leader on that deployment was Capt. Greg Gentry, who had entered the Army in 1988 and was commissioned into the Medical Service Corps. His first assignment was to the 326th Medical Battalion, 101st Airborne Division, as an evacuation platoon leader. Subsequently, he served as a medical platoon leader with a 101st Division infantry battalion and deployed with it to DESERT SHIELD/STORM. That experience provided him with an

excellent grounding in Army medical operations at the "retail" level. Subsequently, he went to flight school at Fort Rucker and then served a very productive tour with the 377th Med Co (AA) in Korea before reporting to the 57th at Fort Bragg in 1994.[70]

The deployment was also supported by a detachment from the 28th Combat Support Hospital from Fort Bragg. Serving with it as the Bravo Medical Company commander was Capt. Bob Mitchell. His tour with the Aviation Standardization and Evaluation Team at Fort Rucker ended in the spring of 1992, and he was then ordered to Korea for two years. He spent the first year with the 377th Med Co (AA) at K-16 Air Base serving as the company operations officer. He was able to get on the flying schedule a lot and flew over most of the country. The next year he moved over to the 52d Medical Battalion (Evacuation) and served as the S-3 operations officer. He found that job to be very challenging because the only way to learn the job was by doing it. His battalion commander, Lt. Col. Bill Nichols, had a very simple command philosophy. He directed what he wanted done and then left it to his subordinates to decide how to get it done. Mitchell had to learn fast, but it proved to be a very rewarding tour, as he learned to balance medical versus aviation issues at the unit level.[71]

He left Korea in the summer of 1994 and reported to the 28th to take command of the company. It included a forward surgical team consisting of 20 physicians and enlisted troops that directly supported the 44th Medical Brigade. That unit belonged to the XVIII Airborne Corps, which meant that the forward surgical team had to be airborne-qualified. Mitchell got the command position because he had gone through airborne training at Fort Bragg a few years prior. He made several jumps with the surgical unit, but they were not required to do so in Haiti.

In September 1994, the coup leaders fled the country and the deposed president triumphantly returned. Rebel elements were disarmed, and more than 15,000 weapons were collected. The weak Haitian Army was then reorganized and retrained as a border patrolling force. Violence rapidly subsided, and the American forces were seen as liberators as thousands who had fled the country steadily returned.

In January 1995, a brigade-sized force from the 25th Infantry Division from Hawaii replaced the troops of the 10th Mountain Division. The supporting aviation task force included helicopters and crews from the 68th Med Det (RG). Maj. Pete Webb, then serving as the medical planner for the Division Surgeon, planned the deployment.

At the time, the 68th was transitioning from UH-1s to UH-60s. Capt. Pete Smart was the unit operations officer. After leaving Germany in late 1993, he had attended the AMEDD Advanced Course and had then been sent to Hawaii to facilitate the unit's conversion to the UH-60. When the arrival of the aircraft was delayed, Smart had to requalify in the UH-1. The 68th still had a heavy commitment to MAST, and the aircraft had to be ready.

For Haiti operations, the six UH-60s were deployed, and six UH-1s remained behind to provide MAST support to the islands. Smart deployed with the detachment,

but Haiti had been stabilized and there was little to do. On 31 March 1995, the U.S. forces handed over all responsibilities to a residual United Nations Mission and departed for their home stations. President Bill Clinton visited them to thank them for their effort. Before the assembled troops he said, "To every one of you who has taken part in Operation UPHOLD DEMOCRACY, on behalf of the American people, I am here to say thank you. Thank you for serving your nation. Thank you for being democracy's warriors. Thank you for helping to bring back the promise of liberty to this long troubled land. You should be very proud of what you have done."[72]

MAST

When the 68th Med Det (RG) returned to Hawaii, Webb was selected to take command of the detachment and held that position for the next two years. It was a busy time for the unit. There was no civilian MEDEVAC capability on any of the islands, and the 68th was in high demand. The unit constantly had helicopters on alert at Schofield Barracks on Oahu and also had to have aircraft available to support the maneuver and firing ranges in the Pohakuloa Training Area on the big island of Hawaii. Additionally, the 68th had to provide MAST coverage. Calls came in all the time, varying from water rescues to vehicular accidents to jungle hoist recoveries. Sometimes 30 calls were received in one 24-hour period. Webb discovered that it was the busiest MAST unit in the Army.[73]

Smart was the unit MAST coordinator who had to ensure that the 68th had two aircraft and crews available 24 hours a day. Smart himself flew more than 150 MAST missions. On one mission, Smart and his crew picked up an 18-month-old baby that had been run over by his mother when she had backed her car out of the driveway. It was the rush hour, and travel by ground ambulance would have taken hours. They picked up the mother and baby for the 10-minute flight to the hospital. As they lifted off, the mother was hysterical, but she calmed down as she saw the intensity and concern of the crew. They landed on the landing zone on top of the hospital and orderlies there took the baby immediately into intensive care. The mother thanked them profusely and then followed.

Smart was very touched by the mission. Returning to the base, he called the hospital and discovered that both the baby and mother were doing just fine. Smart was very impressed with the MAST program and felt that it was a win-win for both the Army and the nation. He said:

> I always felt like the MAST mission was such a good [public relations] vehicle not just for the Army but for the entire federal system because we are all taxpayers… And sure, we are a combat unit and our primary mission is to defend the Constitution of the United States. But, you know, there is nothing better in a peacetime environment than to be able to help your fellow citizens…We hauled a lot of retirees; we hauled a lot of people on vacation; we hauled military folks; we hauled police officers.[74]

Smart served with the 68th until June 1998, when he returned to Germany to command the 45th Med Co (AA) at Ketterbach.

In June 1995, newly promoted Maj. Dave MacDonald reported to Fort Bragg to take command of the 57th Med Co (AA). He intuitively knew that MEDEVAC was a combination of medicine and aviation. It was only when he took command of the unit that he understood what that meant. Medically, the 57th was assigned to the 56th Medical Battalion (Evacuation), 55th Medical Group, which belonged to the 44th Medical Brigade. However, those commanders neither knew nor cared much about aviation. MacDonald discovered very rapidly that he had to establish a solid working relationship with the 82d Aviation Brigade of the 82d Airborne Division to function as an aviation unit. This was a shock for him because he had gotten used to the strong aviation links that the 50th had at Fort Campbell.

He was also disheartened by the unit training plan. Forward support MEDEVAC teams were formed and functioning, but they spent little time with the brigades that they were supposed to be supporting. Little tactical training was accomplished because of the heavy MAST commitment levied on the unit.

MacDonald attended operational planning sessions and attempted to get his unit into the operations or exercises. He discovered that the 57th was viewed as an outsider—a "bunch of cowboys"—who played loose with the rules and were not professional aviators. It was only after he developed personal relationships with some of the aviation unit commanders that he obtained access to some of the exercises. Then he found himself as a bit of a marriage broker as he balanced the demands of both his medical and aviation superiors to maintain relevance in both communities to accomplish his job.

His effort suffered a terrible setback when his unit had a tragic accident. While supporting a brigade exercise at the Joint Readiness Training Center at Fort Polk in February 1996, an attached flight surgeon was killed by the rotating blades of one of the unit's aircraft as he disregarded safety instructions and attempted to board the aircraft while the pilots were doing an engines-running refueling.

The resulting investigations stretched out for nine months. Many extenuating circumstances led to the tragedy. As the investigations played out, MacDonald concluded that their purposes were more to find a scapegoat than to determine the actual causes of the accident. Ultimately, the pilot in command, a young CW3, received blame for the accident, and proceedings were started to remove his pilot wings. MacDonald prevented that by having him transferred to a Special Operations unit on base, but the young soldier was never again promoted.

This unfortunate incident soured relations between the 57th and the 82d Aviation Brigade. As the investigations were conducted, the 57th also received several other inspections. The constant strain of all of this and mundane unit operations took a hard toll on MacDonald. As his tour concluded in June 1997, he seriously considered leaving the Army. Fortunately, his senior rater, Col. Fred Gerber, the 55th Medical Group Commander, supported his actions and encouraged him to stay. MacDonald had been selected to attend the Army Command and General Staff College at Fort Leavenworth, Kansas. That experience gave him an opportunity to shake off the hard events at Fort Bragg and prepare for bigger and better things in the future.[75]

MAST – 25 Years

During 1995, the Army celebrated 25 years of continuous support for the MAST program. In the wake of the post–DESERT STORM force reductions, MAST participation had been substantially reduced. Still, 13 active TO&E units, one Table of Distribution and Allowances unit, one USAR unit (soon to be inactivated as per the "off-site" agreement), and one U.S. Air Force unit maintained aircraft on alert and provided community support across the United States. By the end of the year, aggregate statistics showed that since its inception, 44,664 missions had been flown, lasting 95,204 flight hours and carrying 48,806 patients.[76]

One of the stalwart units in MAST, the 54th Med Det (RG) at Fort Lewis was lauded for a particular mission typical of the overall MAST effort. The unit was honored as the Thurston (Washington) County Emergency Medical Services Provider of the Year for rescuing a man severely wounded by an accidental gunshot. After the emergency call was received, a 54th helicopter launched out of Fort Lewis and flew to the site of the accident in a very remote location where rapid surface transportation was impossible. As the medic cared for the patient, the crew quickly flew him to the closest hospital, where he received immediate surgery and care that saved his life.

To the crews, it was just another mission. "Any possible way people can get hurt, we've flown missions for," said one pilot. The unit operations officer, Capt. Charles Zuber, added, "The medic and crew chief get medical training, and the pilots get combat training by flying real emergency missions." MAST was still doing exactly what it was designed to do a quarter of a century earlier.[77]

About that same time, a new ARNG MEDEVAC unit was formed, the 1042d Med Co (AA) in the Oregon ARNG. Like almost all National Guard units, it claimed a lineage that reached back through units that were at one time perhaps transportation, infantry, or aviation units. The 1042d, which was activated at the Salem Airport, was initially equipped with older UH-1V aircraft. All had hoists so that the unit could perform mountain rescue. These aircraft were replaced in 1997 with new UH-60L aircraft.

The acquisition of those new production aircraft was the result of actions taken by Senator Mark Hatfield of Oregon, serving at that time as the chairman of the Senate Appropriations Committee. One aircraft called a Firehawk was modified with special tanks so that it could carry water for forest fire duty. The unit was also licensed to assume MAST duty for its region.[78]

Europe - Partnership for Peace

In further recognition of the changes sweeping the globe, the United States military in 1993 joined NATO in establishing the Partnership for Peace program. The combined effort sought to draw heretofore neutral nations, former members of the Warsaw Pact, and even former Soviet states into multinational exercises. These exercises focused on search and rescue, humanitarian relief, and peacekeeping

efforts, with initial objectives targeted to develop standard operating procedures, communications formats, and command and control protocols. NATO held a series of exercises for all who wanted to participate and extended these exercises to other areas of the world, although with less consistency. Some exercises were also held at the various training centers in the United States, such as the National Training Center at Fort Irwin. U.S. and allied soldiers, sailors, airmen, and marines developed mutual understanding and respect that was very useful in any potential coalition operations.[79]

Organization

Korea

In September 1995, the 377th Med Co (AA) in Korea was split, with one-half of its assets and personnel being used to create a new unit, the 542d Med Co (AA), commanded by Maj. Tom Bailey. Both units were assigned to the 52d Medical Battalion (Evacuation), commanded by Lt. Col. Rick Agosta, and assigned to the 18th Medical Command. The 542d assumed MEDEVAC duties in the northern part of South Korea, and was given the moniker of the "DMZ Dustoff." The 377th maintained coverage over the rest of the peninsula.[80]

Eight months later, Lt. Col. Scott Heintz arrived in Korea to take command of the 52d Medical Battalion (Evacuation). After his tour as the commander of Delta Company, 326th Medical Battalion, he served three years on the Office of The Surgeon General staff as the Deputy Director of Mobilization and later, within current operations. Then he became the medical operations officer for the Command Surgeon in the United States Special Operations Command. Although he found the tour to be interesting and challenging, he was more than glad to be back in MEDEVAC.

The 52d Battalion headquarters was at Yongsan Garrison located within Seoul. Besides the two MEDEVAC units, the battalion also commanded two ground ambulance companies: the 560th and the 568th. Heintz, who controlled all tactical evacuation assets within the theater with detachments spread all over the country, was responsible for the tactical evacuation plan and operation.

The assignment also afforded him the opportunity to return to the cockpit. He requalified in the UH-60 and then flew with pilots from both the 377th and the 542d whenever he could. On New Year's Eve of 1996, he and Maj. Tom Bailey were pulling 1st up alert at Camp Casey when they received a mission to transport two patients: a female soldier who had been diagnosed with chicken pox and a soldier who had his jaw broken in a New Year's Eve fight. As they launched out on the first mission of 1997 to transport the patients to Yongsan they encountered "moderate" turbulence. The resultant bumpy ride was uncomfortable for both patients.

Heintz also took a strong interest in the training of his medics. Calling on a few

A UH-60 of the 377th Med Co (AA) in Korea. The yellow stripes (called "Bumble Bee" stripes) designated nonhostile aircraft authorized to operate in the Joint Security Area along the DMZ.
Source: Lt. Col. Brian Almquist.

things he learned at the Special Operations Command, he designed a field competitive training exercise for them and then conducted it one month before their weeklong Expert Field Medical Badge evaluation.

Heintz gave up command of the 52d in June 1998. He had enjoyed the tour and the great soldiers with whom he served, especially his two executive officers, Maj. Lou Kozlowski and Maj. Dave Bitterman, his two Command Sergeant Majors, Ricky Terrell and Terry Porter, and his second 542d Medical Company Commander, Maj. Anastasia Ippolito. He felt that everything he had done as an officer before the assignment had prepared him for it, especially the mentoring he had received. More challenges were yet to come. He attended the Army War College at Carlisle Barracks, Pennsylvania, and then served at Fort Rucker as the Director of the MEPD from 1999 to 2002. He would lead the MEDEVAC community into the next century.[81]

Force Structure

In mid-decade, force structure documents showed that the following MEDEVAC units existed:

Active Duty

United States

50th Med Co (AA)	Fort Campbell, Kentucky
54th Med Co (AA)	Fort Lewis, Washington
57th Med Co (AA)	Fort Bragg, North Carolina
82d Med Co (AA)	Fort Riley, Kansas
498th Med Co (AA)	Fort Benning, Georgia
507th Med Co (AA)	Fort Hood, Texas
571st Med Co (AA)	Fort Carson, Colorado
36th Med Det (RG)	Fort Polk, Louisiana
68th Med Det (RA)	Wheeler Army Airfield, Hawaii
229th Med Det (RG)	Fort Drum, New York
247th Med Det (RG)	Fort Irwin, California
283d Med Det (RG)	Fort Wainwright, Alaska
Air Ambulance Det (Flatiron)	Fort Rucker, Alabama

Germany

45th Med Co (AA)	Ketterbach
159th Med Co (AA)	Wiesbaden
236th Med Co (AA)	Landstuhl

Other

377th Med Co (AA)	Korea
542d Med Co (AA)	Korea
214th Med Det (RG)	Panama

ARNG

24th Med Co (AA)	Nebraska/Kansas
104th Med Co (AA)	Maryland
107th Med Co (AA)	Ohio
112th Med Co (AA)	Maine
121st Med Co (AA)	Washington, DC/West Virginia
126th Med Co (AA)	California
148th Med Co (AA)	Georgia
172d Med Co (AA)	Arkansas
198th Med Co (AA)	Delaware/Pennsylvania
681st Med Co (AA)	Indiana
717th Med Co (AA)	New Mexico/Nevada
812th Med Co (AA)	Louisiana/Oklahoma
832d Med Co (AA)	Wisconsin
1022d Med Co (AA)	Wyoming/Colorado
1042d Med Co (AA)	Oregon

1059th Med Co (AA)	Massachusetts
1085th Med Co (AA)	South Dakota/Montana
1133d Med Co (AA)	Alabama
1159th Med Co (AA)	New Hampshire/ New Jersey[82]

Ongoing world events suggested that some of these units would be needed for overseas duty in the not too distant future.

Force XXI – Army After Next

Gen. Dennis Reimer followed Sullivan as the 33d Army Chief of Staff in 1995. He continued the Force XXI concept, but added another concept called "Army After Next," which attempted to define what warfare would be like in 2025. These efforts lead to the realization that the Army needed forces that could be tailored rapidly to respond to unpredictable crises. A middleweight force would be required that could "arrive at a crisis point early with sufficient combat power to deliver a critical blow to an adversary's operation." This could best be done with brigade-sized strike forces composed of modular elements tailored to the demands of each mission and using advanced digital information technologies that provided timely critical data. Reimer would not see their maturity during his time as the Army Chief of Staff. However, the seeds of technological advance and restructuring had been sown, and in time would bear fruit.[83]