Chapter Seven

The Balkans, 1992–Ongoing

"Missions would be less clear, like peace operations, … humanitarian assistance … inherently joint … multinational… with non-DOD agencies in achieving national objectives."

TRADOC Pamphlet 525-50[1]

Conflict in Southeastern Europe

While the Army struggled with the post–DESERT STORM force reductions and contingency operations in Somalia and Haiti, serious issues arose in the southeastern regions of Europe. After the collapse of the Soviet Union in the early 1990s, another communist bastion, the nation of Yugoslavia, started to disintegrate. It had been a post–World War I construct that sat on a cultural fault line between old Europe and the Ottoman Empire. It was designed to conglomerate Serbs, Slovenes, Croats, Bosnian Muslims, Albanians, Macedonians, Montenegrans, Hungarians, and other smaller ethnic groups into six republics and two provinces.

Natural and historic tensions existed among these groups and were exploited by Germany and Italy during World War II. After that conflict, Communist revolutionary/strongman Marshal Josip Broz Tito seized power and applied a heavy hand that forcefully unified this disparate group.

Tito died in 1980 with no clear and agreed upon successor. Ethnic rivalries reemerged, especially when they were inflamed by Serbian leader Slobodan Milosevic. Fearing the worst, two of the republics, Slovenia and Croatia, held free elections in 1991, which established a mandate for independence and they both declared so. Yugoslavia ceased to exist, and Serbia and Montenegro established the Federal Republic of Yugoslavia, a rump nation, with its capital in Belgrade. It also maintained control of what was left of the Yugoslav National Army (JNA).[2]

Both Slovenia and Croatia had strong ethnic majorities and immediately formed local militias that fought off primarily Serbian forces sent to squelch their efforts. Slovenian forces prevailed handily. However, the struggle in Croatia was more difficult as the JNA and local Serbians used heavy weapons for the first time to prevent the separation. The battles were hard-fought before the Croatian forces prevailed in early 1992.[3]

The next bid for independence was made by Bosnia-Herzegovina. It declared its freedom in April 1992. Several European nations immediately recognized it. However, it was more ethnically mixed. Its population was 44% Muslim, 33% Serb, and 17% Croat. The Serbian minority did not agree with the move to independence, revolted against the new government, and declared its own Serb Republic of Bosnia-Herzegovina. The JNA, which was heavily dominated by Serbs, joined with the Bosnian-Serbs and attacked the Muslims and Croats. In a brutal campaign reminiscent of the Middle Ages, they introduced the world to a new phrase—"ethnic cleansing"—as their forces used violent intimidation, murder, and rape to force the Muslims and Croats from areas that the Serbs wanted to own and control.

Operations

The Balkans

Watching the dissolution of Yugoslavia and fearing for the worst, in 1991 the United Nations (UN) passed a resolution embargoing all arms shipments to the former Yugoslavia. Alarmed at the continuously deteriorating situation in the region, the UN deployed a United Nations Protection Force (UNPROFOR) in 1992. Its mission was to guarantee the delivery of relief supplies and perform other humanitarian and peacekeeping duties. Ultimately including forces from 37 different countries and growing to 38,000 troops, it became the largest and most expensive UN peacekeeping operation to date.[4]

The United States supported UNPROFOR with a medical task force. In November 1992, U.S. Army Europe deployed the 212th Mobile Army Surgical Hospital to Zagreb, Croatia, and numerous personnel to act as liaison on several staffs. A MEDEVAC unit was not assigned to accompany it. The 502d Mobile Army Surgical Hospital replaced the 212th in April 1993. The 502d remained in place until October, when a hospital unit from the U.S. Air Forces in Europe replaced it. The 212th and 502d treated more than 9,700 UNPROFOR and civilian casualties from 31 countries.[5]

UNPROFOR's relatively lightly armed forces operating under tightly restricted rules of engagement were no match for the more heavily armed JNA and Bosnian Serbs. After several egregious attacks on UN Safe Areas, both the North Atlantic Treaty Organization (NATO) and the United States provided UNPROFOR naval and air support to enforce the arms embargo at sea and in the air. NATO imposed and enforced a no-fly zone over Bosnia. When Serbian attack aircraft challenged this restriction, U.S. Air Force F-16s shot down four of the six aircraft.

Tensions heightened as Bosnian-Serbs and JNA units seized UNPROFOR

peacekeepers to use as human shields and besieged Muslim areas and the city of Sarajevo. When a Serbian mortar round killed 37 people in a crowded market square in Sarajevo, NATO retaliated with a three-week air campaign to destroy the enemy guns arrayed around that city and eliminate other key JNA elements and forces. A total of 3,515 air sorties were flown, and only one allied aircraft—a French Mirage—was shot down. The crew was captured but eventually released.[6]

Almost simultaneously, strong Croatian forces joined the fight against the Bosnian Serbs and JNA. These two bold strokes convinced Serbian President Milosevic to begin peace negotiations at Wright-Patterson Air Force Base near Dayton, Ohio, in the fall of 1995.

In September, the foreign ministers of Bosnia-Herzegovina, Croatia, and Serbia met and agreed to the basic principles of a cease-fire and peace agreement in Bosnia. The document titled the General Framework Agreement for Peace was finalized and signed on 14 December 1995. It called for a military cease-fire and a confirmation of the existence of the independent state of Bosnia and Herzegovina. The country would be a multiethnic federal body with two political "entities": (1) the Federation of Bosnia and Herzegovina and (2) the Serb Republic. A zone of separation divided the two entities. Within days, the UN approved this agreement, and NATO was authorized to implement the peace agreement with an Implementation Force, Bosnia (IFOR). Five days later, IFOR replaced UNPROFOR and assumed responsibility for enforcing the zone of separation. The mission was expected to last one year.[7]

NATO had anticipated such an outcome and had developed several contingency plans. The chosen plan called for a multinational force of 60,000 troops from several countries. It was more heavily armed than UNPROFOR and was deployed with more robust rules of engagement. The force was subdivided into three multinational divisions (MNDs). MND North (MND-N) was a U.S.-led force. Its core was the 1st Armored Division from Germany, under Operation JOINT ENDEAVOR. Maj. Gen. William L. Nash, the 1st Armored Division commander, also served as the commander of MND-N, which was augmented with forces from other nations.

Starting in late December, the 1st Armored Division, as Task Force Eagle, began to move its units to Bosnia through Hungary and was joined there by brigades from Poland, Turkey, Russia, and smaller elements from nine other nations. U.S. Army Europe pre-positioned a National Support Element at Taszar to support the movement that included elements from the 30th Medical Brigade, which contained the 212th Mobile Army Surgical Hospital. They would form the core of Task Force Medical Eagle (TFME). Also supporting the 1st Armored Division was the 236th Med Co (AA), which was attached to the Aviation Brigade of the 1st Armored Division. It had been reinforced with a Forward Support MEDEVAC Team (FSMT) from both the 159th and 45th Med Cos. All 145 aircraft of the brigade team flew from their home bases in Germany to their deployment sites in Bosnia.[8]

Capt. John Lamoureux served with the 1st Armored Division and then as the medical planner in the Division Medical Operations Center (DMOC). Using his

A MEDEVAC crew from the 236th Med Co (AA) supported the IFOR in Bosnia in July 1996. Source: 421st Medical Battalion (Evacuation) Historical Files.

accumulated medical and aviation skills, he became heavily involved in establishing the medical infrastructure for the operation. After he graduated from pilot training at Fort Rucker, Alabama, in August 1990, Lamoureux had served a short tour at the U.S. Army Aeromedical Research Laboratory—also at Fort Rucker—where he participated in several projects concerning aviation issues that arose in Saudi Arabia during DESERT SHIELD and STORM. Then he did a three-year tour with the 377th Med Co (AA) in Korea, where he served as a section leader supporting the 2d Infantry Division. He logged many sorties flying along the Korean DMZ, doing nap-of-the-earth navigation, and night patient pickups using night vision goggles (NVGs). He also deployed to Thailand for annual Operation COBRA GOLD exercises with Army Special Forces teams and Thai military units.[9]

Lamoureux returned to the United States in 1993 and attended the Medical Service Corps advanced course. He was then posted to a ground job as the medical company commander in the 501st Forward Support Battalion assigned to the 1st Armored Division in Germany. Serving directly with combat soldiers, he quickly came to appreciate what MEDEVAC meant to the front-line troops. He used personal connections to establish a strong relationship with the 421st Medical Battalion (Evacuation) and its three air ambulance companies. Lamoureux also called upon his MEDEVAC experiences to establish procedures within his unit to provide support for FSMTs so that they would have the logistical items neces-

sary to co-locate in the field with his medical company. Those procedures became standard throughout the division.

In the Army just six years, Lamoureux already had the opportunity to see both the aviation and medical sides of MEDEVAC. Juxtaposing his assignments in Korea and Germany, he recalled:

> My first assignment was in Korea and I felt that I had a good firm grip on the aviation piece. You fly a lot and do great things. Being a forward support medical commander allowed me to get my foot firmly planted in the medical community because I was clearly writing plans for the maneuver brigade, I was briefing at the DISCOM level, I was in lockstep with the medical planners at the Division Medical Operations Center. It really gave me a great foundation to match my aviation experience.[10]

It was also the perfect preparation for him to assume the medical planner duties in the DMOC. A few weeks later, the chief of the DMOC was needed for another assignment, and Lamoureux was given the job of chief of the DMOC as the 1st Armored Division moved south into Bosnia. He stayed with the DMOC until September 1996, when he was moved to Wiesbaden to serve as the S-3 of the 421st Medical Battalion (Evacuation), commanded by Lt. Col. Ken Crook.[11]

Moving briskly and purposefully into Bosnia, the IFOR handled its mission fairly handily. The local people were tired of the war and respectful of the NATO forces. They readily identified weapons caches and the location of land mines. De-mining operations were extensive and always dangerous. Civilian contractors hired local workers to build the necessary base camps. The wages stimulated the local economies.

Initially locating at the U.S. air base at Tuzla, the 236th—as part of TFME—subsequently deployed FSMTs to remote locations as necessary to support the MND-N units. Its first MEDEVAC mission occurred on 30 December when two aircraft were launched to a site where an American vehicle was damaged by an anti-tank mine. Only one soldier was seriously injured, and he was MEDEVACed through a snowstorm to the 212th. In early February, two soldiers on foot patrol were injured by a land mine. Crews from the 236th again answered the call and MEDEVACed them to the 212th. In another encounter with a landmine, medic Spc. Chad Blair of the 236th had to be inserted and extracted by hoist as he tried to help a Lithuanian team who had driven into a minefield. At one point, he had to freeze when the soldiers saw that he was dangerously near a live mine. Some very delicate flying by Maj. Tim Hartnett and outstanding hoist work by crew chief Spc. Courtney Cypert made it possible for Blair to recover four wounded troops.[12]

There was really little call for MEDEVAC. The people were tired of fighting. However, that did not mean that there was an end to strife. Emotions were still relatively raw, and the intricate process of undoing so much wrong was very time consuming. Crime was rampant, and drugs and prostitution proliferated. The absence of a credible and respected police force meant that allied forces had to fill the void. As one commander noted in a press conference, as the clock ran out on the IFOR deployment, it did not appear that conclusive peace could be ensured in one year.[13]

Doctrine

TRADOC Pamphlet 525-50, Operational Concept for Combat Health Support, October 1996

As Army units became deeply involved in the Balkans, the Army Training and Doctrine Command (TRADOC) published TRADOC Pamphlet 525-50. Applicable to all Army Medical Department and TRADOC activities that covered doctrine and training development, leader development, organization, materiel, and soldier requirements, it acknowledged the post–cold war international environment that presented the nation with new security challenges unprecedented in ambiguity, diversity, risk, and opportunity. Whereas in the cold war, the enemy was clear and present; in the "new world order," old forces of adventurism, nationalism, and separatism had reappeared with sometimes violent and unpredictable consequences.[14]

The new pamphlet proposed an operational concept for combat health support (CHS) required to support the Army into the 21st century. Missions were less clear, like peace operations, force protection, humanitarian assistance, and operations in aid of civil authorities. All operations were inherently joint, many were multinational, and frequently, Army forces had to work with non-Department of Defense agencies in achieving national objectives.[15]

The CHS system needed to take advantage of evolving technologies. Modern ground and air evacuation systems with enhanced en route medical support capabilities were required along with better communications capabilities over longer ranges, both for command and control (C2) reasons and to provide the medics with access to physician guidance.

These concepts were based on the recent doctrinal guidance in the 1994 version of Field Manual (FM) 8-55. The CHS system had to project support worldwide to help preserve U.S. global interests in operations from forced or unforced entry to humanitarian/nation assistance missions to multiple-corps operations requiring long-term sustainment. Evacuation forces still had to be capable of rapid clearing of the battlefield and the movement of sick or injured soldiers into the CHS system. Air evacuation remained the primary means, and all evacuation vehicles needed to be capable of providing enhanced en route medical care and monitoring capabilities.

The pamphlet also stated that future medical doctrine had to continue to underscore the joint and multinational nature of future operations. Synchronization of all available medical assets should not have duplicated the capabilities of other services and needed to be established in doctrine. This requirement dictated revision or rewrite of all FM 8 series manuals.[16]

The pamphlet also addressed the training of medics and combat lifesavers. Continuous emphasis was needed on their training and sustainment of medical proficiency in the multitude of environments in which Army operations took place.[17]

Although only directly applicable to the TRADOC and the Army Medical Department, this pamphlet was far reaching in its message. The cold war was over,

and Army medicine had to be prepared for the new joint, combined, and possibly intergovernmental mission sets arising while supporting large combat operations if they improbably arose.

Joint Doctrine – Joint Publication (JP) 4-02.2, Joint Tactics, Techniques, and Procedures for Patient Movement in Joint Operations, December 1996

In December 1996, the Joint Staff released another doctrinal document, JP 4-02.2. It was designed to delineate the requirements and considerations for joint patient movement within the health service support (HSS) system as well as the HSS aspects of joint patient movement planning and military operations other than war. It did not present specific tactics, techniques, and procedures, but it did emphasize that they could be found in service documents.[18]

The publication highlighted the role that patient movement played within the HSS. Service components were given the responsibility to provide for patient movement from point of injury to Echelon III facilities. The Army was given specific responsibility for providing medical rotary-wing support to ship-to-shore and shore-to-ship patient transport operations on an area support basis for all services operating within assigned grid coordinates.[19]

Reflecting evolving doctrine and the reality of recent events, JP 4-02.2 also included a chapter on military operations other than war such as: noncombatant evacuation operations, peace operations, terrorism, and combat zones enforcement. In these operations the medical forces were tailored to meet the HSS requirements for the specific type of operation being supported. Planning also had to consider the need to move local civilians or coalition personnel and their ability to provide their own medical support. Their capabilities or host nation support could make up a significant portion of the overall medical and possibly evacuation effort. Essentially, the overall joint guidance provided in this new JP reflected the tried-and-true MEDEVAC procedures developed by the Army but expanded to a joint and theater perspective.[20]

Operations

The Balkans

The mandate for the IFOR ended on 20 December 1996. It was abundantly clear to all that the UN and NATO forces could not leave. The ethnic hatred and strife were just too strong. The parties involved in the effort agreed to continue the mission with a NATO-led stabilization force (SFOR). However, reflecting some progress in the overall effort, it numbered 31,000 troops versus the 60,000+ force of the IFOR, and was expected to last for 18 months.

The force continued to include a sizable U.S. contingent built around a division. The 1st Infantry Division replaced the 1st Armored Division as Task Force Eagle under Operation JOINT GUARD.

Subsequently, several divisions served as the lead command of Task Force

Eagle. It also always had a medical subcomponent known as the TFME. It was manned by various U.S. Army medical elements such as the 44th Medical Command and the 56th Medical Battalion (Evacuation) from Fort Bragg, North Carolina, the 249th General Hospital from Fort Gordon, Georgia, the 334th Medical Group (USAR) from Grand Rapids, Michigan, and the 115th Field Hospital from Fort Polk, Louisiana. MEDEVAC units were assigned to all of them. The following divisions and MEDEVAC units deployed to Bosnia for SFOR/JOINT GUARD:

SFOR – SFOR1: 1st Infantry Division, November 1996 – October 1997. 45th Med Co (AA). The unit, commanded by Maj. John Cook, replaced the 236th. The 45th provided general support to the MND-N and operated 13 aircraft from Tuzla, Kaposjulak, Hungary, and Slavonski Brod, Croatia. Its crews received few calls for support as the number of U.S. forces steadily dropped from 8,500 to 5,300. An element from the 1st Medical Group commanded by Col. Frank Novier led TFME. Novier had his medical teams spread over the same three locations. As a former MEDEVAC pilot, he took particular interest in the preparation of the MEDEVAC crews. He insisted that as part of the training for the deployments, all crews should be trained in proper snow-landing techniques. He also requested that the crews have access to the tactical command centers so that they could get up-to-date intelligence for their flights. He worked very closely with the MND-N aviation staff officer to ensure that his crews were authorized to fly at lower weather minimums than the aviation task force pilots so that they could be more responsive to MEDEVAC calls.[21]

The 498th Med Co (AA) replaced the 45th Med Co (AA) in April 1997. The unit deployed from its home station at Fort Benning, Georgia, to join TFME, now led by the 61st Area Support Medical Battalion. The 498th was located at Tuzla where it worked closely with a Norwegian Medical Company. It was also in general support of the MND-N and kept aircraft on alert at the same locations.

While the 498th was deployed, four helicopters and 27 soldiers were activated from the 812th Med Co (AA) from the Louisiana Army National Guard (ARNG) to backfill for the unit at Fort Benning. They joined Wisconsin Guardsmen from the 832d Med Co (AA), which was also activated for backfill duties. The combined units covered MEDEVAC duties and Military Assistance to Safety and Traffic (MAST) commitments at Fort Benning and Fort Stewart, Georgia, and they deployed with several XVIII Airborne Corps units to major training activities at the Joint Readiness Training Center at Fort Polk.[22]

SFOR2 – SFOR3: 1st Armored Division, October 1997 – October 1998. Operation JOINT GUARD was terminated on 20 June 1998. The follow-on operation was JOINT FORGE, an open-ended commitment to support NATO in its assigned peace enforcement mission in Bosnia-Herzegovina.

The 159th Med Co (AA) supported this operation from October 1997 to June 1998. Upon arriving, this Germany-based unit scattered its 13 aircraft and crews essentially as the previous units had done, while accomplishing the same general support mission. The unit worked closely with Norwegian medical teams and carried them to remote villages for civic action projects. Its crews also worked

directly with Swedish explosive ordnance demolition teams and dogs to clear out minefields.[23]

In June 1998, the 236th made its second deployment to Bosnia and replaced its fellow Germany-based unit with nine aircraft and 78 troops. Six aircraft were sent to a landing area called the Blue Factory, where they sat alert. The other three rotated between various forward locations and Taszar, Hungary. There were few calls for MEDEVAC and the unit logged mostly training missions.[24]

SFOR4 – SFOR5: 1st Cavalry Division, October 1998 – August 1999. The 126th Med Co (AA), California ARNG mobilized and deployed with 10 aircraft and 81 soldiers in August for an October handover. As a Reserve Component unit, the 126th had some problems getting all necessary equipment because it was not a priority unit. Additionally, the late arrival of orders caused problems for some of the unit soldiers. More lead time was needed to do all of the actions necessary to activate, mobilize, and deploy. Arriving at Tuzla, they were assigned to the 41st Combat Support Hospital. The crews received orientation rides from the pilots of the 236th, who then returned to Germany. The unit placed seven aircraft and crews at Tuzla and three aircraft and crews at Taszar, Hungary. Many of the crewmembers were veterans of duty in Vietnam. All agreed that duty in Bosnia was better where the facilities were nicer and the operations tempo was much lower. Most of the Guardsmen were "M-Day soldiers," who willingly volunteered for the activation and deployment, which required stepping away from their civilian professions. When briefed on the potential threats to flying in the theater, most agreed that it was less dangerous than many of the missions that they flew at home to fight forest fires or rescue lost mountain hikers.[25]

The 24th Med Co (AA) Nebraska ARNG, with 77 soldiers of the unit and its sister detachment from Kansas, mobilized and deployed to support the 1st Cavalry Division in March. Personnel took five aircraft from Nebraska and four from Kansas. Aircraft and crews sat alert at both Tuzla and Camp McGovern. On one particularly notable mission two crews rescued a team of NATO soldiers who had wandered into a minefield. They remained in place to support the next rotation when the 1st Cavalry Division returned home in August and performed 35 air evacuations.[26]

SFOR6: 10th (Mountain) Infantry Division, August 1999 – March 2000. The 24th Med Co (AA) was replaced by the 112th Med Co (AA) Maine ARNG, which also deployed with five aircraft and 77 personnel. In February 2000, the 1042d Med Co (AA) Oregon ARNG replaced the 112th. When the 1042d arrived, the TFME was led by an element of the 115th Field Hospital from Fort Polk. The 1042d deployed under the command of Maj. Mathew Brady. Brady, a classic Guardsman, had initially joined the Oregon ARNG in 1984 as an enlisted soldier and was subsequently sent through the state officer candidate program and commissioned as an infantry officer in 1986. Within two years he was branch transferred to aviation and attended pilot training. After attaining his flight wings, he was transferred to the 1st Battalion, 108th Aviation Regiment, and rose to command B Company of that unit. He also started a career with the Oregon Department of Corrections. When the 1042d Med Co (AA) was activated, he transferred to its

parent command, the 641st Medical Battalion (Evacuation), also an Oregon unit. When the 1042d transitioned to the UH-60Ls, he completed the conversion training, applied for a branch transfer to the Medical Service Corps, and was accepted. He then attended the aeromedical evacuation course and the medical officer advanced course to qualify as a 67J.[27]

In 1999, he was given command of the 1042d. He took a leave of absence from his civilian job and went on active duty to prepare the unit for its scheduled rotation to Bosnia.

The unit deployed with six aircraft and 90 troops and arrived at Tuzla in the dead of winter. Traumatic injuries were few, and the unit flew only 25 actual MEDEVAC missions during the tour. Most missions involved patients with broken bones from automobile accidents. The unit participated in a mass casualty drill with the other TFME elements and other coalition medical units.

The aircraft were divided with three maintained at Tuzla and three farther north at Camp McGovern. The maintenance crews were outstanding and kept the aircraft mission ready 97% of the time.[28]

SFOR7: 49th Armored Division Texas ARNG, March 2000 – October 2000. This was the first time that a Reserve Component division-sized unit had deployed out of the United States since the Korean War, and it was a significant shift in use of the Guard commands. Traditionally, the units had been trained and organized to fight in "the big war." But with the reductions that had occurred since DESERT STORM, they were used increasingly for peacekeeping operations. While in SFOR, the 49th commanded active duty units and established a paradigm that became increasingly common in future operations. The 1042d Med Co supported the 49th Armored Division during the rotation and returned home shortly after it.[29]

SFOR8 – SFOR9: 3d Infantry Division, October 2000 – September 2001. The 57th Med Co (AA) supported the 3d Infantry Division for SFOR8. The unit deployed from Fort Bragg with six helicopters and 59 troops. It was assigned to TFME, then under the control of the 56th Medical Battalion (Evacuation), also from Fort Bragg, and commanded by Lt. Col. Pauline Lockard.

Lockard had taken command of the battalion in the fall of 1998, after attending the Army Command and General Staff College and then serving in staff assignments. The position authorized her to requalify in the UH-60, and while in Bosnia she flew several MEDEVAC missions. Returning with her headquarters element to Fort Bragg in April 2001, she subsequently gave up command of the battalion in July and reported for more staff duty with the Office of The Surgeon General in Falls Church, Virginia.[30]

On 1 November, the 57th was called to launch an aircraft to pick up a U.S. Navy sailor who had been badly injured when he fell off a high wall while on shore leave in Dubrovnik, Croatia. This area was not under the coverage of TFME. However, medical authorities determined that the sailor needed to be evacuated to Germany. The best way to do that was to move him to Tuzla where he could then be cross-loaded to a C-130 that could transport him to Ramstein Air Base. TFME assigned the mission to the 57th.

The second up crew of CW2 Michael Philips, CW2 Kevin Smelser, S.Sgt.

Richard Rigsby, and medic Sfc. Donald McMillon received the call to go, but an early winter storm moved in with low clouds and visibility, and heavy precipitation. The crew took off anyway. They were in the weather most of the time but flew into Dubrovnik where the sailor was taken care of by Navy personnel.

When he was safely loaded, the crew took off for the return flight. Again facing terrible weather, they made a refueling stop at Mostar to ensure that they had plenty of fuel to divert in case they could not get into Tuzla. Thankfully, the weather improved as they flew north and arrival at Tuzla was not a problem. As they landed, the C-130 was waiting. The patient was quickly transferred and then flown to Germany for treatment. The entire mission was a great demonstration of teamwork.[31]

For SFOR9, the 1022d Med Co (AA), Wyoming ARNG, which was attached to the 2d Battalion, 3d Aviation Regiment, 3d Infantry Division, supported the 3d Infantry Division. The Wyoming guardsmen deployed with four aircraft and 54 personnel and maintained alert at two locations. In May, the division surgeon held a mass casualty exercise. It had been a while since anything like this had happened, and the exercise highlighted several procedural shortcomings and provided excellent training for all participants. Overall, the rotation was relatively quiet, and only six air evacuations were made.[32]

SFOR10: 29th Infantry Division, Virginia ARNG, September 2001 – April 2002. The 498th Med Co (AA) supported an element from the 28th Combat Support Hospital from Fort Bragg, which led the TFME. Maj. Greg Gentry commanded the 498th and deployed four aircraft and crews and 39 support personnel. He was new to the unit. After his tour with the 57th at Fort Bragg, he served with the 56th Medical Battalion (Evacuation)—also at Fort Bragg—and then at Fort Sam Houston, Texas, as a combat developer before taking command of the 498th in May 2001.[33]

While in Bosnia, the 498th performed 10 MEDEVAC missions, carrying 10 patients. Most missions were relatively routine with a mix of civilian and military patients. On one occasion, the "patient" was a military working dog who was carried from Camp McGovern to Eagle Base. The task force veterinarian rode along to provide expert en route care.

The unit also took part in three larger operations. Two were directed at possible terrorist elements and resulted in the recovery of several weapons and significant quantities of explosives. Another mission involved an attempt to capture a known war criminal responsible for ethnic atrocities. The mission lasted two days, but the criminal was not found.[34]

SFOR11: 25th Infantry Division, April 2002 – September 2002. The 1085th Med Co (AA), South Dakota/Montana ARNG, mobilized and deployed to support the operation when the 498th departed. The unit only deployed four aircraft, six crews, and 47 soldiers. It was under the control of TFME, led by a team from the 249th General Hospital from Fort Gordon, and was attached to the 1st Battalion, 25th Aviation Regiment, 25th Infantry Division.[35]

SFOR12: 28th Infantry Division, Pennsylvania ARNG, September 2002 – March 2003. On 3 January 2003, the MND-N was redesignated the Multi-National

Brigade North, with ARNG divisions in overall command. The total U.S. force commitment was about 1,400 troops. Active duty units were initially scheduled for the subordinate roles. Because of new commitments generated by the horrible events of 11 September 2001 and subsequent Global War on Terror, they were re-tasked and ARNG units replaced them. Subsequently, almost all units and troops dispatched to JOINT FORGE were ARNG and U.S. Army Reserve troops.

The 1159th Med Co (AA) New Hampshire/New Jersey ARNG supported this rotation. The unit deployed with 35 personnel and four UH-60s. Assuming alert duties at the two main sites, the unit supported all the coalition forces and also picked up civilians hurt in the declining but still troublesome internecine violence. On numerous occasions, the unit also dispatched aircraft and crews directly to support teams performing dangerous minefield-clearing operations.[36]

SFOR13: 35th Infantry Division, Kansas ARNG, March 2003 – September 2003, and SFOR14: 34th Infantry Division, Minnesota ARNG, September 2003 – March 2004. The 86th Med Co (AA), Vermont/Massachusetts ARNG, supported these two rotations under the command of the 5th Medical Group, a U.S. Army Reserve unit from Birmingham, Alabama, commanded by Col. Dan Dire. Maj. John Johnston from Vermont commanded the 86th for the first rotation, and Maj. Dave Underwood from Massachusetts commanded the second. The combined unit deployed with two aircraft from each state that remained for the duration. Their crews performed 34 MEDEVACs, although most flying was routine training as the country continued to stabilize.[37]

SFOR15: 38th Infantry Division, Indiana ARNG, March 2004 – December 2004. In December 2004, the SFOR had shrunk to a residual force of only 7,000, of which about 1,000 were U.S. troops. At that point, Task Force Eagle was disestablished, and the U.S. base at Tuzla was turned over to European Union forces who assumed the mission under Operation ALTHEA. A Finnish element took command with a small U.S. contingent of 150 troops that remained to facilitate the transition, continue the search for war crime suspects, and ensure—that if necessary—a stronger NATO force could rapidly re-enter if the need arose. For SFOR14 and 15, an element from the 5502d U.S. Army Hospital commanded the TFME and was supported with a collage of detachments from many units that included four UH-60 helicopters and crews from the 1256th Med Co (AA) Indiana ARNG, and Det 1, 149th Med Co, Arkansas ARNG. They were both attached to the 2d Battalion, 238th Aviation Regiment, also from the Indiana ARNG. There was little to do except to train allied medical units, be ready for any calls, and shut down the operation and go home.[38]

Organization

Unit Realignments

In a larger vein, 1998 was another year of change for the MEDEVAC force and saw the completion of the Medical Force 2000 plan as units in the Pacific were realigned. The 283d Med Det (RA) at Fort Wainwright, Alaska, was inactivated.

Its personnel remained at Fort Wainwright but were now assigned to the 68th Med Det (RA), which was converted to a Med Co (AA). At the same time, the last air ambulance medical detachments, the 247th Med Det (RA) at Fort Irwin, California, the 229th Med Det (RA) at Fort Drum, New York, and the 36th Med Det (RA) at Fort Polk, were also inactivated and transitioned to U.S. Army Air Ambulance Detachments as Table of Distribution and Allowances units.[39]

In Central America, the 214th Med Det (RG), commanded by Maj. Scott Drennon, remained in Panama, although it had changed its base twice. Since the early 1990s, it had also maintained a team of three aircraft and crews at Soto Cano Air Base, Honduras, to support Joint Task Force-Bravo, where it was attached to the 4th Battalion, 228th Aviation Regiment. As part of this change, the 214th was inactivated. Its assets were moved to Soto Cano and reestablished as a U.S. Army Air Ambulance Detachment under the control of the 1st Battalion, 228th Aviation Regiment, which had also moved up from Panama. The detachment had four aircraft assigned to it and was augmented with ARNG aircraft and crews and support personnel.[40]

Literally as this change was occurring, the unit was tasked to provide support for hurricane relief operations when Hurricane Mitch swept through Central America in November 1998. Scott Drennon led a small task force of two UH-60s, two CH-47s, and two MEDEVAC UH-60s that worked directly with Nicaraguan crews to provide relief for the local inhabitants. One crew, "Witch Doctor 36," conducted 10 rescue-hoist missions in severe weather to rescue 36 Honduran civilians from raging floodwaters. The crew also delivered food and water to locals stranded by washed out roads and mudslides. Overall, the crew transported 192 injured patients in 18 days.[41]

The unit subsequently supported ongoing counter-drug operations and civic actions programs with the Joint Task Force-Bravo medical element. It was also routinely supplemented with both active and ARNG MEDEVAC units or detachments from the continental United States.

Operations

The Balkans – Albania and Kosovo

NATO's benevolent and persistent actions brought relative peace and stability to Bosnia. However, they did not completely quash the virulently nationalist enthusiasm of Serbian leader Slobodan Milosevic. He turned his attention to Kosovo, one of the few remaining Yugoslavian provinces. Located just south of Serbia, it had been a historic part of the larger nation where Serbian roots ran deep. However, by the 1990s the population was 90% Albanian, and they had been given a form of local autonomy. After the loss of Bosnia, Milosevic used his overbearing military to suppress the Albanian Kosovars. In response, they formed a guerilla-type movement called the Kosovo Liberation Army (KLA) and retaliated against the Serbs.

The Serbs stepped up their actions, and in one particularly bloody attack, killed

Flight Line at Rinas Airfield, Albania, showing the UH-60s of the 159th Med Co as part of Task Force Hawk.
Source: Dave Zimmerman.

45 Albanian civilians in the Kosovar village of Racak. NATO leaders then invited all involved parties to peace talks in Rambouillet, France, in February 1999.[42]

The talks were futile as Milosevic refused to accept a NATO peacekeeping force, which was vital to enabling any ceasefire and stability in that area. He unleashed his troops to conduct what had clearly been preplanned offensive operations in Kosovo. Heavily armed mechanized troops, Special Forces, and paramilitary elements ravaged both city and countryside in an orgy of arson, murder, and rape. It was a repeat of the horrible events in Bosnia—ethnic cleansing of the worst kind, all designed to drive out the Albanians and establish Serbian hegemony over the area. The casualties mounted into the thousands. Hundreds of thousands of refugees fled into the mountains or into Albania and Macedonia, threatening to overwhelm those small nations and destabilize the entire area.

Allied aircrews flew more than 500 missions hauling supplies into Albania where American engineers quickly built three camps to care for the 60,000+ refugees.

The NATO members resolved to counter the Serbian aggression with strong military actions. However, a ground campaign was ruled out and an aerial bombing campaign was initiated. For 78 days, NATO aircraft pummeled Serbian targets within Kosovo and the homeland with more than 38,000 sorties. Using primarily precision-guided weapons delivered from higher altitudes to avoid the Serbian air defenses, NATO aircraft destroyed oil refineries and reserves, bridges, command posts, and military airfields, as well as more than 100 aircraft on the ground. Ten Serbian fighters were also destroyed in air-to-air combat.

The strategic damage to Serbia was profound, but it did not deter them from terrorizing the Albanians. Additionally, the aerial attacks against Serbian targets in Kosovo were less effective because of weather conditions and the Serbian forces' skillful use of camouflage techniques and decoys. NATO countered by developing connections with the KLA. These forces began feeding targeting data for the air campaign, and the effectiveness of the airstrikes increased dramatically. The KLA coordinated its actions with the air campaign, and the two forces developed a synergy of effort. In effect, the KLA became an effective ground campaign to complement the effort from the air.[43]

Task Force Hawk

NATO could not deny the effectiveness of the KLA forces and quietly built up support ground forces in Macedonia and Albania. The U.S. Army contribution to this force was Task Force (TF) Hawk, commanded by the V Corps commander, Lt. Gen. John W. Hendrix. It included an aviation/mechanized force package commanded by the TF Hawk deputy commanding general, Brig. Gen. Richard A. Cody, and a smaller ground force called Task Force Falcon. Hawk was a brigade-sized element of 24 AH-64 attack helicopters named Task Force 11 (TF-11), joined by a force of support helicopters including MEDEVAC, designated Task Force 12 (TF-12), 27 multiple launched rocket systems, a 105 mm artillery battery, a company of M-1A tanks, a mechanized infantry battalion, an airborne infantry battalion, and a significant logistics element. However, when the Macedonian government vetoed the deployment, TF Hawk moved into Albania.[44]

The task force deployed in April and set up at the Rinas Airfield, 12 kilometers northwest of Tirana. The task force consisted of 5,000 soldiers task organized for deep aviation operations with AH-64s, long-range fires with multiple launched rocket systems, and lift operations to insert peacekeeping forces into Kosovo. Lt. Col. Alan Moloff commanded the medical support package that comprised medical personnel from the 212th Mobile Army Surgical Hospital, which headed up the Contingency Medical Force.

A six-aircraft package of MEDEVAC helicopters from the 159th Med Co (AA), under the command of Maj. Michael Avila, joined TF-12. The unit had recently returned from a humanitarian deployment to Austria where it had been part of a task force that evacuated individuals from the small town of Galtur who had been trapped by a massive avalanche.

Reflecting the recent changes in MEDEVAC doctrine, the 159th was tasked to support combat search and rescue operations as part of downed aircraft and aircrew recovery teams, in addition to its classic MEDEVAC functions. During the predeployment training, its crews practiced these procedures. The attachment of the 159th to TF-12 allowed the MEDEVAC unit to better integrate into the task force aviation supply and maintenance structure; and it afforded better access to all of the intelligence, weather, and airspace control data necessary to integrate properly into theater-wide aviation operations.[45]

Reminiscent of aviation operations for DESERT SHIELD, the majority of aircraft from TF-12 self deployed. Because of airspace restrictions the 1,100-mile flight took the aircraft and crews through France and Italy, and across the Adriatic Sea to Rinas. Arriving there in mid-April under rainy conditions and near freezing temperatures, the soldiers found an airfield awash with deep mud and engineers frantically scrambling to build proper hard stands and roads for the aircraft, ground vehicles, and troops.[46]

Once in place, the aviation and MEDEVAC crews began flying missions. Flying conditions were challenging. Low visibility and turbulence were constant factors over the mountainous region near the Kosovo border. All aircrews also had to be aware of the threat of surface-to-air missiles both along the border and within Albania from infiltrating Serbian teams.

As teams of up to eight AH-64 gunships proceeded to the border region, they were supported by CH-47 "Fat Cow" refueling aircraft and a downed aircraft and aircrew recovery team that included three aircraft:

1. A C2 helicopter;
2. A C2 helicopter with a security team onboard; and
3. A MEDEVAC aircraft.

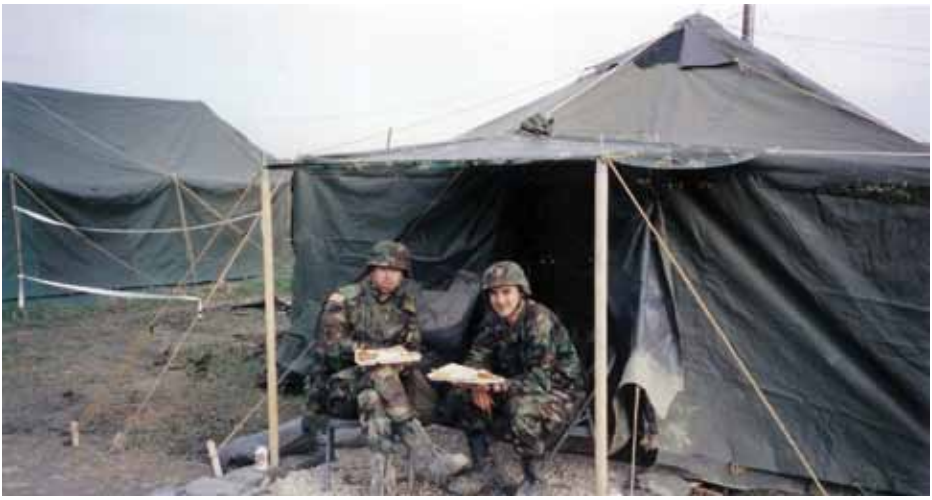
The majority of missions were flown at night utilizing NVGs to give them the maximum protection against enemy forces. While conducting these missions, two AH-64s crashed. In both instances, the MEDEVAC crews responded as part of the downed aircraft and aircrew recovery team packages. They rescued one crew, but the second was killed in the ensuing fire.

The following personnel from the 159th crew made the unsuccessful rescue attempt:

- Pilots: 1st Lt. Dave Zimmerman and CW2 Derek Reel
- Medics: S.Sgt. Judy Mumm and Sgt. Paul Yocum
- Crew Chief: Sgt. Don Stewart

Zimmerman landed the UH-60A near the AH64 crash site, although the intensity of the light from the exploding 2.75 rockets, Hellfire missiles, and 30 mm ordnance made the crew's NVGs almost unusable. When safely on the ground, he immediately dispatched his crewmembers to search the wreckage. Col. Jeff Schloesser, the TF-12 Commander, was also on the ground and attempted to assist. Mumm saved Schloesser's life by protecting him when more ordnance exploded. The heroic efforts of the 159th crew were in vain because neither AH-64 pilot survived the crash. However, all crewmembers received Air Medals for their efforts. Additionally, Mumm, Yocum, and Stewart each received the Soldiers' Medal for their actions, and Zimmerman received the 1999 Aviator Valor Award presented by the American Legion.[47]

Aircrews from the 159th also performed four classic MEDEVAC pickups in support of TF Hawk including the evacuation of local civilians, foreign military



Capt. John McMahan, Flight Platoon Leader, and 1st Lt. Dave Zimmerman, FSMT Leader of the 159th Med Co, in Albania with Task Force Hawk in 1999.
Source: Dave Zimmerman.

personnel, and U.S. service members. The 159th also supported ongoing efforts of the larger humanitarian effort in Albania called Operation SHINING HOPE.[48]

As he had been trained, Avila maintained launch authority for his crews. He briefed them at the beginning of the flying day and then expected them to launch themselves unless conditions had significantly changed. On one evening, a mission came down for a MEDEVAC. The pickup site was up in the mountains, and there was a known threat. The aircraft commander asked that the quick reaction force be launched to escort him. He was told that only the brigade commander could authorize their launch. When the brigade commander was approached, he refused the use of the quick reaction force, and the wounded were eventually brought out by land evacuation. The aviation commanders questioned the handling of MEDEVAC launch authority and whether it should rest with the MEDEVAC company commander.[49]

Operations in Albania only continued until June. They were terminated when—after 78 days of continuous bombardment—the steady buildup of ground forces on his borders, and intense international diplomatic efforts, Milosevic capitulated and evacuated his forces and sycophants out of Kosovo. The Military Technical Agreement was signed on 9 June 1999. The next day, the UN Security Council signed Resolution 1244 directing NATO to establish a security presence in Kosovo so that displaced persons could return home safely, a transitional administration could be established, and humanitarian aid could be delivered. NATO established a Kosovo Force (KFOR) under Operation JOINT GUARDIAN consisting of five international brigades—one led by the United States—that divided the country into zones similar to Bosnia.[50]

Task Force Falcon

Few incidents occurred as the Serbian forces departed and the various national task forces quickly deployed. Speed was essential to prevent a power vacuum and the caching of weapons possibly left behind by the Serbs. Many of the U.S. forces were from TF Hawk. They were moved into Kosovo and joined TF Falcon, led by the 2d Brigade of the 1st Infantry Division, from Schweinfurt, Germany, which was assigned duty as the lead command for the Multi-National Brigade East (MNB-E).

As the task force moved into the region, it was initially prepared to protect the ethnic Albanians. The reality on the ground was much different. The hatred among all ethnic groups was so rife that the larger threat was general anarchy. The disparate groups were so intermixed that there was no practical way to physically separate them. One unidentified infantry battalion commander noted, "The hatred is so intense and irrational it is unbelievable." He could not believe that the internecine strife had led to the virtual destruction of all public service and utilities. Whole villages had been burned. Cemeteries were destroyed, vandalized, or mined.[51]

One of the units that moved forward to Kosovo was a detachment from the 159th Med Co (AA), still attached to the aviation task force. Its crews received all of their taskings through the maneuver brigade operations center because it was the only command node with any communications capability.

TF Falcon also had a medical element - TF Medical Falcon (TFMF). The mission of TFMF was to provide up to Echelon III combat health support to the MNB-East. It also was on call to support the larger UN Mission in Kosovo and various nongovernmental and international organization initiatives to establish a stable health care system for all Kosovars. TFMF comprised about 200 personnel from many specialties, with small detachments from many different units. A detachment from the 30th Medical Brigade from Heidelberg, Germany, provided overall command and control, with personnel from the 67th Combat Support Hospital based at Würzburg, Germany, providing critical support. The structure was essentially maintained as units and personnel from both active duty and reserve units rotated through it. The 159th detachment directly supported them.[52]

Joining the task force, the 159th sent two helicopters and crews to Camp Able Sentry, which was set up near Skopje, Macedonia. The crews provided MEDEVAC coverage for the large convoys moving all of the heavy equipment and supplies being unloaded at the Greek port of Thessaloniki for the Kosovo force. The 159th left two aircraft and crews in Albania to cover the remnants of TF Hawk until all had either moved over into Kosovo or returned to their home stations. At one point, Avila had his crews and support personnel scattered between three widely separated locations. He could only communicate with them via the Internet.[53]

For the next several weeks, as the NATO forces moved into Kosovo, 159th crews flew 55 missions to evacuate wounded soldiers and civilians, several of whom were women in labor. In July, several missions were flown to evacuate

some of the 30 Serbs wounded when a bomb was detonated in an open air market in the small city of Vitina. The MEDEVAC crews also flew many medical teams on a weekly basis to remote villages to work with local medical personnel to stem the spread of diseases such as tularemia, a bacterial disease usually found in water contaminated by dead animals and spread by rodents.[54]

The TF Hawk deployment to and employment in Albania only lasted about 100 days. Yet it was eventful from a MEDEVAC perspective. The MEDEVAC lesson learned collected by the Army Center for Lessons Learned stated:

> A particularly valuable innovation involved the attachment of the Air Ambulance Company to the Aviation Brigade, instead of the Medical Command. This enabled the company commander to play an active role in the development of evacuation planning instead of working with the aviation assets externally. The commander sat in the meetings as a green-tab commander and had complete access to all information necessary for him to accomplish his mission. Access to aviation supply and maintenance was easier to attain, as well as integration into the Army Airspace Command and Control (A2C2) plan…To ensure prompt release authority is available to them, medical commanders traditionally prefer to retain aeromedical evacuation under their direct command and control. But the many benefits derived by placing the MEDEVAC units under aviation control in the field makes this a viable option for future operations.[55]

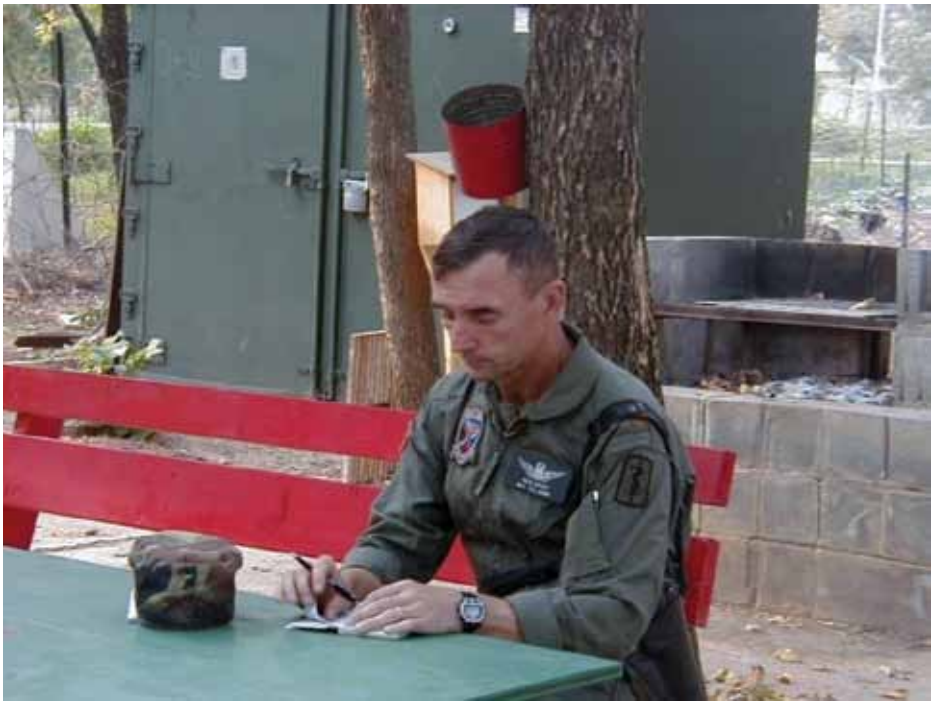
The commander of the Contingency Medical Force, Lt. Col. Alan Moloff, concurred with this assessment, stating in a post-operation interview:

> One of the conscious decisions made was to attach a rotary-winged air evac unit [the 159th Med Co (AA)] to the AV Bde, which was a very smart thing to do in this kind of operation. They have maintenance, the flight operations and…flight following. They came in with the first wave of [AH-64s].[56]

The Task Force Surgeon, Lt. Col. James Bruckart, supported this by saying in his post-operation interview that "The way we have the C2 lined up with the MEDEVAC guys attached to support AV [aviation] is the right thing to do. It allows us access to the C2 structure in the AV chain." When asked if this was doctrinal, he stated:

> It is and it isn't. There are some folks who would like to have release authority strictly with the medical folks, and it depends a lot on the unit. I think this is one area of our doctrine that you can take two different directions, depending on whom in the [medical] community you talk to. I think this is an area of our doctrine that is not as clear as it should be, and there are two ways we can get to our solution…If MEDEVAC were separate, it is much more likely that we would be used as a normal ground force, and would not follow the [AH-64] strikes in. There may be other operations, particularly peace support, where the primary mission may not be to support strikes, but rather to support the medical community. This could be where direct support to a medical [task force] commander is the right way to go as well.[57]

The 159th Med Co (AA) established itself in a semipermanent facility at Camp Bondsteel in late June as part of what was now KFOR1A, and it was then replaced with a six-aircraft detachment from the 45th Med Co (AA). The 45th was under the command of Maj. Pete Smart, who had taken over in July 1998, after four years in Hawaii with the 68th Med Co (AA).



Maj. Pete Smart in Kosovo in 1999.
Source: Pete Smart.

The Bondsteel facility, which covered 955 acres with a perimeter of about 7 miles, was located in the rolling hills and farmland near the city of Ferizaj/Urosevac, about 30 kilometers south of the capital of Pristina. Missions were few as the ground forces found themselves engaged mostly in keeping the various factions separate and helping to develop a functioning government, police force, and peaceful society. Most MEDEVAC calls were for local nationals.

One of the allied elements in the area was a Russian task force. Smart fortuitously had a fluent Russian speaker in his unit who came from a most unexpected background. S.Sgt. Felix Gomez was from Nicaragua. As a young man, he had joined the Nicaraguan Air Force and had learned the language when he attended a three-year technical school in Russia. When he returned home, he defected to the United States and joined the Army. Smart appointed Gomez as an unofficial liaison with the Russians. Overall, Kosovo duty was relatively peaceful and even boring. It was a replay of Bosnia as some semblance of economic activity and civil life returned.[58]

The 45th served with KFOR until December, when six aircraft and crews from the 236th Med Co (AA) from Landstuhl, Germany, as part of KFOR1B replaced

it. Maj. Jon Fristoe commanded the unit. He and the 236th detachment deployed as part of an aviation task force from the 11th Aviation Regiment from Ketterbach. They were assigned to the aviation brigade from the 1st Infantry Division. A team from the 67th Combat Support Hospital led the medical detachment. Fristoe worked directly with them on all medical issues and discovered that they knew almost nothing about aviation.[59]

Missions were relatively routine, with weather posing the biggest challenge. In early January 2000, Fristoe and his crew were called to rescue a young child who had fallen through ice into a stream. Scrambling out just ahead of lowering fog, they reached the site, but could not find the boy. They called for a second aircraft, but none could take off because the weather had moved in at both operating bases. The medic, Sgt. David Estrada, volunteered to go into the water. That was ruled out as far too dangerous. Instead, he was lowered on the hoist so that he could closely search the stream and accumulated ice. For several minutes, the medic dangled from the hoist as the crew chief carefully coordinated the movement of the aircraft with the pilots to allow Estrada to search. However, the boy was not found. Estrada had to be hoisted back into the aircraft and then cared for himself because he became dangerously chilled. The mission was unsuccessful, but showed the determination and professionalism of the MEDEVAC crew. During that rotation, the 236th crews logged 1,242 flight hours and evacuated 188 patients in support of UN forces and the civilian populace.[60]

In May, the 159th Med Co (AA) again replaced with the 236th Med Co for KFOR2A, with TFMF commanded by an element from the 30th Medical Brigade. By that June, the MEDEVAC units had flown 131 missions, carrying 71 U.S. soldiers, eight NATO troops, and 47 local nationals. One-half of them were urgent status, and 80% of the missions were conducted during the day. Given the hilly terrain and poor roads, the air ambulances accomplished most evacuations. The commanding general released a directive requiring all soldiers to be proficient in the utilization of MEDEVAC request procedures. Radio repeaters had to be placed throughout the area of responsibility so that all personnel could make radio contact to pass MEDEVAC requests.[61]

However, the overall political and security situation continued to steadily stabilize, and the size of the KFOR/JOINT GUARDIAN task force also steadily decreased. The 45th Med Co (AA) replaced the 159th in September 2000, as part of KFOR2B, and was then replaced by the 236th Med Co in early January 2001.[62]

On 16 February 2001, Serbian partisans attacked a bus filled with Albanian locals, killing 14 and injuring 32 persons. Crews from the 236th MEDEVACed 13 seriously wounded persons to Camp Bondsteel.[63]

The 50th Med Co (AA) replaced the 236th in May 2001 for KFOR3A. The unit deployed as part of a larger 101st Airborne Division package called TF Sabre. Led by the Company Commander, Maj. Steven Millward, it took six aircraft and 39 personnel. The unit kept four aircraft and personnel at Camp Bondsteel and two aircraft and crews at Camp Able Sentry. Unit crews flew 127 evacuation missions that carried 158 patients including U.S. and allied soldiers and local nationals.

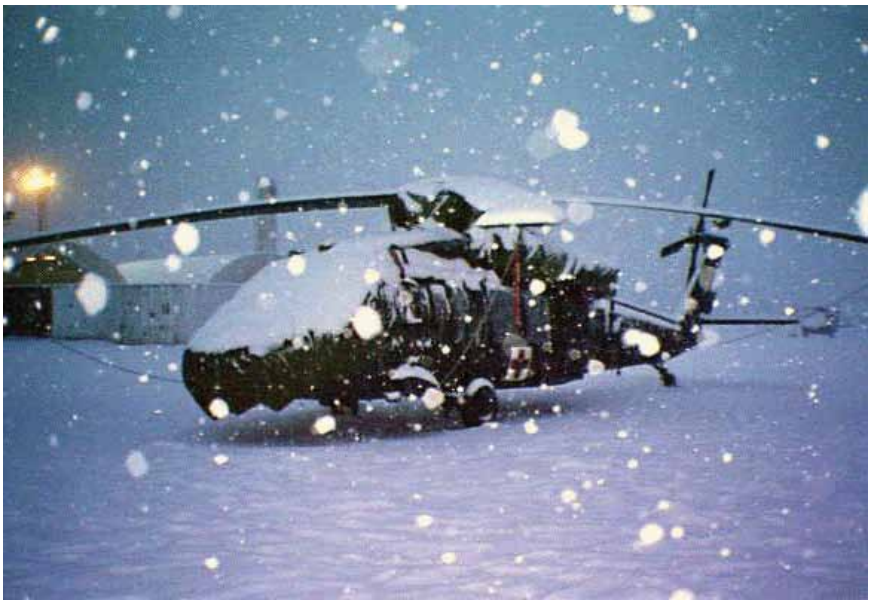
The unit also took advantage of the deployment to conduct some focused NVG training using new goggles for all aircrew. CW3 Andrew Feris was on that deployment and made good use of his NVG training to make several recoveries at night. On a mission into Macedonia he and his crew picked up a badly wounded individual from a British unit and delivered him to Pristina. On another mission they picked up an Albanian who had been severely beaten by a mob. Feris also found that language could be a barrier. It was not uncommon to dispatch to a pickup location to recover a patient with a reported common problem, such as an appendicitis, and then discover that the patient had actually suffered severe gunshot wounds. The non-English speaking teams could not clearly express themselves in detailed medical terms and used a few common phrases to make their requests. For the crews, it made every mission potentially very interesting.

In general, duty in Kosovo proceeded at a more steady and leisurely pace. Newly elected President George W. Bush visited Camp Bondsteel on 24 July 2001, and the summer passed relatively benignly. Likewise, the 11th of September started out as another quiet day. However, that rapidly changed when the few televisions around the base showed the horrific scenes from New York, the Pentagon, and later, Pennsylvania. The base was immediately locked down, and all soldiers were ordered into their full combat gear, wondering—while they donned it—where events would take them in the future.[64]

For KFOR3B, in October 2001, the 717th Med Co (AA), New Mexico ARNG, under the command of Maj. Michael Montoya, deployed to support a brigade task force from the 82d Airborne Division. It was attached to an aviation detachment from the 1st Squadron, 17th Cavalry Regiment, and supported the 67th Combat Support Hospital. Six aircraft and crews were split between Camp Bondsteel and Camp Able Sentry in Macedonia. These crews conducted 60 urgent MEDEVAC missions for U.S. and coalition soldiers, and transfer missions to the large international airport at Thessaloniki, Greece, so that U.S. personnel could be flown to Germany. Crews also provided MEDEVAC for local Albanian and Serbian citizens throughout the KFOR AOR. On 31 December, one of their crews performed a harrowing rescue of a Special Forces team who needed to be recovered from atop a 7,000-foot peak before severe weather overtook them. The crew of Warrant Officers Jason Hyer and Michael Rohrbeck, medic S.Sgt. Robert Parnell, and crew chief Spc. Robert Sage, maneuvered their aircraft onto a narrow ice encrusted ridgeline to safely pick up the fatigued team that was also suffering from altitude sickness. The Guardsmen of the 717th returned home in May 2002, as the American contingent in KFOR dropped to 3,000 troops.[65]

KFOR4A May 2002 – November 2002 and KFOR4B November 2002 – May 2003. The 45th Med Co (AA) from Germany replaced the 717th troops for KFOR4A, and it supported the 67th Combat Support Hospital. The 45th was augmented with personnel and aircraft from both the 236th and 159th Med Cos. On 31 July 2002, their crews MEDEVACed two U.S. soldiers wounded by a mine that detonated as they were conducting clearing operations near the village of Klokot.[66]

As the social and economic landscape slowly stabilized, the UN further reduced



A hard winter in Bosnia.
Source: U.S. Army.

forces in the area. Most incidents included more petty crime like smuggling, drugs, and prostitution, as opposed to ethnic strife or overt challenges to the government or the UN forces. Several national contingents were either reduced or returned to their home nations. Overall, forces had been slowly reduced by 40%.[67]

KFOR5A May 2003 – November 2003 and KFOR5B November 2003 – May 2004. A detachment of helicopters and personnel from the 24th Med Co (AA), Nebraska/Kansas ARNG, supported these deployments. During June 2003, personnel conducted an evacuation exercise with Spanish MEDEVAC helicopters supporting a combined exercise with Spanish Task Force Tizona, and the U.S. Army 2d Battalion, 2d Infantry Regiment. Medics and crews from both units lauded the realism and necessity of the training.[68]

KFOR6A May 2004 – November 2004. The 146th Med Co (AA), Tennessee ARNG, sent a small detachment of helicopters and personnel to support this rotation. The 146th attached to an aviation element from the 1st Battalion, 137th Aviation Regiment, from the Ohio ARNG and worked with the 139th Medical Group, USAR, from Missouri.

In July 2004, 146th crews participated in a mass casualty exercise involving all task forces designed to calibrate operational procedures and communications. Such drills were still necessary because even though the political situation continued to stabilize, the potential for violence to erupt remained.[69]

KFOR6B November 2004 – May 2005 and KFOR7A May 2005 – November 2005. In January 2005, the 717th Med Co (AA), New Mexico ARNG, arrived to support KFOR6B and KFOR7A, as part of an all ARNG aviation task force built around the 1st Battalion, 104th Aviation Regiment, from the Washington, DC ARNG. A detachment from the 332d Medical Brigade (USAR) from Nashville, Tennessee, commanded by Maj. Michael Rieske led the medical task force. The medical task force was also based at Camp Bondsteel. The political situation was relatively stable, and few recovery missions were flown. The medical task force conducted a large mass casualty drill that involved all of the various national units. The 717th also participated in a task force wide celebration of six years of successful peacekeeping operations in the region as dictated by UN Security Council Resolution 1244. Designed to reestablish conditions for a peaceful and normal life for the inhabitants of Kosovo, the KFOR slowly but steadily achieved that goal. The 717th remained part of the KFOR until it deployed home and demobilized in January 2006. Operations in Kosovo remain ongoing, and U.S. Army MEDEVAC units continue to support the deployments.[70]

Nigeria

When the 159th Med Co returned home from Kosovo in late September 2000, the troops expected to have a break. However, as the decade ended, the 159th Med Co (AA) was tasked for another deployment. It sent a team of three helicopters and crews and 23 support personnel as part of a larger task force from the 30th Medical Brigade to support Operation FOCUS RELIEF. This operation directed the Special Operations Command Europe to send a 250-soldier training detachment from the 3d Special Forces Group to train five Nigerian battalions to conduct peacekeeping operations in Sierra Leone. The only aviation asset sent was an aviation intermediate maintenance package of six troops sent specifically to support the 159th. As opposed to the TF Hawk operation, this time the 159th remained under medical control. The task force was in Nigeria mid-October through mid-December 2000. The team flew 59 sorties, mostly operations support and training. No serious injuries or medical problems were encountered. The deployment was uneventful, but it was a classic example of the flexibility of MEDEVAC units to support peacetime operations under medical vice aviation control.[71]

MAST

As the only MEDEVAC unit in Hawaii, the 68th Med Co (AA) at Schofield Barracks in the middle of Oahu was constantly in high demand for MAST calls and had flown an average of 250 missions per year since the beginning of the program. On Thanksgiving Day of 1999, CW3 Tyron Freeman and Capt. Scott Eichel flew the unit's 6,000th MAST mission to transport two teenagers who had been hurt in an automobile accident.

"We didn't make too much of it," said the 68th's commander, Maj. Steve

Bolint, "but we are proud of our record. Any time we can help save someone's life it makes us feel good." Donna Malawa, the state chief of medical emergency services, was more expansive.

"There is no doubt that the 68th has greatly improved survival of patients and made a tremendous contribution to the health and welfare of our citizens," she said.

Freeman was more self-depreciating. "What amazes me is that I get paid for flying around the islands and helping people." Their sentiments represented what MAST had become.[72]

Doctrine

Service Doctrine - Field Manual (FM) 8-10-26, Employment of the Medical Company (Air Ambulance), February 1999

In February 1999, the Army Medical Department Center and School again updated its MEDEVAC doctrine using a different approach. A new document, FM 8-10-26, was written to provide guidance directly for the MEDEVAC companies. The new FM described the tactics needed for implementation of the company's role as a combat service support unit. It was specifically crafted for the company commander and personnel, and individuals on staffs at several levels for the planning for overall combat health support. The aviation community could use it to determine what support it needed to provide to facilitate MEDEVAC operations.[73]

The document reflected the changes in threat environment and possible mission assignments since the end of the cold war. It also expanded the panoply of taskings to include regional instability, ethnic or territorial disputes, proliferation of weapons of mass destruction, and threats to democracy or democratic reform.

The document also reaffirmed the vital role of the CHS system as a force multiplier that protected the health of the soldier in war as well as stability and support operations. Medical evacuation was a part of the CHS system, and the Army was the only U.S. military service with dedicated assets to perform the aeromedical evacuation mission.[74]

The manual continued by explaining that aeromedical evacuation was the execution of this process with the use of aircraft that had the capability to provide en route care. The use of aircraft for patient movement without en route patient care was designated casualty evacuation or CASEVAC.

MEDEVAC or CASEVAC could be accomplished with three different systems:

1. A *dedicated* system is one in which aircraft and crews were solely dedicated to the mission of MEDEVAC. This was the case with the MEDEVAC units.
2. A *designated* system was a system whereby aircraft were identified for use as either a MEDEVAC or CASEVAC platform. During mass casualty situations, other aviation assets, such as CH-47s, could be designated for CASEVAC.
3. A *lift-of-opportunity* system was a system that utilized empty aircraft for backhaul as available.[75]

FM 8-10-26 included a detailed chapter that described the air ambulance company's organization and functions, including a new tasking to conduct combat search and rescue missions for downed aircrews. The company was organized with a company headquarters that provided the unit command and control, and several subordinate platoons. The flight operations platoon provided all flight planning, flight dispatch, aircraft fueling, and operation of the heliport. The aviation unit maintenance platoon provided all unit-level maintenance for the aircraft. The evacuation platoon commanded the three FSMTs of three aircraft and crews that could be deployed forward to directly support maneuver forces. Also assigned was the area support MEDEVAC section consisting of six aircraft and crews that provided general area MEDEVAC support in the vicinity of the company headquarters, performed patient transfers, or reinforced the FSMTs.

The company could be employed in direct support of a division with which it would then establish direct liaison, or in general support of a corps. The company established the necessary communications links with all relevant headquarters.[76]

The rest of the FM was a detailed discussion of the employment of the company in a variety of environments, operations, and contingencies. It included a suggested series of tactical standing operations procedures, team leader's guides, liaison officer's checklists, and commander's checklists for a variety of concerns. Also included was a discussion of relevant portions of the Geneva Conventions pertaining to MEDEVAC operations, a section on risk management, a section on aviation countermeasure techniques and survivability equipment, practical guidelines for the flight medics, and medical support for combat search and rescue operations. It was a doctrinal rewrite for MEDEVAC that was stretched into a useful "how to" guide.

Service Doctrine - FM 8-10-6, Medical Evacuation in a Theater of Operations, Tactics, Techniques, and Procedures, April 2000

Reflecting recent operations in the Balkans, the next doctrinal rewrite was an update of FM 8-10-6. Dated 14 April 2000, it addressed medical evacuation as part of the CHS system and captured the evolving threats and technological trends of the decade since the last iteration of the FM in 1991. Dovetailing nicely with the recent FM 8-10-26, it recognized the new international environment presented to the nation with security challenges unprecedented in ambiguity, diversity, risk, and opportunity, presented by the "new world order," which was neither new nor orderly. The old forces of adventurism, nationalism, and separatism had reappeared with sometimes violent and unpredictable consequences. Challenges to national security now required military forces to participate in peacekeeping operations, nation building, and humanitarian assistance. The U.S. Army had to be prepared to face a variety of threat forces, many with credible military capabilities.

The FM also offered expansive discussion of the evolving medical evacuation system and considerations for specific environments and medical regulating. Several

chapters on tactics, techniques, and procedures followed. Lastly, as an ominous harbinger, it included a section on combating terrorism and force projection, and suggested difficult missions ahead for MEDEVAC.[77]

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The 1990s was a busy period for the U.S. Army. Having developed the concept of AirLand Battle and then reorganizing to wage it, the necessity arrived, but not on the Plains of Europe as had been expected. Instead, the test came in the heat and dust of the Persian Gulf. The MEDEVAC force, busy reorganizing to support the new concept, pushed forth its largest effort ever to serve the needs of the soldiers. It did so, but was stressed in the effort. Yet that experience validated the changes that needed to be made. That process would continue.

The conflict also validated the efforts of Gen. Creighton Abrams, who reorganized the Army after the long war in Vietnam so that it would once again rely heavily on its two Reserve Components as it had historically done. At one point, more than 50% of all MEDEVAC assets were in these two components. They answered the call for DESERT SHIELD/STORM and performed admirably both at home and in the conflict. Necessary force cuts after the war saw the complete elimination of all U.S. Army Reserve MEDEVAC units. In one stroke, the MEDEVAC community lost almost one-third of its capability and an uncounted number of highly experienced and motivated pilots, medics, crew chiefs, and support personnel. There is no pretty way to eliminate forces.

After DESERT STORM, taskings changed for the MEDEVAC units. Nature provided challenges with devastating hurricanes and earthquakes. They required response, as did manmade disasters at places such as Fort Bragg. MAST missions were still being flown, although steadily, and more communities were developing their own capabilities as the program had been designed to stimulate.

With the demise of the Soviet Union and the successful conclusion of the war in the Persian Gulf, the strategic focus changed, because no single adversary dominated the nation's attention. Humanitarian missions and peacekeeping taskings took the Army to places like Northern Iraq, Somalia, Haiti, and Bosnia, and Army doctrine in general—and MEDEVAC doctrine in particular—changed to meet the new challenges. The men and women of MEDEVAC saw duty in all of those locations, doing what they were trained to do. MEDEVAC remained under medical control. However, the increasing sophistication and complexity of aviation operations in DESERT STORM and Albania suggested that MEDEVAC should be more closely aligned with aviation operations.

As the decade approached its end, Gen. Eric K. Shinseki became the 34th Army Chief of Staff. He was commissioned in 1965 and was a Vietnam combat veteran. Throughout the 1990s he served as a commander of mechanized units and held several key posts in Europe, including command of U.S. Army Europe. He was acutely aware of the problems facing the Army as it attempted to address the challenges of the current world political realities with forces optimized for

heavy battle. Reflecting on the efforts of former Army Chiefs Gordon Sullivan and Dennis Reimer, he also believed that the Army needed to transform so that it could leverage new and evolving technologies to move faster with a lighter but smarter and more lethal force. He wanted an Army that was highly maneuverable, technologically advanced, and strategically mobile. He was determined to lead that transformation.

That evolution—within just a few short years—would lead to significant change for the Army and MEDEVAC force. Before that process would play out, however, other unforeseen and dramatic events would abruptly intrude.