Chapter Five

The 1990s: Trouble in the Balkans

A Changing World

The end of the Cold War brought profound changes to international relations. During the Cold War, both the Soviets and the West had supported client states around the globe, sometimes suppressing internal dissent in those countries to prop up friendly regimes. Now that the Cold War's strategic rationales had dwindled away, dissent could reappear, sometimes turning into conflict. Countries and alliances either adapted to the changed situation or disappeared.

The US Army was also facing major changes, most notably, a substantial reduction in size. With fewer threats on the horizon, neither the public nor politicians were willing to spend as much money on the military. The American public expected a "peace dividend" of lower defense spending, and the political question shifted from whether candidates were hawkish about defense to how they would spend the "dividend." Some favored spending the money on various programs, others preferred tax cuts. Meanwhile, the active duty Army fell by 32%, from 772,000 to 529,000. A less obvious change for the Army was a shift in the locations where it might see combat. Since Vietnam, the Army's major emphasis had been preparing to fight a Soviet/Warsaw Pact attack in Europe. Now that the Soviet threat was over and an invasion of Germany unlikely, major reductions of American forces in Europe, especially in Germany, were planned. Remaining troops had to be ready to deploy elsewhere, wherever the trouble was. Germany would be a starting point, not the scene of action.

Concurrently, the Army was grappling with different kinds of operations. After Vietnam, the Army had switched from counter-insurgency wars and fighting in developing countries, and prepared to fight high-intensity battles against massive Soviet armies, with thousands of tanks and plenty of artillery and aircraft. Doctrine was focused on how the smaller NATO forces could win. This doctrine had served well against the Iraqi forces in Operation Desert Storm. However, it

might not be as effective against a more amorphous enemy, nor in a multisided conflict. The 1993 edition of the Army's central doctrinal manual, Field Manual 100-5, *Operations* (which describes the Army's vision of its functions), gave far more attention to "operations other than war" or "stability operations," including missions ranging from humanitarian relief, to peacekeeping, to "peace enforcement," an entirely new term. As countries collapsed and groups within them came into conflict, missions such as humanitarian relief and peacekeeping became more likely and more common. During the Cold War, the United States had seldom engaged in peacekeeping operations, but American diplomacy changed in response to the world's changes.

Meanwhile, the UN was also changing. Without superpower rivalry to stymie action, the UN Security Council could reach agreement and it was easier to intervene in conflicts. Instead of peacekeepers arriving after a conflict had subsided (and either East or West had won), now the UN tried peace-enforcement or peace-implementation missions that sought to end the fighting. Often the UN's motives were mixed; it was not just about saving lives by stopping the fighting, but also about keeping countries and regions stable. The Army's normal training routine still prepared soldiers for high-intensity warfare, but predeployment training focused on mission-specific topics, such as the rules of engagement, how to handle provocations, and how to avoid giving offense in unfamiliar cultures. Additionally, the United States would be working with (and possibly for) the UN, and although US and UN methods, procedures, and goals often overlapped, differences were still problematic. It took significant coordination and experience to make the partnership reasonably smooth.

Yugoslavia's Gradual Implosion

Yugoslavia was a multiethnic, multinational product of World War I, made up of Serbs, Slovenes, Croats, Bosniaks, Albanians, Macedonians, Hungarians, ethnic Germans, the Romani people, and other groups who identified themselves along ethnic and religious lines. Yugoslavia's peoples distrusted and disliked each other for reasons stretching back centuries. Serbs were the largest ethnic group, comprising about 40% of the country's population, and ended up with the most power, dominating not just the country but several of the regions, even those in which they were a small minority, such as Kosovo.

In 1941, the Axis powers invaded Yugoslavia and quickly conquered it, partly by playing ethnic groups against each other. However, a strong leader and a supranational ideology arose that allowed Yugoslavia to reunify after the war. Communism promised an end to ethnic and religious differences, and Josip Broz, also known as "Tito," who had built up the communist forces, had earned credibility as the national liberator and unifier.

Tito ruled Yugoslavia from 1945 until his death in 1980, maintaining communism and suppressing ethnic and nationalist dissent. However, communism had

Map 5-1. The Socialist Federal Republic of Yugoslavia, 1990.
Map reproduced from: Central Intelligence Agency, DI Cartography Center, 753540AI (A04646) 8-01.

failed to dissolve ethnic and religious differences. As it waned around the world in the 1980s, its unifying power in Yugoslavia also faded, and minority groups increasingly complained about Serb dominance. At the same time, a group of Serb nationalist politicians, headed by Slobodan Milosevic, shored up their power by provoking non-Serbs, then rallying Serbs by claiming a threat to Yugoslavia and Serbia. They also deployed the Yugoslav National Army to maintain order. In mid-1991, both Slovenia and Croatia declared independence; Slovenia (on the northwestern edge of Yugoslavia) was buffered by Croatia and broke away cleanly, but there was fighting in Croatia from mid-1991 into early 1992.

Map 5-2. Ethnic composition in the former Yugoslavia, 1991.
Map reproduced from: Central Intelligence Agency, DI Cartography Center, 753543AI (R00472) 8-01.

Outside countries (mainly European, but including the United States) wanted the fighting to end but would not directly intervene and could do little to resolve the causes of the conflict. Negotiations periodically resulted in cease-fires, but the fighting spread as Bosnia-Herzegovina (BiH, a province bordering both Croatia and Serbia) declared independence in April 1992. A three-sided contest

developed with both Serbia and Croatia sending troops to the province.

In response, the UN asked NATO to block arms shipments to the region, and NATO deployed ships to block maritime shipments. As the fighting grew and more civilians were affected, international pressure to protect civilians grew. Again, ceasefires came and went, but humanitarian safe havens were agreed upon, with UN troops assigned to monitor them. Humanitarian supplies were delivered by air (in a few cases by parachute drop, more commonly by aircraft landing at airfields), and later trucked to the safe havens. US involvement was limited in hopes that other countries, especially European countries with deeper ties to the region, could bring peace. American warships helped enforce the arms embargo and US aircraft transported supplies. The Army's role was to provide medical support to UN forces in Croatia and BiH. Medical support was to include a hospital, the new 212th MASH.

The 212th's First Deployment: Camp Pleso, Croatia, November 1992–April 1993

The 212th was selected for the mission for two reasons. First, its deployment readiness was higher than that of any other field hospital in Germany. Second, using the small MASH would be less disruptive to healthcare for Army personnel and families in Germany than sending a larger hospital. USAREUR, trying to avoid inconveniencing large numbers of personnel and their families, asked for reservists to be activated to replace the deploying medical staff.

Preparations and Deployment

The 212th was out on a training exercise, testing its new personnel and equipment on a corner of the Landstuhl medical facility, when it received word of its deployment. The 212th was given 3 weeks' notice, time it needed to bring in the commander, extra staff, and extra equipment. The AMEDD still required that physicians command deployed hospitals, and Lieutenant Colonel Everett "Mike" Newcomb, who was listed as the deployment commander, but who had had little contact with the unit, arrived (the garrison commander, Lieutenant Colonel Felipe Casso, had previously handled day-to-day activities, and became the executive officer during the deployment to Croatia). Although the MASH's personnel and equipment were ready to go, the assigned mission (Operation Provide Promise) did not match the unit's abilities. The UN wanted a hospital that could hold patients for up to 30 days and cover a broad range of medical and surgical problems. The MASH was focused on battlefield surgery and designed to hold patients only 3 days. Ultimately, the 212th had to be augmented with personnel and equipment. It was not difficult to find the personnel; equipment was harder to procure. The 212th had to obtain and pack the all the equipment it might need in that narrow 3-week period. Part of tailoring the unit

meant getting the right kind of beds, and instead of the normal 60 intensive care unit (ICU) beds, the MASH used 12 ICU, 40 intermediate-care, and 8 minimal-care beds.

The extra personnel turned the 212th MASH into "Task Force 212," about double the hospital's strength. There were more medical staff, including preventive medicine, mental health, dental (including oral surgery), and family practitioners, extra internal medicine staff, a radiologist, and a physical therapist. The increased number of personnel necessitated a larger laboratory, pharmacy, and blood bank, and more medical maintenance personnel. Some nonstandard equipment was also taken. For example, a medical equipment company had given the Army some laparoscopic surgery gear, hoping it would prove useful and reliable and the Army would then buy more. The extra troops also required a larger food service staff, more logistical and general maintenance personnel, and extra communications staff.

A task force headquarters was created from elements of the 30th Medical Brigade, assisted by military police (including working dogs), legal advisers, a public affairs team, and even a team from Armed Forces News. The taskforce headquarters was in charge of all American military personnel in Croatia. However, aside from the MASH, only a few small teams of US military personnel deployed, mainly logistical units checking supply routes. Because the 212th was the only US unit deployed for an international operation at the time, and in fact the first US unit under foreign command since 1918, it was getting a great deal of attention: V Corps, USAREUR, US European Command, Army Staff, and the secretary of defense were all watching and asking questions. The task force headquarters could answer some of the questions, but the level of interest and involvement from all those US headquarters raised questions about whether the 212th was truly under UN command or if it was under the command of myriad US organizations.

Working for the UN imposed new requirements on the 212th. Vehicles and equipment had to be painted white with light blue UN markings; 73 MILVANs and expandable containers and 17 vehicles needed paint. The Army did not have enough white paint on hand in Europe, so troops had to buy more in German paint stores. Helmets had to have the right blue cover, none of which were in Army stocks, so more paint had to be bought. There was so much UN paperwork (both everyday reports and financial documents) that extra soldiers were assigned to handle it.

An advance party left Wiesbaden on November 5, 1992, and the equipment was transported on three trains (about 50 railcars). Although the unit was deploying for no more than 179 days, it was unclear whether additional equipment could be sent later, so the MASH deployed "heavy." The rest of the unit left on November 10 and 14, and the hospital was operational on November 15, with the tents and shelters erected inside a hangar on the outskirts of Pleso Airport, Zagreb. Setting up inside a metal building caused some trouble. The

building distorted compass readings, and marker stakes could not be driven into the concrete floor (measuring tapes and spray paint were eventually used instead).

Operating the Hospital

When the MASH arrived, it received a surge of 19 patients as UN patients were transferred from local hospitals. General Gordon Sullivan, chief of staff of the Army, visited in the early days and complimented the 212th on its efficiency. But after the initial surge, the number of patients fell off rapidly. On average, two patients were admitted per day, and there were only a dozen inpatients. The dental and mental health teams stayed fairly busy, although the mental health team ran into some difficulties working through interpreters with soldiers from other cultures. On the other hand, the overall UN mission was successful at reducing tensions and fighting, so few casualties needed surgery. At times the doctors performed vasectomies and removed tattoos by request just to stay busy.

Despite the scarcity of patients, the unit still faced medical challenges, some entirely unexpected. Language problems arose as the MASH worked to treat patients from 34 countries and five continents. Task force personnel spoke a variety of languages, and some countries deployed translators with troops, but at times the medical staff had to point and mime. Fortunately, language problems never cost lives. Landmines caused the most wounds (nine); and only two patients received gunshot wounds. The laparoscopic equipment the unit brought along proved useful for a few patients, and while it did not fit the MASH mission, it was judged to be useful for an evacuation hospital or CSH. The arthroscopic equipment saw less use, and no recommendation was made on its utility in the field.

The commanders soon realized that the deployment would not be a high-pressure operation, and personnel were rotated in and out of the 212th through the normal system of permanent change of station. Other soldiers were released on a case-by-case basis to attend classes or leave the Army. As the stable situation continued, the MASH commander authorized 7-day leave for individuals to go back to Germany (but never for all of a section at once, so that all hospital functions remained operational). The Corps commander (Lieutenant General Jerry Rutherford), who was monitoring his only deployed unit, had not been briefed on the leave program and reacted angrily, and for a while it seemed he might cancel it. Ultimately, he refrained, and as the threat level to UN troops dropped, staffing at the MASH was reevaluated. Finally, the MASH released 46 soldiers back to Germany to work in hospitals and clinics there, although they had to be ready to return to Croatia on 48 hours' notice in case of a flare-up. This reduction, 46 of the 257 soldiers in the MASH, significantly affected the MASH's capability. Even though the average of 12 inpatients meant the MASH was operating at only about 20% of capability, it could not send staff forward to

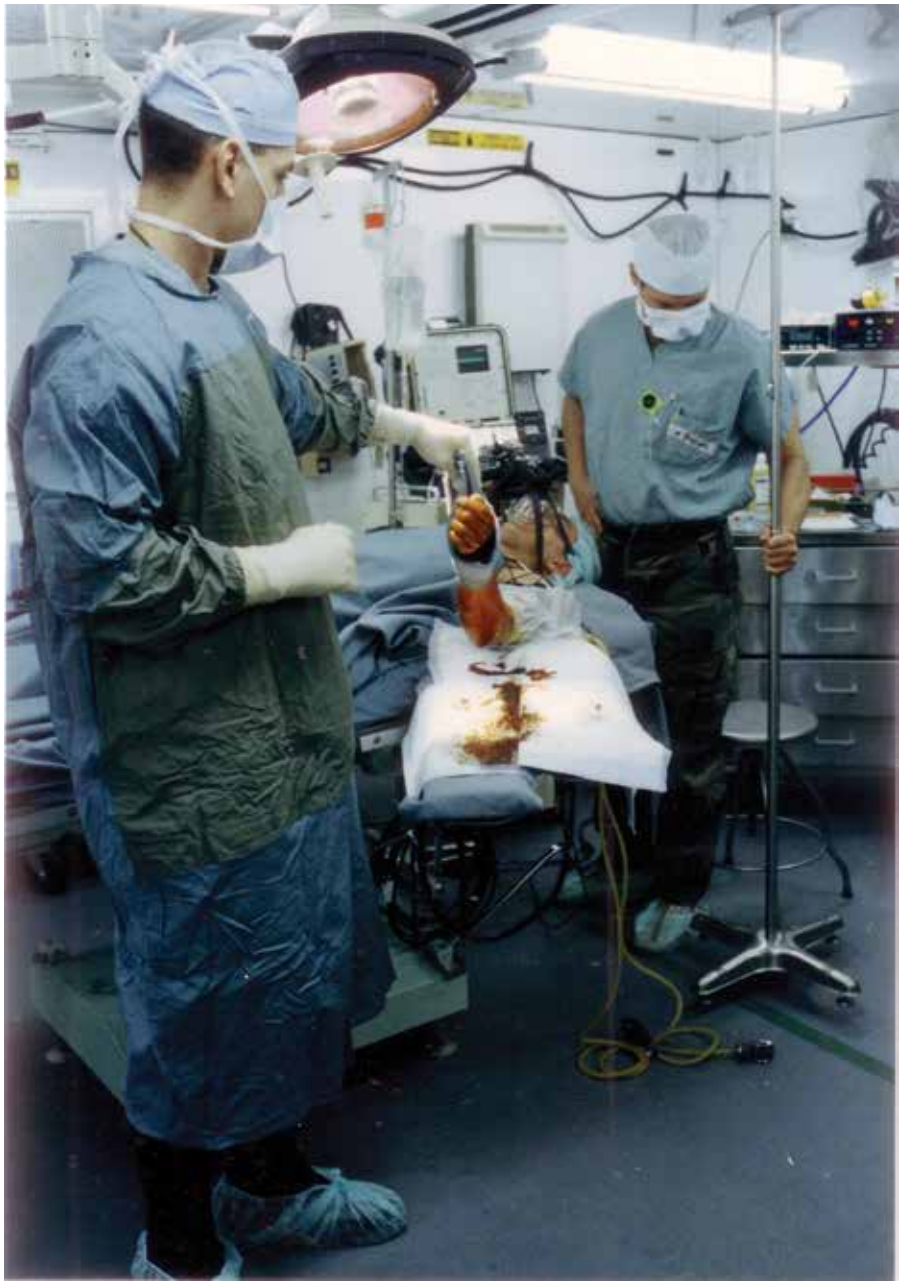

Figure 5-1. Surgery in one of the 212th's operating rooms.
Photograph courtesy of Lieutenant Colonel Felipe Casso.

treat patients for two reasons: first, it was not the US mission (the British were providing forward medical care), and second, US soldiers might be captured by various military or paramilitary groups.

Some UN countries did little medical screening before deploying their service members, and patients from around the world brought different diseases (eg, tuberculosis) to the MASH. The uneven levels of medical care in some units also caused life-threatening conditions to develop. One patient came into the MASH with a gum infection that had simply been ignored until it grew so severe he needed several teeth extracted and IV antibiotics. Another soldier had a chest tube inserted, but was not brought to the 212th for 2 days. In that time, the tube became clogged and infected, and the soldier needed urgent care.

Fortunately, supplies were plentiful. The UN provided some, the US supply system provided others, and a few items were purchased locally; however, paperwork had to be done for three supply systems. The 212th did not bring some needed equipment, for instance, a CT scanner, which was too bulky to ship, and probably not worth the effort. As a result, the Army contracted to use one in a Croatian civilian hospital when needed. Another shortcoming was lack of a public address system. In World War I and World War II, the 12th Evacuation hospital had buglers who could send out a call for whatever team was needed, but in the 1990s, physicians wanted pagers, or at least a loudspeaker system.

UN guidelines also dictated who "eligible" patients were. The 212th's mission was to care for UN personnel, meaning military personnel under UN command, UN civilians, and UN contractors. The mission did not include caring for local civilians, unless they were at risk of dying or losing eyesight or a limb. Helping refugees or victims of the fighting was deliberately not part of the mission: the UN sought to stay neutral in the fighting, and aiding civilians could alienate one of the warring factions, putting UN personnel or more civilians at risk. US soldiers were told they could not even volunteer their time and skills at refugee camps. Over time, the medical staff grew frustrated at being unable to help refugees, especially because they were underemployed caring for UN personnel, and consulted with the US chain of command about the issue. Several months passed before the US chain of command also denied the request. However, even if the 212th had been investing large amounts of time and energy into helping refugees, its limited staff and facilities would barely have made a dent in the problem. Ultimately, civilian patients were treated by Croatian hospitals or by humanitarian organizations.

Another frustrating problem for the 212th was whether or not to treat family members of UN personnel. These people fell into a gap; the UN was not required to care for them and neither was Croatia, yet they were in Croatia instead of their home countries because of this mission. The UN told the MASH not to care for family members of its personnel, but the US command channels gave a different answer: because the MASH was using supplies paid for by the United States, the MASH could treat the family members. However, it took about 4 months to get this ruling—4 months of a 6-month deployment.

Figure 5-2. Supplies arriving at the 212th on a flatbed truck. These are medical supplies; other supplies and the mail arrived in a similar fashion.
Photograph courtesy of Lieutenant Colonel Felipe Casso.

In theory, the UN was providing medical care for up to 30 days only, but it had little leverage with member nations. If the UN tried to enforce agreements, nations might not send troops another time, or might even withdraw troops from the current mission. The 212th ended up caring for patients on an as-needed basis (one patient received 10 surgeries, another stayed 97 days) because some countries only took back fully recovered patients. In one instance, a Serb soldier was flown in to the MASH, already on a ventilator after sustaining a severe, life-threatening head injury. He had to stay overnight at Zagreb because no hospital in Belgrade was ready to receive him. The UN command requested that he remain overnight at the MASH, fearing that if he were sent to a local hospital in Zagreb, Croat nationalist fervor might place his life in jeopardy. News leaked to the public that a Serb soldier was at the airfield, and a small crowd turned up at the front gate protesting his presence. There was even a bomb threat, which seemed credible amid the heightened tension. Although the crowd protested, it never threatened the UN guards or the Croatian police outside the gate. The next morning the patient was flown to Belgrade and the MASH returned to normal. Ultimately, the 212th cared for 4,454 outpatients (an average of 27 per day) and admitted 333 inpatients, 2 per day.

Life at Pleso Airfield

Initially, troops were billeted in hotels in Zagreb because there had not been enough time to erect tents. Dutch troops helped erect the tents in exchange for living space until they moved out to their operational area. Unfortunately, this took longer than some US soldiers liked, and in the doubled-up living conditions, tempers were short. Mice and rodents got into tents if troops left food out; traps and poison were soon necessary to control them.

The airport was in range of Serb artillery and rockets, but a security plan was not a high priority for the UN commander, so the US soldiers established their own security measures. For the first time, the Army authorized weapons for all hospital personnel (except the chaplain), but MASH soldiers went on guard duty unarmed, while the military police from Task Force 212 were armed. That difference was hard to explain to the troops. There was never an attack, or much threat of one, but some weapons were displayed. Sometimes local civilians celebrated by shooting into the air and, on New Year's Eve, a US soldier was grazed by a bullet falling back to earth. His arm was barely injured—he was doing pushups in a few days—but senior officers still acted promptly to prevent any rumors of an attack. Booby traps and landmines had been scattered through the area before the UN arrived, and Americans were supposed to stay on paved areas. The message was driven home in the first few days when a civilian bulldozer driver detonated a landmine and was injured. Through the winter, mines periodically exploded as the ground froze and compressed the detonators.

As the initial work of setting up the hospital and treating initial patients slowed, boredom and frustration rose. Before deploying, the troops had been told they

Figure 5-3. US troops clearing mines from the immediate vicinity of the 212th MASH at Pleso Airfield, Croatia.
Photograph courtesy of Lieutenant Colonel Felipe Casso.

would be living in tents for only 6 to 8 weeks. But because the space available to Task Force 212 was limited and the hospital got first priority, the tents had to be used longer than planned. Mail was important for keeping up morale, especially before Christmas. A satellite dish brought in television, and a convenience store sold small items. The Army and Air Force Exchange Service also sent videotaped movies to Croatia, and a morale, welfare, and recreation tent was established that offered a range of activities, including books, board games, bicycles, a dart board, and air hockey and ping-pong tables. Telephones were available, but calls to or from home were expensive. Troops were allowed to wear civilian clothes when off duty. Before the 212th left Germany, the question of whether this was a combat-zone deployment had been sent up to the Army staff, who decided it was not, which denied soldiers combat pay and decorations.

Discipline proved troublesome, although most problems were routine issues that could have developed in Germany as well as Croatia. Men and women fraternized, which undercut discipline, and a senior NCO was relieved for falsifying his military records. An unexpected issue was alcohol. After Operation Desert Shield, the Army adopted a "no alcohol" rule for deployed troops, but

Figure 5-4. The morale, welfare, and recreation tent. Troops were allowed out of uniform off duty, but the vehicle barriers and sandbag protection were a constant reminder that there was a threat. Photograph courtesy of Lieutenant Colonel Felipe Casso.

five all-ranks bars were open at Camp Pleso within the living areas of other non-US units supporting the UN operation, and the French dining facility (where Americans normally ate) served wine with lunch and dinner. The impossibility of preventing people from drinking, especially when soldiers from all the other nations could drink, led to a change in rules. "Responsible" drinking was permitted, but this decision had to go all the way to the Army chief of staff.

The varying rules applied to different UN contingents brought other frustrations as well. US soldiers were not allowed out of the Zagreb area, even for golfing or skiing, while other nations' soldiers could travel more freely. At the same time, US civilians could visit Zagreb, and some soldiers' families came to visit. Task Force 212 tried to discourage families from coming to Croatia, pointing out that soldiers could be banned from leaving Camp Pleso, but a ban was never implemented. Instead, family members were shown around the hospital, as were a substantial number of other visitors. However, the number of prestigious visitors diminished after another, larger UN mission started: Operation Restore Hope in Somalia involved greater risk and employed combat troops, thereby garnering more public attention.

Figure 5-5. A public affairs officer greeting a Swedish general. Enough VIPs visited to fill entire photo albums.
Photograph courtesy of Lieutenant Colonel Felipe Casso.

Back to Germany

Even as the 212th approached the 179-day mark, the United States was obliged to continue providing medical support to the UN. USAREUR prepared another Germany-based MASH to deploy, and on April 27, 1993, the 502d MASH took over the Task Force 212 facilities and equipment at Camp Pleso.

The 212th returned to Wiesbaden and was soon busy reconstituting itself as a unit and converting from 60 beds to the new 36-bed organization. The unit had adequate staff but not much equipment, either medical or unit equipment, such as vehicles. Meanwhile, V Corps wanted the 212th to be ready to deploy again as soon as possible because it had few other deployable hospitals. The drawdown of forces in Germany freed up some equipment from units that were being disbanded or moving back to the United States; other equipment had to come from Army depots in the United States. The problem was not an overall shortage of equipment, it was finding equipment in the system, ordering it, and awaiting its arrival. Once the equipment arrived, the soldiers of the 212th had to unpack it, check it, perform any required certification tests (whether it was a truck or a radiation machine), and begin routine maintenance. When Lieutenant Colonel

Newcomb handed over command in July, 3 months after returning from Croatia, most of the equipment had arrived, but the unit was not fully trained.

The new commander, Lieutenant Colonel William Fox, was the first physician in day-to-day command since the Vietnam War. He faced significant turmoil caused by the changing military situation in Europe, including the cutbacks (the Army was reduced from 772,000 soldiers in 1989 to 529,000 in 1994, ultimately bottoming out at 480,000 in 1998) and the even more dramatic withdrawal of forces from Germany. USAREUR policies allowed soldiers to return to the continental United States if they were moved to a new base in Germany or if they had been deployed for over 6 months. Fox argued against moving the 212th to a proposed new barracks precisely because such a move would allow many soldiers to return to the United States. Moreover, V Corps considered the new barracks to be substandard. Fox won the argument because the personnel turnover would have left the 212th, the most deployable hospital in USAREUR, ineffective for months.

Fox stressed training the unit for deployment, especially moving on the battlefield, detaching the forward surgical element (FSE), and operating both the FSE and the main hospital. The 212th MASH had never before trained for these tasks because the time between converting from the 12th Evac and deploying to Zagreb was too short. Because the clinical staff were assigned to hospitals and belonged to the 212th only when it mobilized, it was hard to train the whole unit. However, Fox devised a program to train various sections of the hospital in sequence, assigning each section a physician and a nurse from PROFIS and having them work with the permanently assigned enlisted personnel, so that the officers would learn the capabilities of the DEPMEDS equipment. The 212th's PROFIS staff was gradually replaced with personnel assigned to the unit but who regularly worked at the Wiesbaden hospital. Because the 212th now "owned" them, it became easier to schedule whole-unit training, although the hospital commander pointed out that clinical work still needed to be done.

In addition to the field exercises, the 212th participated in three MEDFLAG operations in 2 years in Africa (in Ghana, Cote d'Ivoire, and Botswana). MEDFLAGs were medical training exercises that allowed US military medical units to practice deploying and operating in the developing world. During the exercises, US units trained local medical personnel and treated patients. MEDFLAGs involved a substantial amount of planning so the US force could be tailored to train the host nation's forces on the selected topic (frequently disaster relief), sites could be planned, appropriate medical equipment and materiel selected, and transportation arranged. Physicians trained physicians, nurses trained nurses, and medics trained medics for a week to 10 days. The events included a MASCAL exercise, after which the Americans cared for patients. The initial plan was to work mainly in cities, with classroom and clinical training for the host nations, but Fox pushed for more time in rural clinics and austere environments. He believed his clinical staff needed the field experience more than they

needed to demonstrate their hospital skills in a foreign hospital. Fox recounted the story of a 12-year-old boy, inoculated against yellow fever during a MEDFLAG, who knew little about the United States, but said he knew that "Americans like to help." The 212th took part in the MEDFLAGs with attached dental, veterinary, and other medical personnel, but never as the whole 212th. Fox took care to rotate troops so more would gain experience.

In mid-1994, Army leadership considered sending the 212th to Rwanda to help refugees fleeing from the brutal ethnic fighting there. Perhaps because of repercussions of the "Black Hawk Down" incident (in which 19 Americans were killed and about 100 wounded in Somalia during what started as a humanitarian mission), the US government was reluctant to send troops, even medical units, to help in Rwanda. Instead, in the summer of 1994, the 212th provided medical support for the 50th anniversary commemorations of D-Day and the subsequent campaign across France and into Germany. The whole unit went to Normandy for the large-scale events there, and elements were then sent to several sites for smaller commemorations.

Continued Trouble in Yugoslavia

While the 212th was in Germany, conflict continued in BiH. There was no peace for the UN forces to keep, and NATO became involved, including the alliance's first combat operations. In December 1995, the General Framework Agreement for Peace was developed. It was formally signed in December, with a NATO force forming the core of what was known as the "implementation force" (IFOR). IFOR was to be in BiH for a year, beginning December 20, 1995. The US portion was known as "Task Force Eagle," the reinforced 1st Armored Division from Germany. The 30th Medical Brigade would monitor the 212th as well.

The IFOR mission was to enforce the ceasefire, supervise the "zone of separation" between the formerly warring factions, demilitarize the area by taking control of heavy weapons and monitoring troop withdrawals, and supervise elections. The mission was expected to be peaceful, especially because Serbia and Croatia had both withdrawn support from local factions. However, in a region with recent fighting and smoldering tensions, potential existed for fighting and for casualties. IFOR troops had to move quickly, and the 212th MASH was well suited for treating expected casualties.

The 212th Gets Ready

Lieutenant Colonel Steven Gouge, Medical Corps, had been in command of the 212th for about 6 months and had inherited a highly trained unit. In September 1995, under Gouge, the MASH had participated in Exercise Mountain Shield 2, a planning exercise that validated Lieutenant Colonel Fox's concept that a small element of the MASH would be ideal for small missions. In another

training exercise that October, the 212th set up its equipment in the field, testing personnel and equipment. As personnel were cleaning and repairing equipment after the exercise, orders arrived from the 30th Medical Brigade headquarters for the MASH to start planning its deployment. Instead of a routine recovery from the training exercise, the unit faced an increased pace of 12-hour workdays, 7 days a week.

The original plan called for the 212th to go to Hungary to provide medical support to Task Force Eagle as it deployed to BiH, and then to care for troops along the lines of communications between Task Force Eagle and Germany during the year. The 67th CSH, the V Corps's other deployable hospital, would go into Bosnia to support the troops during the year. However, the V Corps commander required all units to perform a validation exercise before they deployed. The 212th proved it could perform all required tasks, but the 67th had less training time and was less successful. Moreover, by design, CSHs rely on other units for basic functions such as moving and unloading equipment, and the 67th was judged incapable of executing a mobile mission. Therefore, the 212th was given the leading role in Bosnia, while the 67th was told it would be stopping in Hungary.

The 212th's mission in Bosnia was primarily to support Task Force Eagle and associated Americans. IFOR nations were supposed to provide their own medical support, so the 212th was expected to treat relatively few foreign military patients. The guidelines for treating civilians were fairly restrictive: except in the case of emergency (if life, eyesight, or a limb were at stake), only civilians injured by US forces would get care. However, Gouge's advice to his troops was to treat all patients who needed treatment and sort out the paperwork later.

Task Force Eagle expected sporadic fighting but reasonable amounts of disease patients and so based its patient estimates on numbers from the time of sporadic fighting in Italy during the winter of 1944–1945, projecting a need for 56 hospital beds. To supplement the 212th MASH's 36 beds, a 20-bed ward from the 67th CSH was added, although it arrived slightly later.

Early Days in Bosnia

The first step for the MASH was setting up the FSE. At the time, the Army was building a pontoon bridge longer than the Brooklyn Bridge across the Sava River (from Croatia into Bosnia) and wanted medical support on site in case of injuries or resistance. The FSE, consisting of about half the soldiers but one-third the hospital capability of the entire unit, and two ambulances were quickly on site at the village of Zupanja.

The FSE soon had patients: one soldier with psychological trouble and two seriously burned by a pot-bellied stove on Christmas morning. Other medical elements joined the FSE at Zupanja, including MEDEVAC helicopters, a dental team, a preventive medicine unit, and the main body of the MASH. The first

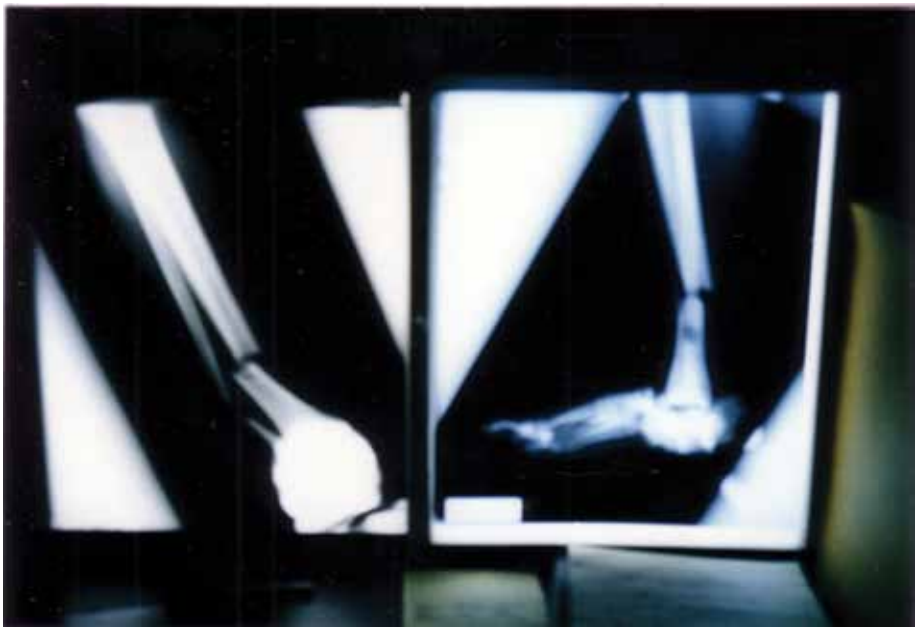

Figure 5-6. X-rays of a landmine injury cared for at the 212th MASH. Photograph courtesy of Lieutenant Colonel Steven Gouge.

battle-related casualty also arrived: a soldier who had triggered a landmine. The 212th's orthopedic surgeon saved the soldier's foot and morale rose as the news spread around Task Force Eagle.

As more of Task Force Eagle moved into Bosnia, the main body of the 212th moved forward. The FSE stayed at Zupanja, taking several more patients. The FSE learned that the physicians were not necessarily the key personnel: the generator was troublesome, and no one could accomplish any work until the mechanic fixed it. Several sites for the main unit were scouted but were either muddy or filthy, and the best option was a hill near Tuzla, which got the nickname "Bedrock" because the mud there was thinner and frozen. Casualties began arriving at the newly established MASH on January 23. Several were victims of landmine injuries and there was a steady flow of other patients, the victims of icy roads and other accidents instead of combat. In February, the FSE rejoined the main body of the MASH, and it was clear that some FSE members had started to think of themselves as an elite group. Ultimately, the solution was to rotate personnel between the two deployed groups and to change the terminology. The groups became MASH forward (the FSE group), main, and rear (those back in Germany), and all were reminded they were members of the same 212th MASH.

Figure 5-7. Erecting tents at Bedrock, January 1996.
Photograph courtesy of Lieutenant Colonel Steven Gouge.

The Long Year in Bosnia

The 212th set up its tents and expandable containers and established a functional hospital. However, improvements soon began. The Army had begun contracting outside personnel to perform noncombat functions, and a contractor built wooden platforms for both the DEPMEDS tents and the expandable containers, allowing easier patient care and reducing the wear-and-tear on the equipment. After a few weeks of operations, locals were hired as cleaners, which pleased the soldiers who no longer had to do their own laundry and also put money into the Bosnian economy. Friendships formed, and, as a joke based on the television show "MASH" (whose fictional Colonel Potter had a horse), the Bosnians brought a pony for Lieutenant Colonel Gouge to ride.

For the first part of the year, the MASH averaged about 12 inpatients at any one time. At first, these were mainly trauma patients who had been injured in vehicle accidents or by landmines, but as the year passed, medical cases predominated, with eight to ten inpatients at a given time. Some of the patients' cases were not serious, but because of scheduling, they had to be admitted as inpatients. When units sent convoys to pick up supplies at the main base at Tuzla, they brought sick soldiers back with them. If the problem could not be treated by

Figure 5-8. The 212th at Bedrock, June 1996.
Photograph courtesy of Lieutenant Colonel Steven Gouge.

the time the convoy headed out, the soldier stayed until the next convoy, likely the next week.

The 212th maintained its full allotment of trauma surgeons because of the ongoing potential for fighting and a sudden surge of casualties. The medical companies with each of the combat brigades rotated their physicians back to the MASH, which kept the physicians busy and gave them refresher training. Two infectious disease specialists accompanied a medical laboratory that deployed to Bosnia to support the troops, and they helped diagnose some of the complex cases. During the year, the MASH saw 9,934 outpatients, cared for 1,517 inpatients, and performed 275 surgeries. Although the MASH was a surgical hospital, 81% of the patients were treated for disease and only 19% were treated for injuries.

The unit had some extra elements, such as advanced diagnostic capabilities, which were useful because the MASH acted more like a general hospital than a mobile battlefield hospital. A CT scanner helped answer questions about a soldier's clinical signs and symptoms, preventing the evacuation of several soldiers back to Germany. At the time, the AMEDD, especially the senior leadership (including the civilian leadership in the Pentagon), was interested in telemedicine, linking patients to off-site physicians for diagnosis through the real-time

transmission of pictures. However, in the mid-1990s transmitting pictures was slow and the quality mediocre, and physicians often opted for telephone discussion rather than looking at images. Telemedicine also involved scheduling problems; the off-site physician had to be warned ahead of time, while patients often arrived unannounced on their units' weekly supply convoys. X-rays were sent back to the 67th CSH in Hungary for confirmation reading by a radiologist, but the doctors at the MASH typically read the x-ray themselves and acted on it. Although senior officers considered these difficulties to be short-term and solvable, Lieutenant Colonel Gouge repeatedly pointed out that telemedicine was not helpful and distracted his physicians from their daily work. The two views were never reconciled. "Cutting edge" telemedicine equipment was scarcely used because of the problems involved. The program's supporters later admitted that training and support to the MASH were inadequate, and they had forgotten to provide the 212th a high-resolution digital camera.

When the UN was trying to stabilize Bosnia, a Pakistani hospital had been on the hill (really a slag heap) that the 212th now occupied. On Sundays the Pakistanis had opened their gates and treated local civilians, and when the American

Figure 5-9. Ambulance bringing a patient to the EMT, July 1996.
Photograph courtesy of Lieutenant Colonel Steven Gouge.

hospital arrived the locals expected this care to continue. However, the US rules on treating civilians were much stricter, and disappointed both the civilians and the clinicians, who wanted to help suffering people. Gouge was willing to bend the rules only so far, and had to resist admitting too many Bosnians. Nobody wanted to deny care, but the 212th's mission was to support Task Force Eagle, which meant having beds empty and ready as a surge capacity in case fighting broke out. Consequently, fewer civilians could be seen, especially because (with the inadequate Bosnian health system) they would likely occupy a bed for a prolonged time. Soldiers likely to have a prolonged recovery time were evacuated even for minor conditions (one soldier was flown to Germany because his athlete's foot would likely take 3 weeks to cure). When casualties were expected, an extra effort was made to have empty beds as insurance. For instance, IFOR thought it had cornered fugitive Bosnian Serb leaders at a bunker complex and expected heavy resistance, but after a delay IFOR troops were allowed to search and there was no resistance or casualties. Another possible flashpoint was the September elections, when it was feared that the losers might resort to violence. Beds were again kept empty, but no fighting broke out. Over the summer the situation improved, Gouge obtained permission to reduce staffing from two operating tables to one, and medical staff were temporarily released back to Germany to see more patients and keep their clinical skills sharp.

The lack of fighting meant the 212th had few wounded patients; disease and injury rates were also relatively low. American troops were forbidden to drink alcohol, which doubtless reduced the number of accidents and fights. During the summer, the 212th conducted a substantial vaccination effort against tick-borne encephalitis among the troops. Staff had to organize the effort and oversee the arrival, local transport, and delivery of all the doses, as well as documenting every shot in the soldiers' medical records. Unsurprisingly, some doses and paperwork got mislaid. Inspectors also noted flaws with the blood bank and the medical maintenance sections; in both instances the soldiers responsible had done their job but not necessarily documented everything. Another medical responsibility for the 212th was screening soldiers for health problems prior to leaving BiH. The military had been heavily criticized after Desert Storm for keeping poor medical records and failing to screen returning personnel for health problems that developed in Saudi Arabia, and a postdeployment health assessment was now in place.

Despite the lack of combat, Lieutenant Colonel Gouge strongly enforced the Task Force Eagle uniform policy requiring that troops wear helmets and armored vests and carry their weapons. After Desert Storm, the AMEDD had been criticized for allowing staff to be out of uniform, failing to present a military appearance. Gouge was determined to make sure the 212th kept its credibility within the whole Task Force, and disciplined his soldiers as needed. By June, however, Task Force Eagle began encouraging sports, and soldiers no longer had to wear their helmets and armored vests whenever they were outside. In better

Figure 5-10. Force protection measures continued even without a direct threat. Here, MASH personnel build a sandbagged bunker, July 1996.
Photograph courtesy of Lieutenant Colonel Steven Gouge.

weather sports alternated with physical training to keep people fit.

At the MASH, Sundays became a day off, except for a minimal staff on duty, and eventually Saturdays were also rest days once the camp at Bedrock was completed. Showers, running water, and flush toilets were among the amenities installed, a post exchange sold snacks, and sandbags protected the entire hospital. Troop assemblies for announcements and orders, with staff in formation in full uniform and equipment, declined from every day to three times per week. Cookouts and volleyball became routine. A gazebo was built for picnics, and ice cream makers sent by family members made holiday weekends memorable. Foreign troops in IFOR were invited and often came to picnics. In February, a windstorm sent the chapel tent flying, first onto the latrines, then onto the hospital tents. Several other tents were damaged. In March, personnel rotation resumed as the permanent change of station (PCS) system rotated people into and out of the unit, and paperwork was completed for promotions. At the same time Gouge began allowing 2 weeks of leave for all staff in turn.

Few troops could visit Bosnian towns because of security risks; the US command did not want to lose any soldiers during a peacekeeping mission. Soldiers

Figure 5-11. Snow doctors treating a snow patient, March 1996.
Photograph courtesy of Lieutenant Colonel Steven Gouge.

talked about being "prisoners of peace" as they sat in their camps. Local craft vendors were periodically allowed into the camp, and occasionally troops were able to travel to Sarajevo. A few of the staff, mainly nurses, accompanied patients being evacuated back to Germany. Troops also got out of Bedrock, some on short passes to Hungary, others on official visits to Bosnian or IFOR facilities. There were exchange programs with Swedish and Norwegian medical facilities, partly to share knowledge, partly to see how other countries handled medical issues, and partly to fight the tedium. The 67th CSH had deployed an intermediate care ward, which rotated troops with the 67th's main body in Hungary, providing more new faces at Bedrock. On the bright side, an Armed Forces Network satellite dish brought in television, the mail service was reliable and free to troops in BiH, and telephones and Internet access were soon established, although calls could still be expensive. Videoconferences were also possible, and a few times they linked the families back in Germany to promotion ceremonies in Bosnia. A steady stream of VIPs (from First Lady Hillary Clinton and the secretary of defense to senators and representatives) also visited. Occasional foreign patients, including Russians, caused flurries of extra activity.

The End in Sight

In October the 212th prepared for another move, from Bedrock on the west side of Tuzla to an old factory (painted blue and known as the "Blue Factory") on the east side of town. Gouge protested against leaving well-established facilities at Bedrock just as the unit was overhauling equipment and vehicles for the return to Germany, but the protests were ignored; the secretary of defense had agreed with the Norwegian government to replace the Norwegian hospital that had been in the Blue Factory, and the 212th moved on November 6.

The MASH was larger than the Norwegian unit and facilities needed to be expanded, although some personnel felt the work was a waste of time because the next unit to rotate to Bosnia (the 21st CSH) would want to make its own changes. Meanwhile the 212th had to provide continuous medical support, and critically injured patients continued to arrive. A Bosnian civilian arrived who had been hit by a car; he may have been drunk and demanded to be released while he was being treated. He died the next day, probably from a heart attack; he was the only patient to die in the MASH that year. Earlier, an American soldier arrived seriously burned; he had pulled another soldier from a burning tent after it had caught fire following the explosion of a cooking stove. The MASH's

Figure 5-12. First Lady Hillary Clinton at the 212th, March 1996.
Photograph courtesy of Lieutenant Colonel Steven Gouge.

Figure 5-13. The Blue Factory, June 1996, with the Norwegian hospital occupying the buildings at the top left. The site would become somewhat more crowded when the 212th replaced the Norwegian unit.
Photograph courtesy of Lieutenant Colonel Steven Gouge.

staff did what they could and arranged his quick evacuation back to the Army's burn care unit at Brooke Army Medical Center in San Antonio, Texas, but the soldier died there. On the 212th's last day in Bosnia, a Danish tank slipped into a stream, and the commander was killed when it rolled over. The gunner was trapped in the flooding tank, and an orthopedic surgeon was flown out to the tank in case the soldier's leg had to be amputated to free him. Fortunately a towrope tugged the tank's gun out of the way, freeing the gunner's leg before he drowned, and he was treated for shock and hypothermia.

During the year the MASH had also become the center of a medical task force. The 212th oversaw dental care, preventive medicine (including elements of a medical laboratory to run complex tests), and mental health for all of Task Force Eagle. The mental health team treated mental illnesses among the roughly 25,000 troops in Task Force Eagle, including talking several soldiers out of suicide attempts, but near the end of the year a soldier completed suicide.

Back to Garrison

On the way back to Germany in December, the MASH stopped for 3 days in Hungary. Officially the purpose of the stay was to clean up, but a big beer tent

was set up and, unofficially, the soldiers were expected to blow off steam away from cars and families. Everyone relaxed, even Lieutenant Colonel Gouge, and a nurse decided she was "Hot Lips" and kissed people on the forehead. After sobering up, troops returned to Germany and reunited with their families.

In Germany, the entire 212th was granted 2 weeks of leave, which not only provided time off, but also minimized the time the unit would be ineffective compared to the situation if troops had been allowed to take leave any time they wanted. Even before the block leave was granted, a training schedule was established, with weapons qualification in January 1997, some time working at the Pirmasens medical supply depot, and a field training exercise tentatively scheduled for March. Gouge knew he had experienced soldiers and solid teamwork in the unit, so when staff returned from leave he decided to fulfill training requirements but not do extra training. The unit received new medical equipment, checked it, and proceeded with a training exercise at Hohenfels. In the exercise, the hospital was run smoothly, but the soldiers were out of practice at setting up tents.

Yugoslavia Continues to Crumble

In December 1996 the IFOR completed its mission in BiH, but foreign troops were still needed to maintain stability. Although President Bill Clinton had pledged that US troops would stay only one year in BiH, some stayed for the new Operation Joint Guard, when the "stabilization force" (SFOR) took over. SFOR had a smaller US force, two brigades, which tapered down to one brigade as the situation improved. Initially the troops were from the Germany-based 1st Infantry Division, but soon forces based in the United States were also deployed. By 1999 National Guard units were being used, and these remained the main forces deployed through 2004, with 6-month rotations of various units.

The Next Flashpoint: Kosovo

Serbs were a minority in Kosovo but dominated the government. Prolonged discrimination provoked resistance from the ethnic-Albanian minority, loosely organized into a Kosovo Liberation Army (KLA). In 1997 the weak government in Albania collapsed and heavier weapons began filtering to the KLA. NATO worried about another outbreak of civil war, especially since thousands of NATO troops remained in BiH, and fighting in Kosovo could easily spill over into BiH, Albania, or Macedonia, another ethnically mixed part of Yugoslavia that was holding on to a tenuous calm. Peace talks involving the Kosovars and Serbs went nowhere, and in mid-March 1999 Milosevic sent troops and paramilitaries into Kosovo. NATO began aerial bombing, but over 2 months passed with the bombs having little effect on the Serb government. NATO began putting forces in Albania to increase pressure on the Serbs. The United States planned to deploy a regiment of attack helicopters and a battalion of artillery, both units

that could operate in Kosovo without US ground troops crossing the border. But the effort escalated: the deep-attack units needed ground troops to protect their base (the Serbs might well send ground troops to attack an undefended US base), and also needed supply and maintenance units. As the US force grew to 6,000, it became clear that medical support was also needed, especially if combat was a possibility. Once again the 212th MASH got the call, but this time only because the 67th CSH had just returned from a rotation in Bosnia.

Task Force Hawk: Operations in Albania

NATO bombing began on March 24, 1999. The 212th had received a warning order (in quite vague terms) 2 days earlier. The initial intention was for American forces to be based in Macedonia, but the Macedonian government decided hosting the base would be too provocative, both upsetting some of its people and potentially causing the Serbs to invade. Instead US forces were sent to Albania, which may have caused a delay in deploying; the MASH flew out in mid-April.

The entire MASH did not deploy. Previously, the commander, Lieutenant Colonel Alan Moloff, had worked with his staff to develop a contingency medical facility (CMF), deliberately drawing in as many of his senior subordinates as possible, partly to develop their planning and leadership skills. The CMF was intended to serve a different purpose than the HUSF, which was still the doctrinal detachment of the MASH. The CMF included only the bare minimum of what a hospital needed and divided the remainder of the MASH into elements that could be added as needed. The core of the CMF was 45 personnel with a two-table operating room, four EMT tables, four ICU beds, and ten minimal care cots. It stocked enough supplies for 24 major operations and 100 medical patients, for an estimated 3 days' activity. With some sleeping tents and a small operations tent, the entire CMF fit onto seven cargo pallets and could be flown by a single C-17 transport aircraft. The CMF was deliberately planned not only to serve as a surgical hospital but also to include a medical capability not normally found in the MASH, or anywhere else in the Army at that point. The CMF deliberately sacrificed vehicles (and thus tactical mobility) to remain small and have strategic mobility. It could be ready for deployment in 48 hours, far faster than the entire MASH. Yet deploying the CMF would gut the MASH; while the CMF was very small, it took most of the surgical capability out of the small MASH.

When the warning order arrived, MASH planners measured the requirements of the deployment against the CMF's capabilities and decided the CMF would be deployed. Planners also intended to evacuate patients quickly (if they would not recover in 2 days), which meant the few beds of the CMF would suffice. Two levels of higher headquarters agreed, and on March 28 the MASH warned its clinicians to get ready to deploy. Everyone rushed to prepare, expecting to leave

within 3 days. Instead, it was 18 days before deployment, and everyone had time to settle their personal affairs. However, the equipment was already loaded on pallets, and it was not overhauled.

Then on April 15 the CMF flew to Rinas Airfield, the international airfield near the Albanian capital of Tirana. Rinas Airfield was not only the base for Task Force Hawk, but also for other NATO forces, the UN relief flights, and continuing Albanian flights. The paved airfield was in good condition, but the ground around it was knee-deep in mud. A crumbling concrete building had a hand-written sign labeling it the welcome center for Task Force Hawk, but nobody wanted to go into the foul-smelling building. The CMF's set-up site was on the other side of the runway, which was not safe to cross for several hours. Eventually the group got to their designated site, erected a single GP-medium tent, and settled in for the night. The tent was not large enough for everyone, and some slept outside in the mud, or at least tried to. Some soldiers decided trying to sleep was a waste of time and borrowed a truck, planning to retrieve the rucksacks, but the 5-ton truck stalled in axle-deep mud.

The next day staff set up tents, but rain continued that night and by dawn the cots were islands above the water. For several days the troops dug trenches to drain their swamp, filled "mud-bags" (they could not be called sandbags), and spread 80 truckloads of gravel with wheelbarrows and a borrowed utility vehicle to provide the base for the CMF's medical facility. Shared hardship and plenty of work kept spirits up, especially once medical work began. When the rains stopped, the ground as well as equipment dried out quickly, and the engineers worked to get more facilities operational. Within a few weeks (the CMF was at Rinas only about 2 months) a wide range of facilities were up and working, including a volleyball court, a café, and telephone and e-mail contact with the outside world. In fact, phones and e-mail were established before showers and hot food since communications were a priority to the Army. When television became available, the 212th learned that NBC's Tom Brokaw had credited the 82d Airborne Division with building the hospital.

As a medical facility, the CMF faced some problems, some due to being a new concept, some caused by hurried packing. In March the 212th thought the CMF would deploy within 72 hours, and equipment had been packed without recent maintenance tests; some was found to be nonfunctional in Albania. Similarly, some medicines had expired. Because the CMF was at an airfield, it was easy for the MASH in Germany to send personnel and equipment forward; in fact, the ability to reach back into the unit and pull needed elements forward was part of the plan. Another 29 soldiers were deployed, along with some vehicles, over the next few weeks, adding medical capabilities such as dentistry, preventive medicine, and behavioral health. Supplies proved troublesome at first; pallets of supplies arrived but were hard to find amid other pallets. Some items were identified as useful but not vital, including laptop computers instead of bulkier desktop models and a more flexible x-ray system. Additionally,

female personnel were in demand because of local cultural preferences for a female healthcare provider.

These hurdles did not stand in the way of patient care. Other medical facilities were located around the Rinas Airfield runway, including a US Air Force clinic and Army battalion aid stations. Lieutenant Colonel Moloff, who was in charge of the overall medical effort, told the other medical commanders, "We are going to work together and nobody is going to die on us." The CMF had the only operating tables, so it handled the surgical cases.

Patients began arriving. A British C-130 cargo aircraft crashed one night, killing one and wounding a dozen, which triggered a MASCAL call at the CMF. Two Apache attack helicopters had planned to simulate an accident, but crashed instead, killing a two-person crew and injuring the other crew. The MASH was ready for the injuries but a bit confused when the patients were real. Some patients were hard to handle: a few Serbs had been taken prisoner by friendly forces and they had to be treated and detained at the same time, with questions about how their after-care would be handled. Many patients had asthma or hay fever, or sports injuries, including joggers who had run-ins with the barbed wire around the airfield. There were also appendectomies, and a case of trench foot in a soldier who did not keep his feet dry in the mud and rain. To cope, Moloff wrote stress-relief "prescriptions" for some of the senior officers: a daily cigar before bed. The 212th had set up the CMF with some physicians to handle sick patients, and they proved very useful: 661 patients arrived, but only 28 needed surgery.

Task Force Falcon: Operations in Macedonia

Mounting NATO air pressure and Kosovar resistance resulted in a cease-fire on June 10, and the next day NATO troops began moving into Kosovo as Serb forces pulled out. At the same time, a new commander for the 212th arrived, Lieutenant Colonel Alan Janusziewicz, who spent the first week observing operations. However, he was politely asked to stop asking questions when the generator failed after he asked about the power supply, there was a MASCAL after he asked about mass casualty planning, and movement orders arrived after he asked how they would handle a move. Janusziewicz formally took command on June 17, just as the CMF was packing up for its next move. Because Rinas Airfield was so congested, the bulk of US forces moving into Kosovo flew into Macedonia and staged through Camp Able Sentry, the base established for the American forces helping to stabilize that country. As the CMF was packing up at Rinas, an American soldier required surgery after accidentally shooting himself in the leg, and a MASH surgeon performed the surgery at a Dutch medical unit.

Nationality may have played a role in the CMF's move. Germany had a MASH-type hospital in Macedonia, which could have handled US patients if an agreement were reached. But medical support is generally a national responsibility, and the CMF was the US hospital available to move into Macedonia quickly,

so it was sent. The 313-km trip from Rinas Airfield to Camp Able Sentry was memorable. The CMF had only three 5-ton trucks and two high-mobility multipurpose wheeled vehicles (HMMWVs), so civilian buses and flat-bed trucks were hired to carry personnel and equipment, escorted by military police. The roads were rough, and breakdowns (from traveling as fast as 10 miles an hour) added another 9 hours to the planned 14-hour trip. The next day was scheduled as a rest day with visits from President Clinton and other VIPs, but some soldiers moved ahead to start erecting tents. The head start meant the work on June 23 went fast: contractors started building the floor at 0800 and by 1400 the CMF was ready to perform surgeries. That evening, two Serbs (possibly drunk, certainly not soldiers) who had taken potshots at some US marines were brought in; the marines had returned fire and hit the two men. The 67th Forward Surgical Team (FST) did the initial surgery in Kosovo, then the patients were flown back to the CMF, one with a complex hand wound and the other paralyzed from the neck down. A few days later it was belatedly recognized that prisoners had been transported across an international border, and while the Macedonian government did not expel wounded men, it urged the United States to transport them to Serbia as soon as they were stable to travel.

By moving to Able Sentry, the CMF had allowed the 67th FST to move forward. Many of the patients received by the CMF over the next 5 weeks had already received surgery at the 67th. Fighting in Kosovo continued, although very little involved US troops. Although the 67th did not ask for help, staff experienced fatigue and burnout, and Janusziewicz was ready to rotate personnel between the FST and the CMF. The CMF had been built up from its original 14 beds; now it could staff 23 beds and had a few extra in case of a surge. On average, more than half the beds were occupied, and over time 26 intensive care patients were admitted, but only four patients received surgery. While some patients in serious condition were seen (including a patient who died from a traffic accident), most cases were respiratory infections, skin problems, and injuries from minor accidents.

One of the biggest problems at Able Sentry, as it had been at Rinas, was deciding who to treat. American and NATO forces were a given, and anyone could get emergency treatment, even if it would be hard to find a place for them to recuperate. Kosovo suffered from a lack of medical facilities, and Serb patients refused to go to Kosovar facilities, and vice versa. Sick Americans were treated and, as appropriate, told they should go to their own unit medics next time they got sick. It was also hard to categorize many of the American contractors. Some companies provided healthcare on site, others reimbursed the Army for care provided—if the Army documented the care given, which caused more paperwork for hospital administrators working in tents. Furthermore, some of the contractors were military retirees who by law were entitled to care in military facilities, but what the law envisioned was care at military hospitals in the United States, not in tents in foreign fields. Fortunately this administrative complication did not lead to any medical problems.

Ultimately, in early August 1999, elements of the 67th CSH arrived in Kosovo and Macedonia to take over the mission. The 212th handed over the hospital operation and flew back to Germany. Overall, the unit had seen 788 patients (104 of whom had been in intensive care), and had treated 32 surgical patients.

When reviewing the CMF, the 212th thought it had done many things well. It had packed up faster and more efficiently than during training exercises; it had been an excellent way to get a mini-hospital into theater early; and it provided a base that could be built up as needed, until capability matched requirements. Some facets needed attention, such as the equipment and drug problems during packing. Also, the command-and-control element had been trimmed very tightly based on the capabilities of the personnel then in the 212th; this blend of expertise could not last, and it would be very hard to keep the CMF at 45 staff. Deploying the CMF also "broke" the MASH, which could then be used only to beef up the CMF. While the idea of slipping a mini-hospital into a combat theater early was attractive, as a concept it might work better with the larger CSH, which could send a CMF-size element into operation and still be able to deploy a functional hospital.

Busy Times in Germany

After a quick rest on the return from Macedonia, it was time to overhaul the 212th. The commander of the 30th Medical Brigade, the MASH's headquarters, gave guidance to drop the CMF concept, revert to the doctrinal MASH and HUSF, and focus training on these missions. Also, the substantial postdeployment backlog of equipment maintenance swamped the available maintenance personnel (the 212th was shorthanded since other units had priority for the available mechanics). However, in January 2000, news arrived that the 212th would be rotating to Kosovo for 6 months starting in March. The unit had to switch to training for that specific mission and held mission rehearsal exercises from February 2nd through 11th. The observer-controllers watching and grading the exercise had recently been in Kosovo and knew precisely where to focus to help with the exercise.

Meanwhile, the MASH was tasked to help other medical units prepare for their own deployments. USAREUR added another responsibility: the MASH had to move from Wiesbaden to Miesau, about 117 km away, because the Army was adjusting its German bases and the 1st Armored Division would get the space at Wiesbaden. Training for the deployment had to continue during the move, and responsibilities were split: the commander focused on deployment training and preparations while the executive officer handled the move to Miesau.

Routine Return to the Balkans: Camp Bondsteel, Kosovo

On March 26, 2000, 90 troops from the 212th arrived in Kosovo for a week of orientation and familiarization with the equipment and the situation, what

the Army called a "right-seat ride." Only some personnel deployed, for several reasons. First, the number of US troops in Kosovo was capped, and not all the unit could be brought. Second, the whole MASH was not needed for the limited number of troops in Kosovo. Third, leaving troops behind made it easier to move from Wiesbaden to Miesau, and nonmarried soldiers would later be rotated back to Germany to finish their personal move, with other soldiers rotated forward from Miesau to get experience in Kosovo. For the arriving troops, the orientation process was particularly important because the MASH was taking over equipment from the 67th CSH, some of which (such as the CT scanner) was new to the staff. Some extra staff were attached to the MASH to handle the nonstandard equipment. The 67th had been in Kosovo for 9 months, and standard procedures for most activities had been settled. The main question the 212th had to address was how thoroughly to screen the health of locals working on the US bases.

The formal change of authority came on April 3, and the 212th took over the three-part mission of providing hospital support for Multi-National Brigade–East (MNB-E), helping build up the local healthcare system, and caring for acute local patients. MNB-E was mainly a US brigade, but the overall Kosovo Force had six other national contingents, each with some medical support. None of the nations provided full-spectrum medical coverage, and they helped each other with some specialties; for instance, the Italians had deployed a neurosurgeon and the Germans had an ophthalmologist.

The facilities were standard DEPMEDS tents, which were hard to keep warm in winter and cool in summer, not so much for the staff's comfort but to reduce stress on patients. As the MASH was preparing to deploy, it assessed the amount of work needed to repair the tents for the coming winter. The hospital had 32 beds, 4 ICU, 10 intermediate care, and 18 minimal care; if needed, it could be expanded to 64 beds. There were four OR tables installed, but only two were routinely staffed. Because the Army was looking to keep soldiers in theater and reduce the number of soldiers evacuated back to Germany, a physical therapy section was added.

Although Kosovo was stabilizing after the serious fighting, conflict between Kosovars and Serbs continued as scores were settled between individuals and communities, politicians were targeted, random ethnic violence occurred, and criminal gangs fought for profit. In the first month, the 212th received 46 trauma patients and 19 serious medical cases, but these averages soon stabilized at around 30 and 10 per month. The hospital stayed about 50% full as patients recovered on the wards. Between 600 and 700 sick call cases were seen each month, fluctuating as the seasons brought pollen or sports injuries. Most of the trauma cases were from motor vehicle accidents (neither drivers nor vehicles had to be licensed in Kosovo, and the roads were in poor condition), gunshot wounds, and mine blasts. The MASH was supposed to treat urgent local patients and the rules were interpreted fairly broadly; the very day the 212th began operations at Camp Bondsteel, a newborn girl was found abandoned in a ditch. She

arrived at the hospital so cold that no vein could sustain an IV, and fluids had to be fed in through the remaining piece of her umbilical cord. She was resuscitated and named Baby April, and ultimately a local family adopted her.

Later, a young Serb girl who had been shot in a drive-by attack on a family picnic was brought in, and news that she had been well treated warmed relations with the Serb community. Adults also had high political visibility: a Kosovar politician was brought in after an assassination attempt and stabilized, but had to be evacuated to Germany for definitive care. Three Serb priests were shot while leading a funeral procession. They were treated, but the mourners turned into a protest group until they were satisfied that the MASH was caring for the men, who would not have received care at most Kosovar medical facilities because of their ethnicity. When the MASH treated local patients who were discharged to their homes, they worked at teaching family members how to give follow-up care, reducing the strain on the patient and on the healthcare system. US patients who were evacuated longer distances tested the advanced prototype of an elaborate new piece of equipment, the "life support for trauma and transport," or LSTAT. The LSTAT, a litter with built-in patient-monitoring equipment, prefitted for IV bags and oxygen, could handle critically ill patients, but it weighed over 200 pounds without the patient.

Part of the 212th's mission was helping expand the local healthcare system, which required building up two systems, one Kosovar and one Serb. MASH physicians helped train the next generation of doctors at the local teaching hospital in Pristina; staff nurses taught there and in Kosovar clinics. Most nurses in Kosovo were high school graduates with some on-the-job nursing experience, and the US nurses helped with some fairly basic instruction such as infection control, anatomy, and medication administration. Classes averaged 30 students per week. For several months the 212th allowed local hospitals to use the CT scanner, but had to stop doing so because local physicians sent patients who did not need CT scans as well as patients who had bribed the doctors to get them to the American hospital.

Soldiers also volunteered their time to help improve the facilities at local clinics and hospitals, and the 212th helped distribute medical supplies. Troops also took part in MEDCAPs in local villages. The MEDCAPs started out well controlled, but when troops attempted to treat chronic conditions that would need follow-up care, Janusziewicz had to impose restrictions because the US Army could not take over long-term care for the local populace. Trips off Camp Bondsteel required a high protective level; helmets and armored vests had to be worn, and any group needed at least three soldiers.

Living conditions were considered tolerable. The well-established base camp had fine weather from spring to early autumn, and personnel had radio and television, movies, exercise gear, a post exchange, USO tours, and intramural sports. The 212th won the "Bondsteel Cup," a prize for a mix of 12 individual and team events, beating several much larger units. R&R weekends were available from

mid-August to resorts at Lake Ohrid on the Macedonian-Albanian border. At $75 for four days and three nights, they were a bargain, but spaces were limited.

As the end of the fiscal year approached, various plans for the next year were contemplated. New facilities for the hospital were considered, but none seemed affordable. Discussions about the United States and Britain jointly staffing and funding a hospital that would support both Multi-National Brigades East and Center proceeded. Over the past 6 months, the 212th had handled 339 major cases, both surgical and medical: 76 were from motor vehicle accidents, 45 were gunshot wounds, 6 patients were wounded by grenades, and 6 by landmines. Then, on September 25, 2000, the 313th Hospital Unit, Surgical (an Army Reserve unit from Springfield, Missouri) took over the facilities at Camp Bondsteel and the 212th returned to Germany.

Adjusting in Germany

When the unit arrived back in Germany, the 212th adjusted to several new conditions. The unit had to settle in to the new compound at Miesau, and about 30 personnel were new, arriving through normal PCS moves or returned from schools. There was also wholesale turnover of the clinicians. At Wiesbaden the 212th had taken its clinical staff mainly from the nearby hospitals, and many of them had deployed twice with the MASH. Now that the unit was only 13 km from Landstuhl, the clinicians at Landstuhl Regional Medical Center (the Army's largest hospital in Europe) were tapped for duty with the 212th, causing some feelings of inadequacy among older staff. However, the normal PCS system moved soldiers around every 2 or 3 years, and after that time few personnel would be left in Germany to remember the episode.

At Miesau, Janusziewicz returned to managing priorities: integrating new personnel, conducting training for both individuals and groups, and getting the maintenance problem under control. The 226th Medical Logistics Battalion, also based at Miesau, was a major help to the five mechanics of the 212th, but contract workers were also needed. Contractors were hired with "operational recovery" money from the 30th Medical Brigade. The extra hands allowed the 212th to conduct a normal amount of unit training. In mid-2001, as Janusziewicz's 2 years in command were ending, his final training exercise with the 212th was providing support for the next Army reserve unit going to Kosovo, the 399th CSH from Brockton, Massachusetts.

Sources

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Copies of this material are on file in the historical research collection of the Army Medical Department Center of History and Heritage, Fort Sam Houston, Texas.