

Chapter Six

Operation Iraqi Freedom

In June 2001, the Army's personnel system sent the next commander to the 212th MASH for a 2-year assignment. Lieutenant Colonel Kenneth Canestrini had joined the Army as an enlisted soldier, then earned his college degree and rejoined as a Medical Service Corps officer. Canestrini had specialized in hospital administration, but also had 2 years' experience with deployable hospitals as executive officer of the 115th Field Hospital. After arriving at the MASH, Canestrini announced a simple goal: the unit would become trained, equipped, and deployable. He later recalled:

My focus was to be a medical unit that could move from Point A to Point B, set up on the battlefield, and provide combat health support in an austere environment. I looked at the unit and said, "OK, what can we do to tighten up, get everything squared away equipment-wise, supply-wise, and then bring real world training in to the medics?"

Had we deployed within the first six months, I doubt we could have met the requirement [that developed in Iraq]. The mission changed on us, we had an unplanned 4-day convoy operation. When I took command our equipment just wasn't maintained to the degree that it needed; it wasn't there yet. All of the checks and functions and training things that we did in the unit during that 18 month prep period insured that I could operate by myself for two weeks without support.

Also arriving about the same time were new senior medical officers, including a deputy commander for clinical services (DCCS; Lieutenant Colonel John McGrath), an executive officer (Major Ronald Krogh), and a chief nurse (Major Suzanne Richardson). Compared to normal personnel rotations, this new leadership was unusually stable as the MASH went through the usual individual, group, and unit training.

The next deployment was scheduled for September 2002, a 6-month rotation supporting the remaining US troops in Bosnia. However, Al Qaeda's terrorist attacks of September 11 changed the plans. Intense international diplomatic pressure on the Taliban, governing Afghanistan and protecting Al Qaeda, failed to

obtain the surrender of Al Qaeda leaders, and a US-led military coalition began operations in Afghanistan to topple the Taliban and capture Osama bin Laden and other Al Qaeda leaders. The US operations, called Operation Enduring Freedom, involved relatively few ground troops and thus required relatively little hospital support. Despite being the Army's most mobile hospital, the 212th was not sent to Afghanistan, and a warning order to prepare for deployment was cancelled in April 2002. When the order was cancelled, rumors arose that the 212th had been selected for unspecified operations elsewhere. All Canestrini could tell his troops was to watch the news and be ready to deploy.

NEGOTIATIONS WITH IRAQ

The 212th's soldiers watched the uncertain progression of US-Iraqi negotiations through 2002 into what became Operation Iraqi Freedom. They could not be sure what they might be called upon to do, nor when anything might happen. They followed the news about Iraq and the military preparations should negotiations fail as US Central Command (CENTCOM) expanded military support facilities in the Persian Gulf. CENTCOM had been refining plans for Iraq since late 2001; changes would affect what troops to send and also when to send them. In outline, the operational plan shaped up as a ground advance from Kuwait into southern Iraq, possibly combined with a thrust through Turkey into northern Iraq; this would first isolate Baghdad and Saddam Hussein's regime. If necessary, the city of Tikrit (Saddam's hometown and a stronghold of the Ba'ath Party) would also be surrounded. With the regime cut off from the country, operations would continue, breaking down Ba'athist control and freeing more of the country. Resistance was expected mainly from Ba'athist organizations and the Special Republican Guard, while the Iraqi army was expected to put up little resistance.

In early 2003, with the diplomatic situation unclear, the Army had to make decisions that locked it into a particular course of action. Units were being mobilized from the United States and Europe, and combat troops flowed into Kuwait simultaneously with support units. Secretary of Defense Donald Rumsfeld had overruled the military's standard deployment system that tried to give units at least 2 months' advance notice. Feeling it hampered diplomatic options, Rumsfeld did not want an all-or-nothing approach. Instead he retained control over "force packages," smaller numbers of troops to gradually escalate the pressure. While deployment preparations are always disruptive, at the unit level this new system added to uncertainty. Amid all the uncertainties, from whether there would even be a war to what units would be needed and when, plans for the 212th MASH remained undetermined. Canestrini kept his troops informed of the big picture, and everyone knew that V Corps' high-readiness hospital might be needed. On January 14, 2003, the 212th got deployment orders, and the equipment had to be at the port of Rotterdam in only 3 days.

READINESS

A unit's readiness for war is a balance of staffing, training, and equipment—each important, intertwined, and in constant flux. Instead of the often-cited “hurry up and wait” situation in the Army, the MASH's deployment process was a case of “wait and hurry up.” The diplomatic uncertainty brought delays, allowing the soldiers to take normal leave and holidays at home, but also causing a great rush in the few days available to assemble troops and load equipment after receiving the deployment order.

Personnel

Units in Germany are on a 3-year personnel rotation cycle, so roughly one-third of all soldiers are within 6 months of arriving or departing. Some soldiers in the 212th were scheduled to leave the unit but opted to stay for the deployment, feeling they owed it to the unit. Sergeant Shamika Cheeseborough shared her thoughts: “Me being the only quartermaster equipment repairer and working with dolly sets for three years, why would I leave the unit now? I thought, ‘I can't leave, because I'd been working with these people for three years and we have a pretty good rhythm and we know what to do.’” (As the 212th deployed, the Army did not apply stop-loss and stop-move policies, the orders that held individuals in the Army or in a particular deploying unit, which would later be controversial.)

Unfilled positions in the unit were filled by transferring soldiers from other units, called “cross-leveling.” Since the MASH was the only hospital deploying from Germany, it could borrow personnel, mainly from the 67th CSH. It also received two doctors from PROFIS who worked in Washington, DC, at Walter Reed Army Medical Center. Most Army doctors and nurses are assigned to a fixed-facility hospital and train only a few days annually with their field unit; for the 212th it was the other way around, and clinical staff spent much of their time at Landstuhl Regional Medical Center, a few kilometers away. Unit leaders paid attention to how PROFIS personnel would integrate when they arrived; to facilitate integration, the MASH brought its clinicians in for battalion runs, professional development work, and other activities. Lieutenant Colonel Alfonso Alarcon, an orthopedic surgeon, thought this policy contributed to efficient teamwork. However, unusually, the two doctors from Walter Reed, who arrived February 1, had never before visited the unit. Cross-leveling also occurred within the unit; the 212th was over strength in the laundry and bath section, so one of the sergeants who had served in the infantry was reassigned to overseeing force protection training, such as guard duty, security for convoys, and protecting the hospital when it was operational.

The MASH was also augmented with individuals and several small teams who provided specialized nonmedical support. An additional warrant officer

brought maintenance experience to keep the generators running, but a medical maintenance team was considered unneeded and declined. A signals team would travel and work with the 212th. An air evacuation liaison team was also added, as well as a casualty assistance team to coordinate notifications to units and families, but a mortuary affairs team was not attached.

In the MASH, many specialties were filled by only one or two soldiers, and a single medical emergency could send the command scrambling for replacements. The 212th had to deal with losing its DCCS, arranging his replacement, and also filling some other staff positions. The emergency room doctor broke his arm in January 2003, but did not take himself off the deployment roster because he thought his arm would heal in time. He had pain and limited motion for 6 weeks, but he judged he was not a risk to others for that period, and once healed he would be extremely useful—not least because he was in charge of the chemical decontamination team. However, a pregnant physician had to be replaced because pregnant soldiers are not allowed to deploy.

Few units have no soldiers who want to avoid going to war by reporting a medical problem, or claiming to be conscientious objectors, or taking some other administrative route. In these cases there is little that commanders can do except work with individuals and ultimately proceed with legal action under the Uniform Code of Military Justice, if necessary. Most such soldiers are eventually discharged, leaving unfilled positions in their unit. Fortunately such problems were rare for the 212th, whose men and women were ready and willing to go. Chaplain David Bowerman specifically noted that nobody in the 212th came to him seeking reasons not to deploy. As company commander, Captain Sean Farley dealt with the personnel problems, hearing concerns from many but losing only two soldiers.

There were days that I just beat my head against the wall. We had redone our family care plans for a command inspection in November. They looked really pretty in the files. We even called and confirmed all of it, so that way when brigade came down we'd say, "We did all of this beautiful stuff, our family care plans are perfect." It wasn't 24 hours after the deployment order that people started coming in with family care issues.

We had two soldiers that ended up getting in trouble because their family care plans totally broke down. In the end there was no way to resolve it and they ended up having to get expelled from the Army. We thought about it and decided one was a good NCO; we'd keep her to help the rear detachment. So she volunteered. We kind of held the paperwork back. I don't know how the legal beagles would have liked that, but we kind of held the paperwork back and did it when we got back to Germany. But our focus wasn't on the UCMJ; they weren't bad troops. They did have some extensive issues on the outside with taking care of the family, and their family care plans didn't work. I don't think it was their fault, but all of a sudden people were saying, "Wait a second, this is now a reality, I can't do this."

To be deployable, troops need to be medically ready, including all vaccinations mandated by the Department of Defense and satisfactory dental health. All troops had to go through the predeployment procedure. The Soldier Readiness Process (SRP) screened troops for physical conditions, medications, im-

munizations, and a number of administrative factors including life insurance and whether they had completed their wills. The SRP depends on the information entered; if troops want to deploy, they can leave out information or down-play it to their doctor. Major Tou Yang, the 212th's pharmacist, felt that troops were not rigorously screened and deployed despite needing hard-to-obtain medications. Another part of the predeployment process was obtaining personal equipment, not just desert uniforms but also the items normally kept in unit stocks such as chemical protective suits and weapons. The initial issue of uniforms was on January 21, a week after the deployment order arrived.

Training

Canestrini focused on training the entire unit. Surgical exercises run at Miesau showed the unit could operate as a hospital. Personnel were also trained to function as a military unit, including providing security and driving in convoy. When the Army shrank in the 1990s, all units, including medical units (which per the Geneva Conventions can carry only light weapons), became responsible for their own security, in contrast to previous eras when medical units might have no weapons, or only one weapon between two enlisted soldiers. Before receiving the deployment order, the unit had finished an exercise in erecting the hospital, then packing up, driving 230 miles overnight, and reestablishing the hospital and establishing guards, which proved to be valuable training for the wartime mission. As Captain Farley noted, the process involved more than taking items out of a warehouse, packing trucks, and unpacking in a field.

Equipment

Given the short notice to deploy, there was virtually no time to address gaps. Some of the MASH's equipment, such as the laundry washer, was new; some was about to wear out, like the dryer; most was in adequate condition. The 212th kept sufficient stocks of almost everything except medicines because many pharmaceuticals are perishable. A unit deploying got medicines, x-ray film, and other perishables from warehouses, then received blood in theater. However, it was common for some items to be in short supply before deploying, so units often arrived overseas expecting to obtain missing items in theater. Canestrini decided to take as many medical supplies as possible, squeezing in more than the authorized amount. The basic load was 3 days of supplies, but Canestrini deliberately tried to pack for 15 days.

Units have an annual budget to cover all their routine equipment and operational and training needs; extra money becomes available when a unit receives deployment orders. Regardless of how much a unit buys, it has to transport it, which limits both space and weight. The MASH leadership had taken a calculated risk in 2002, spending most of the fiscal year 2003 money by January 2003,

which would have left them without funds through the end of the fiscal year. Major Suzanne Richardson summed it up: "OK, we're spent for the year. There isn't any more money for the entire FY, so if we don't get deployment orders we're not going to be doing anything at all." Spending the money early proved to be the right decision, especially because the deployment order left only 3 days to order, receive, and pack equipment. However, the time available could be used to obtain a mixture of crucial medical supplies and items that would make life easier in the field, such as hand-washing sinks.

New equipment can be a mixed blessing. A new item could be useful, but might be complex, bulky, or expensive when compared with the adequate older items. Major Ronald Krogh, the executive officer, laid out the problems:

Getting this new equipment added a biomedical maintenance trail that we weren't prepared for. It added several different burdens. One was to do the initial technical inspection on the equipment before they put it into use. Second, everything we do goes back to the "100 percent mobile" idea and all of the new equipment needed space too. Then if you get new equipment, you want to turn in old equipment, but the medical logistic system in theater was not mature enough to be able to take the equipment we wanted to turn in, so we were stuck with old and new. But you're not going to look a gift horse in the mouth, we'll take the equipment. We made it work.

Items were still left behind. Some equipment was so new that nobody knew how to repair it if it broke; leaders decided to take older but more familiar equipment. The chief wardmaster, Sergeant First Class Zimbalist Hester, also recalled taking some older equipment when newer items were not functioning. Some doctors found that preferred equipment, or medicines for their specialty, was left out or in short supply. Cardiothoracic items were not stocked because Lieutenant Colonel John Cho had not had an opportunity to visit the 212th. On the other hand, an unauthorized chest of pediatric equipment had been packed because some nonstandard equipment was justified for treating civilians.

SHIPPING OUT

The MASH had a total of 37 vehicles, 32 trucks (most towing trailers or containers) and 5 HMMWVs. Trailers carried cargo, generators, and water tanks, while the containers were of two types. Many were ordinary cargo containers to protect equipment from the environment; others were more specialized expandable containers, with sides that could drop down to form a wider floor, and roofs and sides that could be extended to form a tightly enclosed space. The operating room and pharmacy, for instance, were in expandable vans.

With only 3 days to obtain necessary supplies, equipment, and parts, then pack it all up, fill in all the necessary paperwork, and get the vehicles to the port for sea movement, the command group doubted it could accomplish the task. Fortunately, a recent decision had kept most material stored in the MILVANs rather than on warehouse shelves. The MASH borrowed a dolly set from a neighboring

unit that was not deploying, but maintenance had kept the rest operational. However, the 212th had to rely on its own people to sort out paperwork. They had to document what hazardous materials (HAZMAT) were in which vehicles (which changed with loading adjustments), then secure and label it properly. Different types of HAZMAT required separate checklists, and it required patience and perseverance to get the inspection crews to use the right lists and approve the loads. Since the MASH was the first unit to deploy from Germany, the clerks had no recent experience, which slowed the process.

When the vehicles were loaded and checked, they went through three assembly areas, then by barge down the Rhine River to Antwerp, Belgium. There, three MASH soldiers drove them onto the ship headed to Kuwait, but had to offload and then reload the ship when the initial loading plan proved to be unbalanced.

Medic Tashiana Graves reflected the uncertainty facing all the staff at the point of departure:

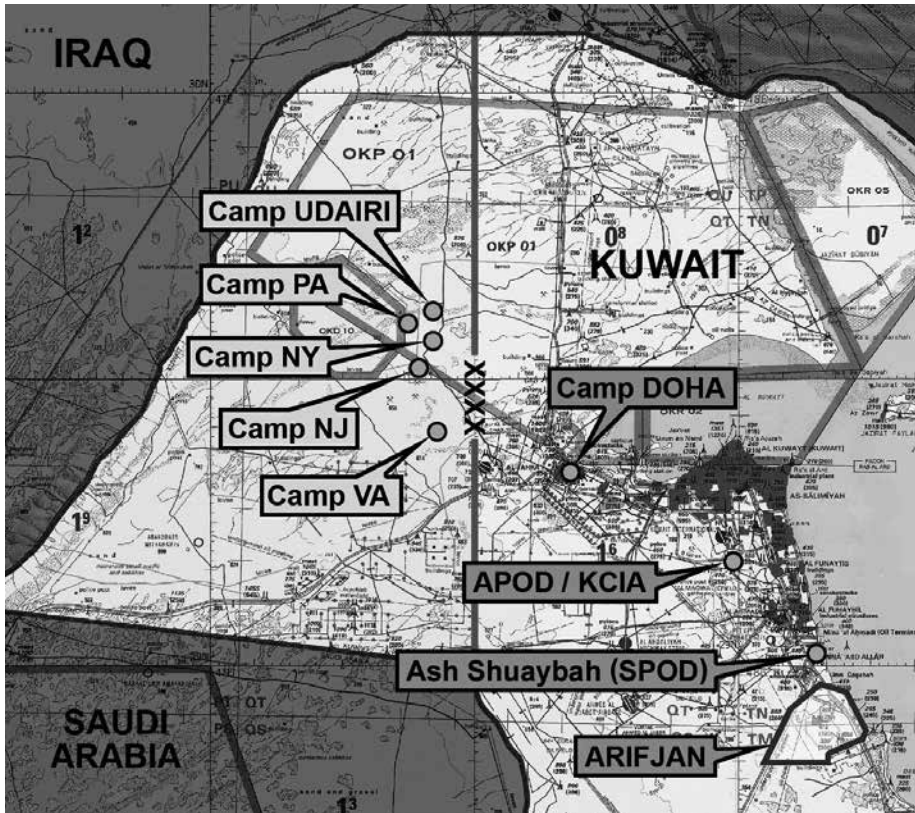
I think I was as prepared as I was going to be. They prepared us to the fullest of their capabilities. But nothing can prepare you for war. There are things that you can't really train on, and we learned that as we went on. I didn't know if I was going to come home. I didn't think about death too much because if you think about that, you'll probably go crazy.

ARRIVAL IN KUWAIT

The MASH traveled to Kuwait in two groups, an advance party of 10 that gathered, inspected, and repaired the vehicles, and the main body a few days later. The advance party included Sergeant First Class Travis Otis, the NCO in charge of maintenance, and a few mechanics and drivers. They found the MASH's vehicles scattered among several acres of other vehicles; Otis's tools arrived late, and he lacked a rental car to help the search, but e-mail ensured that documentation arrived. Through hard work, most of the vehicles were running by the time the main body arrived, despite a shortage of spare parts. He recalled:

I was at the motor yard where our equipment was staged, just going through checking every vehicle, finding any deficiencies I could that would disable the vehicles. I had one mechanic with me. We were just trooping the line, taking the equipment one-by-one. If you would, imagine a big junkyard where all of our vehicles were stowed. Not just our vehicles, but vehicles from other units. I had identified our equipment and where it was located so I could at least have a plan when [the main body] arrived. And they just appeared, jumped in the vehicles, assisted us lining them up, and probably within one hour those vehicles that were not disabled were lined up ready to move.

The main body arrived on February 14 to a short briefing instead of a comprehensive reception process. They joined the advance group and headed to Camp Virginia, located in the desert about 12 km north of Ali al Saleem Airbase in central Kuwait. Administrative arrangements were problematic despite using computers and electronic identity cards; some pay and tax cases were still being sorted out after Baghdad was occupied. The Army had maintained facilities



Map 6-1. Kuwait, showing military installations, 2003. Camp Udairi was renamed Camp Buehring in 2004.

APOD: airport; KCIA: Kuwait City International Airport; SPOD: seaport

Map courtesy of the US Army Combat Studies Institute, Fort Leavenworth, Kansas.

and support units in Kuwait and the Persian Gulf since 1991, but although these facilities could support roughly a division, in early 2003 there were at least three times that many troops in Kuwait with more arriving. The support infrastructure was not expanding fast enough; the Department of Defense's priority was for combat rather than support units. Supplies also faced paperwork problems, and staff had trouble obtaining supplies that should have been available in theater.

Not only were some medical supplies slow to arrive (although such key items as x-ray film and laboratory chemicals did arrive), but common items including sandbags and boots were hard to come by. Company commander Captain Sean Farley had to write six memos to get a soldier boots that were only a half-size too small, and heard a supply soldier say, "We will be glad when you leave."

Supplies were landing at Doha, and the 212th had to send vehicles daily to collect supplies. Both Farley and the supply officer, Captain Stephan Porter, commented that there were not enough logistics personnel to manage the increased number of units and quantity of supplies. The central receiving supply point was unable to inventory everything, and units collected pallets without the usual checks. Items shipped to the 212th were taken by other units, and at times the 212th picked up the wrong pallets as well. The medical logistics base in Qatar



Figure 6-1. 212th soldiers playing cards to pass the time, 12 March 2003. *“It was just really remarkable, I thought, how modern-day conveniences followed us out there. I remember 12 years ago [in Desert Shield], if you got a newspaper or a magazine that was two months old, you were lucky; it was like gold. Here you had the Internet, and you had newspapers and magazines—I wouldn’t say up to date, but within about two or three weeks, and they had a relatively nice setup. I remember 12 years ago you had to be bused everywhere. If you wanted to get a phone call, you had to be bused someplace and wait two or three hours in line, and if somebody didn’t pick up the phone or the phone was busy, you had to get back in line. I think our unit was really great; we had our own internal phone system and our own Internet. We didn’t have to wait on somebody else’s stuff. They were really great about having movies for us out there. Somebody had a laptop with DVDs and they tried to make it as pleasant as possible. The unit I was with before didn’t have movies, we didn’t have modern conveniences.”* —Captain John Keener
Photography courtesy of the 212th MASH.

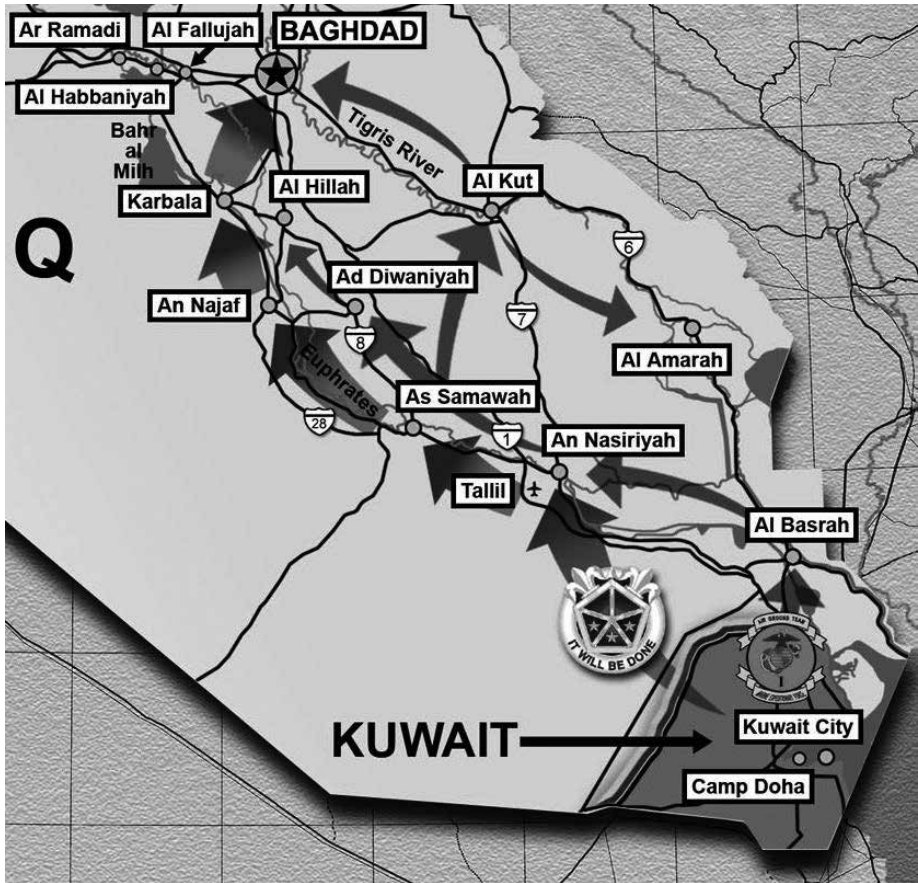
was using a different computer system, which caused some problems. More troublesome was a period of “fill-or-kill” supply orders, when items would be provided if available but the remaining order was canceled. Without being able to back-order items, the 212th sent troops to Doha every day to check.

Three days after driving to Camp Virginia, the MASH was ordered to Camp Udairi. Both were nondescript areas of Kuwaiti desert, but Udairi was 30 km closer to the Iraqi border, where the MASH was poised for movement into Iraq should diplomatic negotiations collapse. Units were arriving continuously, causing moves and adjustments. The MASH troops had to leave their initial billets in large semipermanent tents after 10 days when another unit was given higher priority. Canestrini was given a patch of desert, and the troops dug a sump for wastewater, then set up their own tents and facilities. In the new quarters the 212th had its own showers, laundry, air conditioning, satellite television, DVDs, and Internet connections. With dust, dirt, sandstorms, and boredom, life was not luxurious by any means, but it was far better than conditions for the infantry in 2003, and also better than during Operations Desert Shield and Desert Storm.

THE WAR PLAN AND CONSEQUENT PREPARATIONS

The Coalition revised its operational plans several times while the 212th was in Kuwait. While each revision caused the MASH to reexamine its plans, the war plan ultimately simplified: the 212th would move forward with elements of the 3d Infantry Division, establish the hospital at Logistic Support Area (LSA) Bushmaster southwest of Karbala (close to other support units), and treat casualties from fighting near Karbala and Baghdad. This was the classic MASH mission, straight from the doctrine manuals: drive forward, then establish a surgical hospital to support combat operations. This could be repeated as necessary if the combat troops got too far ahead for the wounded to be transported promptly back to the MASH. However, the attacking Coalition force would not be particularly large, and there was a substantial chance that Iraqi elements would be able to sneak through the cordon and attack the supply routes and units in the rear areas. These Iraqi elements were small units, but likely to be Fedayeen Saddam, hard-core members of the Ba’athist Party and fanatically loyal to Saddam Hussein. They were expected to employ hit-and-run or suicide tactics and to be heavily armed, more heavily armed than the MASH. Serious resistance was expected at the narrow Karbala Gap, possibly including chemical weapons. The high casualty predictions were a concern for a 36-bed MASH, so a contingency plan was devised: a 25-bed ward for minimal and intermediate care patients would be created, staffed mainly by licensed practical nurses and medics, with additional support to be provided by registered nurses, if necessary.

A key task was picking the personnel for the HUSF, which Lieutenant Colonel Canestrini had merged with the advance party to create the initial operating capability (IOC). The IOC was responsible for picking a hospital site and setting



Map 6-2. Outline of the scheme of maneuver. 3d Infantry Division was the southern/western thrust, and the 1st Marine Expeditionary Force was the northern/eastern thrust. Map courtesy of the US Army Combat Studies Institute, Fort Leavenworth, Kansas.

out stakes to indicate where everything should go. The IOC not only had surgical capability from the HUSF, it also had some ICU beds to hold postoperative patients. The HUSF needed meaningful surgical capability, but the rest of the MASH had to stay capable if the IOC took casualties. Canestrini accepted the risk of putting some people with unique skills, such as the orthopedic surgeon, in the HUSF, while medics and nurses were chosen to balance medical and military skills for such tasks as setting up tents. Captain Terrence Mark, the HUSF's head nurse, recalled that the plans had been finalized in Germany but not yet tested. The final HUSF included 17 soldiers with two 5-ton trucks, a generator, and one

MILVAN. The advance party squeezed 13 soldiers into two HMMWVs, making a total of 30 soldiers in the IOC.

The whole unit trained for the long drive ahead; many soldiers were trained to drive the trucks and tow trailers, and officers were shown how to help the drivers repair vehicles and perform basic maintenance. Major John King, a nurse anesthetist, enjoyed doing vehicle maintenance and also driving with night vision goggles. Drivers towing ISO shelters rehearsed lining up and dropping the shelters for the DEPMEDS tents to properly attach. Major Jeffrey Hermann, an obstetrician/gynecologist, remembered:

You had to do practical training. We would take the master drivers, get vehicles and attach dolly sets to them with MILVANs and drive over the sand. They would purposely find routes that were not particularly friendly, so we could experience some of the maneuvers that you would have to use to get around and not get your vehicle stuck or jack-knifed, which would be horrendous in a large convoy.

Medical training was also necessary, and not just for the doctors and nurses. Everyone learned how to carry a patient on a litter, learned which litter team they were on, and was warned about the scenes they might see, including a slide show of wounds. As Major Suzanne Richardson described it, “Hey, this is what you’re going to see. It’s going to be gross. It’s going to be brutal, but we want to tell you now so that you’re ready for it.”

To improve teamwork, Colonel Ismail Jatoi, the DCCS, directed the clinicians to give classes to each other in their areas of expertise, perhaps burn treatment, chest trauma, or abdominal wounds. On alternate nights operating room rehearsals were conducted with the enlisted technicians, some of whom were quite junior and had not worked during major surgeries; this increased confidence and teamwork. Military necessity, largely the likelihood of large groups of wounded arriving at once, led to training for medics in tasks they did not perform in garrison, such as inserting a chest tube to expand a collapsed lung. Clinicians also discussed triage priorities and worked at the 86th CSH, which was treating patients at Camp Udairi.

The physicians planned to treat patients conservatively, as described by the chief of surgery, Lieutenant Colonel John Cho:

What’s the conservative play for an injury? The conservative play is taking out a spleen and not trying to save it. The conservative play is taking out a kidney and not trying to save it if it doesn’t look like it’s salvageable. The goal is to save the soldier’s life. We set our thermostat to conservative play; aggressive operation if there was an indication for surgery, not sitting on any patients by placing them in an observation status, and using the air evac system aggressively to get folks back to a higher level of care. It seemed to work out great, and that plan was laid out during the training we had in Kuwait.

Another discussion was how to treat prisoners. Early plans called for wounded Americans to be sent to the 212th and wounded POWs to another hospital. However, it appeared impractical to send the wounded from a single firefight to

different hospitals (which would require more ambulances or helicopters, causing longer time before treatment and thus greater risk of death for some), so the 212th made plans to treat wounded Iraqis the same way it would treat wounded Americans. The ethics were clear, as were the requirements of international law.

A topic receiving little attention was what would happen after the defeat of Saddam Hussein. V Corps had focused on combat operations, and the first order to Canestrini to consider post-hostilities operations arrived only 2 weeks before combat began. Major David Vetter, the internist, had experience with humanitarian operations and led the planning, which, given the unit's personnel and transportation constraints, consisted primarily of pre-ordering supplies.

The belief that Iraq had chemical weapons was one of President George W



Figure 6-2. Training on convoy procedures. *“We had to deal with the threat of having our convoy ambushed. So we had a full afternoon where some of the NCOs set up a rock map showing us how we would deal with a situation like that, and what we were expected to do in the various scenarios. And then we went out and put it into action. We hopped in the back of trucks, wearing gear, calling out gas alerts, popping the mask and putting your face in the sand with your weapon drawn, getting ready to handle whatever it is that they were testing us on, whether it was an ambush or an obstacle in the road.”* — Major Jeffrey Hermann
Photography courtesy of the 212th MASH.

Bush's reasons to attack Iraq, and the military planned for the possible use of chemical weapons. Major Hermann recalled:

We had people, including the 30th Medical Brigade Commander, come in and tell us that they were anticipating a 70 to 80 percent chance of coming into contact with chemical or biological weapons on the route that we were taking. They actually pointed to specific locations that they thought this might occur.

Lieutenant Colonel Canestrini recalled the information he received:

In some of the briefings I had with the Corps commander, Lieutenant General Wallace left no doubt that there was anticipation that the enemy would slime us. NBC was a real potential and possibly going to happen. The assessment was probably not initially, but that once we got close to the Karbala Gap, the concern was going through the Gap, because of the channeling of the forces through there, that the unit would be slimed.

However, Canestrini declined to take chemically protected DEPMEDS tents because they were too bulky to move with the available vehicles, and the MASH had to be completely mobile to accomplish its mission. Emergency room physician Major David Wolken, in charge of nuclear-chemical-biological (NBC) training, recalled a shortage of decontamination supplies and the purchase of liquid bleach to fill the need. He attempted to assuage the concerns of the soldiers assigned to his decontamination team about the risks from contaminated patients by discussing the medical properties of the chemicals (mustard gas, for instance, is used against some cancers). Staff Sergeant Viet Nguyen noted that normally NBC stood for "nobody cares," and routine training was unpopular. "But because of this war, and everybody knowing in their heart they're going to get deployed, and the good possibility that chemical warfare was going to happen in the Gulf, everybody wanted to learn, and took it seriously."

THE CONVOY INTO IRAQ

Orders arrived the night of March 20–21 to finish packing and move to Tactical Assembly Area (TAA) Las Vegas. Adding to last-minute nervousness was an alert as an Iraqi missile flew over Camp Udairi and was shot down by a Patriot air-defense missile. No damage was done beyond lost sleep, but MASH soldiers donned gas masks and chemical suits, staying in the suits for the next several weeks because of the threat of chemical weapons. TAA Las Vegas became a parking lot as units waited to pass through gaps opened in the berm that marked the Kuwaiti border. Few soldiers could sleep as they waited, and most fidgeted and joked; mechanics patched two leaking radiators.

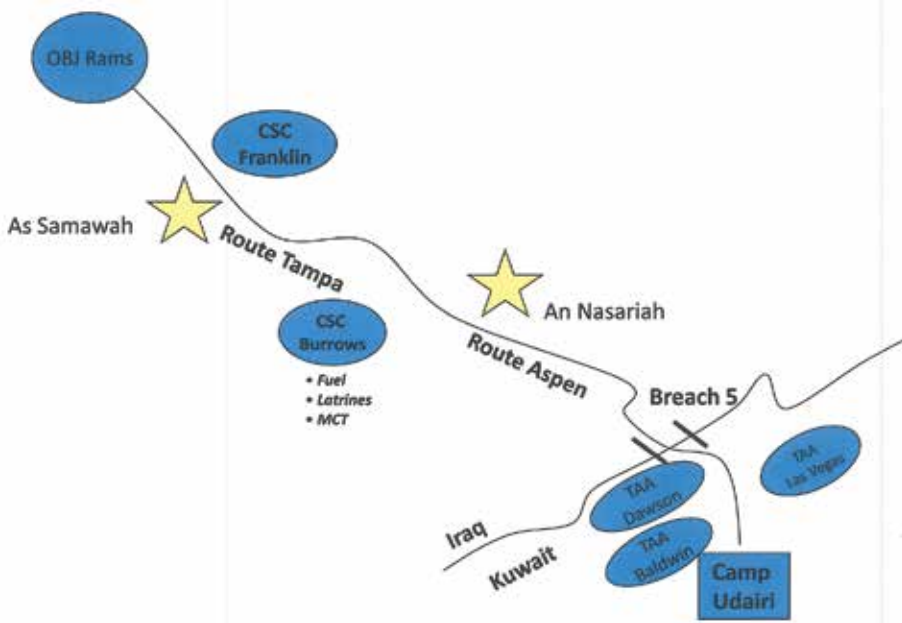
The trucks rolled north on the afternoon and evening of March 21 with two or three personnel in each cab: a driver, a truck commander (the NCO or officer responsible for the vehicle, who acted as another set of eyes and relief driver), and possibly a passenger. Some vehicles had passengers in the back, cramped



Figure 6-3. 212th convoy waiting to move from Camp Udairi, March 21, 2003. Photography courtesy of the 212th MASH.

for space amid rucksacks and weapons. At halts, passengers were responsible for security while the drivers and truck commanders checked over the vehicles or rested.

The convoy plan called for the MASH to move in two parts: the IOC started first, the main body would follow. The MASH would travel with elements of the 11th Aviation Regiment, moving first across hard-packed desert, then along major highways on the south bank of the Euphrates River (bypassing the cities of An Nasiriyah and As Samawah), before setting up in the desert south-southwest of An Najaf. Convoy support centers would provide fuel, food, and latrines. The MASH's wrecker would be the last vehicle, stopping to help any broken down vehicle; it could tow one vehicle, but if another broke down (or the wrecker crew could not fix a vehicle too heavy to tow) the vehicle would be left behind for another unit to fix. At the 30 km/h planned speed, a limit imposed by the MASH's 10-ton forklift, the convoy should have taken less than a day to arrive at its destination. Strip maps were issued, showing the route to be followed but not the entire area; if the convoy had to change routes, it would be operating without maps.



Map 6-3. Schematic of the planned route to Rams.
Map courtesy of the 212th MASH.

The convoy plan did not last long. Changes started with a slight delay for the 212th waiting to cross the Iraqi border. Then the combat troops took more time than anticipated clearing Iraqi resistance. The Iraqi 11th Division, located near An Nasiriyah, was expected to surrender before the MASH arrived. However, no one discounted the chances of individuals or small groups sniping at the highways or setting up ambushes. Resistance centered on the cities, as expected, but small Iraqi parties also left the cities to attack supply routes. As a result the main supply route was soon blocked, and the 212th was held up (along with many other units) outside An Nasiriyah. Fighting could be seen, ranging from artillery fire to tracers; the MASH would be at great risk if the Iraqis had artillery to shell the road. Some combat units of the 3d Infantry Division tried to open the road by sweeping for Iraqi groups, while other parts of the division bypassed the resistance and continued heading north. Sergeant Shannon Malloy recalled an episode along the road:

They started yelling for us to get out of the vehicles because we were taking sniper fire from somebody in a field. So we all cleared out of the vehicles, got in a prone position and we were watching the field to see if we saw anything. . . . So two in the morning, no map, on the side of the road, pulling security. My platoon sergeant, who's on the staking team too, came up to me: "How many rounds do you have?" I've got 120; that's a two-minute firefight. I'm thinking if an Iraqi squad comes, pretty much we're dead tonight.

As support units jostled up the roads, stopping and starting depending on the latest reports about whether the road was clear ahead, they encountered danger. The 507th Maintenance Company drove into a suburb of An Nasiriyah, made a wrong turn into the main part of the city, and was attacked by Iraqi forces. News of the ambush and the capture of American troops spread throughout the theater. An increasing number of ambushes caused V Corps to divert units from the intended main supply route. The 212th had to make a U-turn, then pick up another road farther west in order to move north along a reasonably secure route. At times the MASH passed combat units, which led some personnel to think they were ahead of the combat troops. However, the 3d Infantry Division was moving its brigades on different routes for different purposes, and the 212th was always behind the forward troops. Along the way, the MASH treated two soldiers injured in a vehicle accident. Because the 212th needed to stay packed up for movement, the doctors checked the patients and cleared them for helicopter evacuation back to a hospital in Kuwait.

The convoy plan was abandoned because of these delays. Some units had already been scheduled to travel on the roads that all units now had to use; traffic piled up, speeds dropped, and tempers rose. Movement was stop-and-go, day and night. Drivers had trouble staying awake. As fatigue mounted, officers had to end a halt by moving along the convoy and banging on doors to awaken drivers. Captain Nina McCoy, a nurse, recalled how disorienting the night driving was, especially while fatigued:

Being kind of in and out of sleep, I never got the feeling of moving. It felt like we were moving but we weren't moving. It's just the red dots moving, like being in a video game. There were red dots in front of you, and you don't want to get too close to them, so you're always going to like go back and forth, getting closer and farther away from the dots in front of you.

The unit had trouble staying together as vehicles squeezed between other trucks, bending mirrors and scraping MILVANs. At least once the driver training in Kuwait paid off: Captain Gary Ruley recalled that his truck almost flipped over on soft ground, but the driver had been trained how to react and prevented the accident.

There was little interaction with Iraqis. At times the 212th drove through villages. Some Iraqis gave thumbs-up signals and shouted "Bush," while many were subdued. Although the MASH was moving through an anti-Saddam part of Iraq (in the 1990s Saddam had violently oppressed the southern Shi'ites), harmless-looking civilians might be scouting or concealing weapons. Troops had been told not to hand out rations because it would encourage Iraqis to approach Americans, increasing the risk of misunderstanding or an accident near a vehicle; however, some of the civilians were so destitute that troops tossed them MREs. Moving to Objective Rams, which became LSA Bushmaster when it was occupied, ultimately took the 212th over 3 days.

SUPPORTING THE FIGHTING TROOPS: THE 212TH AT BUSHMASTER

At Bushmaster the MASH needed to switch gears and run a hospital in a war zone. Priorities had to be balanced amid the demands of combat: while some soldiers were pulled away to defend the perimeter, the hospital had to care for however many patients arrived, whenever they arrived, without overloading the staff. Moreover, the lights had to stay on, food had to be available, and vehicles needed maintenance in case headquarters ordered another move forward.

Arriving and Establishing the Hospital

The IOC arrived before dawn on March 24 and waited a few hours as troops from the 3d Infantry Division cleared Iraqi forces from the area. Then they checked that they were in the right place, making sure a large expanse of empty desert was where 30th Medical Brigade intended them to be. Sergeant First Class Tony McDonald recalled, “The area looked like the surface of the moon; nothing as far as the eye could see, might as well have been in the middle of the



Figure 6-4. Front gate of the 212th at Logistic Support Area Bushmaster. Photography courtesy of the 212th MASH.

ocean. Very little vegetation, very little of anything other than brown.” Once the location was confirmed, the advance party began setting up the HUSF and also setting down stakes and cord to mark where the remaining parts of the hospital would be established. The HUSF was only a few tents, and it went up fairly easily in 2 hours despite rising winds. When the main body arrived, the HUSF was ready to receive casualties, although none arrived. (Once the main hospital arrived, the HUSF became the EMT.)

The main body showed up around dusk and Canestrini decided to let his people sleep rather than immediately setting up the hospital. He deliberately took the risk of a minimal security force; a few soldiers were put on guard duty and everybody else went to sleep. On the morning of 25 March the work began to set up the bulk of the hospital. As Sergeant First Class Tony McDonald recalled, “We got up and went to work hard and heavy establishing the hospital. It goes in a certain priority. The EMT goes up and a certain portion of the operating room goes up, and one of the ICUs. ICU2 goes up first and that’s because it’s designated to take patients first. So that was established. Then the other two ICUs came within the next day or so after that.” Instead of a military compound with a variety of support units providing a perimeter, the 212th found itself in a section of open desert, 6 or 7 km from the nearest unit, with an impassible quarry in between.

Unfortunately, the wind intensified until a massive sandstorm, reputedly the worst in 40 years, forced a halt. Visibility dropped to inches, and even night vision goggles were useless. Major Scott McDannold was out with the field sanitation team building latrines:

It was a wall of sand coming towards us. We were maybe 20 steps from the closest tent. We started packing our stuff up and then within ten minutes it was dark from sand. We held hands. I had a compass with me and before it went perfectly dark I got a reading on where the closest tent was and, using my compass, over a period of 15 minutes we walked 20 steps and found the tent.

We all got into the tent and got accountability for everyone. It was loud. I remember at one point just yelling, “Hello,” and not being able to hear anybody around me or see anything. It was like you were on Mars or something, just incredible. I got the idea I should go to the hospital and let people know that we were OK. So with my trusty compass off I went. Now, it’s maybe 40 steps, and I’m trudging along and the sand was blowing so hard that my compass started to act up because it was getting jammed, so I’m messing with that. I went about 60 steps and I started thinking, “If I miss the hospital who knows where I am?” I’m by myself, debating whether I should turn around or not. It was so disorienting. I had a compass, I’m good at that kind of stuff, I didn’t really feel like it would be a problem, but I learned pretty quickly it could be. I ended up at the guard post at the front of the hospital; I had actually missed the hospital and went maybe 20 yards in front. There were a bunch of guys in there, just kind of hunkered down, and it started to rain mud.

The storm went on into the 26th, and two female soldiers got lost while heading out just a few meters for a latrine break. The MASH wrecker was sent out, with its lights flashing as beacons; then troops went out with flashlights and yelled, without results. HMMWVs with GPS were sent out. Parties went out



Figure 6-5. Troops sheltering in a tent as the sandstorm intensifies. *“I’ve set up Combat Support Hospitals as the Chief Wardmaster in ice. I’ve set them up in rain. I’ve set them up under slightly windy conditions. But I have never set one up under conditions such that at two in the afternoon it was pitch black because there was that much sand blocking out the sun. With three feet from me and you, and you holding a chem light, I can’t see you.”* —First Sergeant Robert Luciano
Photography courtesy of the 212th MASH.

with compasses to move in square search patterns without results. None of these methods worked and the soldiers were lost, without their weapons and gasmasks. Shortly they would stumble into another American unit 7 km away, unharmed.

The uncertainty about the fate of the lost soldiers may have contributed to concerns about the security of the MASH. The various US units at Bushmaster were widely spread out, and since few were combat units there was relatively little combat power. Initially there was no quick reaction force (QRF) to respond to attacks. At a time when the main supply route from Kuwait was being attacked, V Corps believed there were no troops to spare as a QRF at Bushmaster. The bottom line was that the 212th had to provide its own security. Varying numbers, at times the majority, of the enlisted soldiers were put on guard duty, feeling nervous in an area where armed Iraqis roamed and with a nearby unit reporting its perimeter probed. Canestrini later acknowledged anxiety among his

“battle-focused, scared soldiers” but thought they were always ready to engage an enemy. As Staff Sergeant Melvin Diggs commented, “Even though we are a hospital, we’re soldiers first. No matter how you look at it, you’re a soldier.” Sergeant Shannon Malloy said, “We had to be operational, because we were told the 3d ID was waiting on us to go in and engage that Iraqi division and they couldn’t do it until they had hospital facilities set up.” On the other hand, Major Jeffrey Hermann perceived more risk:

I relayed some of my concerns to Col. Canestrini and he and I had to eventually agree to disagree about what our unit’s capabilities were. I have tremendous respect for what he did as the leader of the organization, but my perspective at the time was that we had a fairly soft unit and very hostile environment, and that if we wanted to stay intact and do our job—which is why we were there—that something had to change, either more security or retreating at least back behind a secure line.

Lieutenant Colonel Canestrini knew the MASH was a “soft” target. Unknown to US commanders, an Iraqi patrol had noticed the arrival of US units at Bush-



Figure 6-6. Sergeant Okraku on guard duty. Photography courtesy of the 212th MASH.

master and reported it to the commander of the II Republican Guard Corps, commanding the defenses south of Baghdad. However, a combination of Coalition deception operations that implied a thrust from Jordan, Special Forces activity west of Baghdad, and Saddam's preconceptions caused the information to be ignored. Canestrini also evaluated the resources he had: the rifles and pistols of the MASH, the few automatic weapons of the signals team and air evacuation team attached to the MASH, and the weapons of the 30th Medical Brigade headquarters element that was with the 212th. Canestrini contemplated requesting permission to relocate closer to other American units, but doing so would require about a day of taking tents down, packing and moving, then re-erecting the MASH. During that period the MASH would be unable to treat any patients; it could not accomplish its mission. Canestrini decided to stay put, finish setting the 212th up in its original location, and let other units, en route, thicken the perimeter around the MASH.

Security and operation of the hospital were both vital. Colonel Ismail Jatoui felt that the assignment of enlisted personnel to security duties did not interfere with running the hospital.

The rest of us basically pitched in and pulled up the slack. . . . I think that's one of the things that you learn when you do field training exercises; as a physician all of us kind of asked ourselves, "Well, why am I doing this, this doesn't pertain to healthcare, or it doesn't pertain to surgery, or whatever?" but it does out in the field. There, you're not going to be doing just surgery, you're not just going to be doing nursing care, or devoting your time to cardiology, or whatever your field may be. You're going to broaden your repertoire and do other things that you're not generally accustomed to doing.

Over the next 5 days the situation improved. Other units arrived and strengthened the defenses. V Corps also found troops to establish a small QRF for Bushmaster, and the advance of US combat troops around An Najaf made it harder for Iraqis to slip out for attacks. Even then, the QRF might need 10 minutes to arrive, and a determined attack could significantly damage the 212th in that time.

Canestrini later reflected on why he had pushed his soldiers:

V Corps is getting ready to go and fight. I know that the Corps can see with their night vision goggles, they have the capability to engage the enemy. So I said, "No, we've got to keep going because the battle's going to start." So that was it, we're going to get this hospital up no matter what it takes. . . . So we pushed on. We motivated, got things going, and when that first chopper set down, we brought in our first casualties, and those EMT doors popped open. I said, "That's what it's all about, right there, the whole Army Medical Department and healthcare system that we provide. Are you at the right spot? Are you there to treat the soldier and take care of him?" And we were there.

Triage and Surgery

Patients started arriving almost as soon as the hospital was operational, and arrived at any hour of the day. Most arrived by helicopter, with the landing zone

about 300 m from the EMT. If several helicopters arrived at once, one might land closer and one set down around 50 m away; the rotor wash threatened to knock tents down. After patients were offloaded, two or four people carried the litters to the EMT. The ground at Bushmaster had a hard crust over soft, powdery sand, but the crust quickly broke under vehicle traffic, and the wheeled litter carriers had to be hauled over the ruts several times between the landing zone and EMT. It was fatiguing work, especially with chemical suits on. Sergeant Shamika Cheeseborough of the Support Platoon mentioned another aspect:

Maintenance people, we really don't see blood and naked soldiers. . . . So when they come in you want to just throw your guts up, that's how gross it was to me. A lot of soldiers said, "I don't want to do this again." We had to suck it up and go out there and get those patients. You have to do this, because that's what you signed up for.

Once patients were into the EMT, their assessment and treatment began. Major David Vetter, the internist, summed up:



Figure 6-7. Patient brought to the EMT.
Photography courtesy of the 212th MASH.

A fair number of our patients had been seen already at the forward surgical teams, had some stabilization care done, some initial wound dressings, but we needed to reevaluate everybody in the EMT. They would arrive there. We would get the x-rays we needed. We would get the lab tests we needed urgently. We would do whatever stabilization care was needed. That was primarily done by the trauma teams, the nurses, the emergency physician and family practice physician and myself sometimes when we had heavy patient volumes. From there the “urgents” would go back to the operating room. The less urgent patients would go back to the intensive care units to await room in the operating theaters.

The physician in charge of the EMT was Major David Wolken, and he described his role:

I was a traffic cop that knew something about who was dying and who wasn't. Really, it's simple, simple stuff; it doesn't take rocket science . . . it takes being able to recognize go-



Figure 6-8. Treatment teams working in the EMT. *“Going over the emergency room and watching these guys work was some orchestrated chaos. But it was kind of a beautiful thing to see, all at the same time. You literally had to be there to appreciate it. You see the blood just everywhere. Every gurney has someone that’s critically wounded, injured. It’s fortunate that we have training mechanisms in place Army-wide, because at a point you click into what you’ve trained and respond and you don’t actually think about what it is. You just execute.”* —Sergeant First Class David Harding
Photography courtesy of the 212th MASH.

ing to die/not going to die. Airway/breathing/circulation stuff is a second look. . . . As a physician, at first being a rookie to the emergency room and having lots of folks coming at you quickly, you're trying to micro-manage, and you're trying to deal with everybody. You wanted to be the doc that signed everything versus being the doc that triaged everybody, and got them in the right hands. So I went quickly to that second role, which is really all I needed to do. If it was something life threatening, yes, you treated that.

While the individuals working in the EMT had the requisite medical skills, they had to learn the details. They might not realize that an item was already in the treatment kit and call for another. But they quickly learned, and the enlisted personnel proved they could handle much of the work. Captain Jay Rames, an EMT nurse, recalled:

We'd run by the table and ask [the medics], "Hey, do you need anything?" "No." "OK." The wounds that we were seeing started to become the same. Traumatic amputations, and fragmentation wounds, and washouts, and that sort of stuff all becomes pretty easy to deal with, so they were doing a great job.

For almost 3 weeks most shifts were busy enough that days became a blur rather than a clear timeline.

Equipment worked well; the biggest problem ended up being broken wheels on various carts. Carts had small wheels, rather like grocery carts, which jammed and broke from moving back and forth on the uneven floor. Chief Wardmaster Zimbalist Hester related that, in general, "the medical equipment held up in the environment, no problems."

EMT staff found that communications were not as good as in training or in peacetime hospitals; sometimes there was little information about the number of patients and their conditions, sometimes there was no warning at all of an inbound helicopter. More warning would allow a faster response and a chance to alert the right clinical personnel. There was a quick adjustment to getting minimal information; as Lieutenant Colonel John Cho said, anything more than notice that a helicopter was inbound was "a luxury and not mandatory." Major Wolken agreed: "Information is not really that important. You just take care of the guy that gets in front of you. We're reacting to the situation, and you just do your job."

Between batches of patients, staff restocked supplies and tried to clean up, preparing for the next casualties. Specialist Sarah Hoffman recalled she had "never been a real big fan of seeing a lot of blood anywhere, but I've scrubbed my fair share off of the floor now." It was impossible to match the cleanliness standards of a hospital in the United States, but the 212th was in a combat zone. Wolken recalled:

You started to realize hospital inspectors aren't around, especially from an EMT standpoint. Until the end of the war we were shaking all packages [clearing dust] before we would open the bandages. It was literally a quarter inch of dust and dirt on there, and you realized that this not going to be like we've ever experienced it before. We felt it throughout the entire

war, because we set it up in dirt, and you just can't get rid of that. That was really tough from a physician's standpoint. We just couldn't get rid of the dirt.

During MASCALs, personnel had to be called in from all around the MASH, pulled from all sorts of duties to carry the litters, and pulled from the wards to help in the EMT. The MASH soon found alternatives to frequent MASCAL calls, because MASCAL procedures woke up all sleeping personnel who needed rest for their own shift and also pulled guards off the perimeter. As Dr Cho noted, the MASH had to sustain its operations in a marathon rather than a sprint. Major Richardson, the chief nurse, described the decisions:

We had rehearsed, in all of our field training exercises prior to deployment, that if we get more than six patients we would call a MASCAL. Well, when you don't know what's coming in, it may not be a MASCAL; we can't necessarily do it by the numbers. Even when you get six urgent patients that need significant care, you don't necessarily need a MASCAL for that. The first time we got notification that we were getting six patients in at once, the DCCS called a MASCAL. Colonel Canestrini said, "Whoa, wait a minute. We need to stop and we need to look at this as a team." He really settled us down into a process where we assessed the situation before we ever thought of calling a MASCAL. Ultimately we realized we didn't ever need to call them. We had focused teams that we could identify and pull folks from to help with patient care, and even on the nights that we had 56 patients in house we didn't call a MASCAL. We progressively woke folks up and brought them in as we needed them, instead of having an entire hospital sitting and waiting for stuff to happen. I think doing that without too much fatigue saved us.

The 212th saw 701 patients, admitting 394. Sixty-six percent of admission were American and 34% Iraqi, but only 74 Americans (28% of admissions) had battle injuries. The orthopedic team was extremely busy, with 132 procedures on 74 patients, mainly washouts, but also 17 external fixators and 4 complete amputations. There were only 55 abdominal and thoracic procedures for 33 patients, with 11 thoracic procedures, 2 neck explorations, 16 abdominal procedures, and 24 washouts. The orthopedic workload was so high that other surgeons began doing minor orthopedic procedures so Dr Alarcon could focus on the complicated patients. As he noted, "Certainly there's an element of working in an austere environment that changes the way you practice surgery or medicine. Speaking for myself, we have a lot of luxuries in civilian practice. When I put a metal frame on somebody's leg or thigh, I have the luxury of having a portable x-ray machine that shows me the bones and shows me how to put it together and all of that. Over here I was doing it by feel, no x-rays, and no way to assess whether the setting of the bones was perfectly straight. I had to do it all by feel, and after putting on 17 external fixators you get pretty fast at it." Most wounds were from bullets and shell fragments, and the goals are easy to describe on paper but complex to perform under pressure: remove the projectile, control bleeding, debride dead tissue, and wash out the wound to remove foreign material that could cause infection.

In addition to the wounded, there were non-battle injuries, mainly accidents.

Some of the American patients were accidental woundings from an American weapon discharging. One soldier was clearing his pistol but shot himself in the foot; a squad automatic weapon (SAW) burst of 20 rounds hit three Americans in a building. Usually the soldiers said whether the wounds were from friendly fire, although there was never documentation. Captain Ruth Roettger-Lerg said it was usually obvious whether it was an accident or a combat injury, but it was seldom clear which accidents might really be self-inflicted wounds.

There were also sick and combat stress casualties. Among the medical cases were appendicitis, kidney stones, and diabetic reactions; patients went to the closest hospital, whether or not it was titled a surgical hospital. Some of these the MASH could cure, most it could treat, and it could certainly coordinate any evacuation needed. By doing so the MASH returned soldiers to duty, or at least let combat units focus on their mission.

Lieutenant Colonel John Cho was a thoracic surgeon and chief of surgery. He was involved in two of the more complex cases, a vascular repair and open-heart surgery; both patients were Iraqis.

We had a 41-year old Iraqi first lieutenant who had an injury to his right popliteal fossa area, behind the knee. He had total disruption of his right popliteal artery and vein. I took the vein from the opposite leg, reversed it, and essentially created a new popliteal artery. We reconnected his vein using an additional piece of vein. This removed the need for an above-the-knee amputation. We gave this patient a world-class repair. My feeling is if he came to an Iraqi hospital, he would have had an above-the-knee amputation. But he was with us in the MASH. We had the surgical capability and we gave him the Cadillac operation. That particular soldier had five procedures performed on him, and that was during a phase when we were busy. But we never really had anyone who was in extremis waiting for an operation, extremis being life, limb, or eyesight. Besides, the operation didn't take that long, only four vascular anastomoses and no cross-clamp time to boot; it's not like I was doing heart surgery. This was essentially peripheral vascular surgery that was performed in an expeditious manner. But we also had the right equipment, right suture, and right personnel.

I thought another guy was in his 50s. He was a 66-year old Iraqi who was in a minivan and drove through a checkpoint with other family members. It was my understanding that two days prior some Iraqis had faked surrendering at a checkpoint and killed three of our Marines. So when this gentleman and his family went through the checkpoint without stopping, our soldiers fired on the van and we received the casualties. I was actually putting a chest tube in this patient's niece when Dr King called me over and said his patient was moving, had a pulse, blood pressure, and then suddenly stopped breathing. I took a quick look and I made an assessment that the patient might have a tamponade as there was a penetrating injury in his left front chest. One also has to worry about tension in the chest. Dr King put a needle in on the right side. I went ahead, performed a similar procedure on the left. There was no improvement. I proceeded with a left frontal thoracotomy and my suspicions were confirmed. The patient has a pericardial tamponade. I opened the chest and found an injury to the left ventricle. The blood and pressure in the pericardium was relieved and with a little cardiac massage and a simple stitch the heart function returned. We took this patient directly back to the OR. The gentleman also had an injury to his right upper extremity and to his left leg. Dr King, Dr Morton, and I participated in his care. I went ahead and closed up his chest, put a couple of chest tubes in and he was doing fine. I also performed a laparotomy as he had a penetrating wound to his abdomen. I fixed the small bowel injuries and proceeded to close him up. Upon doing so, I got word from Barry Vance (our CRNA) that the patient lost pressure and pulse. Did he re-tamponade? I had loosely re-approximated the pericardium so I

wasn't completely certain. I opened the left chest again and found no re-tamponade. I started cardiac massage and continued for about 35 minutes. We couldn't get him back. About the time we called the code, the initial lab values came back. His hematocrit level was 17 in the EMT; normal is around 44. So this 66-year old gentleman might have had a massive heart attack. It's not something that a patient his age, with extensive penetrating trauma, can recover from. But that did not stop us from trying to do everything we could for him. I think I was quoted in the papers saying, "Well, we didn't care who he was; we just wanted to take care of him." I think that was our mantra and we truly felt that way. If someone makes it into the hospital, it's our goal to preserve every life that we can. Everyone worked hard on him. It was a bit frustrating. Life is precious. We didn't like the fact that we lost the patient. I think at the end of the day, when we looked back, we found solace in knowing that we did everything possible for this patient.

Captain Anthony Rhea, an EMT nurse, handled one of the amputation patients before he went into the OR:

I remember one soldier whose vehicle was hit by an RPG. The report was that he was an amputation. When he came in, that's how it appeared. He had a tourniquet on his upper right



Figure 6-9. In the OR. Left to right: Captain Vegter, Majors Vance and McDannold, Captain Breeding.

Photography courtesy of the 212th MASH.

arm and it looked like his arm was missing from the elbow down. But as you started taking care of him and looked closely, his hand was still there. You could still see fingers. The x-ray confirmed this; somehow the explosion, instead of blowing his arm off, just accorioned it, it just made his arm half the length. Of course, with that much damage, you're going to have a lot of bleeding and a lot of mangled tissue. To the medic the initial reaction is, for all practical purposes, "This is an amputation, throw a tourniquet on to control the bleeding." From the x-ray that they took of it, you could just see all of the bones just broken and folded up like a fan.

On his left hand he had a shrapnel wound that went right across his knuckles, and his pinky, middle finger and his fourth finger were all still attached, but there was just so much damage that when they took him to OR they had to amputate the rest of his right arm and they amputated those three fingers. So all that the soldier was left with to go home with was the thumb and his index finger. He was one of the more serious American casualties that I saw.

Surgeons were only part of the OR team; Major John King, a nurse anesthetist, described his role in two surgeries:

I did an emergency exploratory laparotomy for Dr King on an Iraqi who had been shot through the abdomen. There were a lot of considerations. He was kind of obese, and he bled out a little. That case actually went well, although we always enter any case thinking, "What's the worst that can happen?" You can have a healthy 20-year old who's having a toenail removal, and you're thinking, "What's the worst that can happen to him? I better be prepared for that."

Ten minutes before the end of this case, Dr Cho came to me and said, "Now I suppose you're going to be doing my chest case next." I go, "What chest case?" "Well, I've got an open chest case." I go, "You told me at the beginning of this case you weren't going to do that guy." Dr Cho said, "Well, I changed my mind." So now we have an emergency chest case to do, he's going to open up the chest, and there are a lot of anesthesia considerations any time you have an open chest. The lung dynamics change once you separate the ribs and open up to atmospheric pressure.

So after I woke the exploratory lap patient up and brought him to the ICU, I quickly walked over to the bedside of the thoracotomy patient and saw that he was lying in a puddle of blood. So I quickly did a management assessment on the fellow, looked over his labs, and he was an Iraqi gentleman who spoke no English. With the sense of urgency that Dr Cho gave me, I went to the blood bank directly, got an emergency release for two units of O-positive blood, ran back to the ICU, hung that first unit of blood, went to the OR, spent five minutes getting my area ready with the other unit, walked back to the ICU, personally brought the patient into the OR. By the time we had him on the table the first unit of blood was in. I hung the second unit of blood so that would be going. The second unit of blood was running at the time I was inducing anesthesia. I felt good that, number one, the turnover time was less than 20 minutes from the time I woke the first patient up until the time the second patient was on the table and getting anesthesia induced. You'd have to work in an operating room to appreciate just how darn fast that is.

After I'd induced anesthesia, intubated the patient, Dr Cho runs in and says, "He's going to need blood," and I pointed to the second unit that was almost empty, and said, "Well, he's gotten two units already." It's always nice to hear surgeons say, "Wow, that was fast," but it wasn't without some effort on my part. That was very challenging. That was a very challenging case, the two very urgent emergency cases back-to-back.

Some of the most critical patients were burn patients. There were only a few, but they were urgent and needed special care. The largest group was the result of an enemy shell; it was early morning and the soldiers were undressed and washing. Experienced physicians could still be surprised by burn patients. Major

BURN PTS

60% BODY SURFACE AREA BURNS

2°-3° BURNS - CHEST, LEGS, ARMS

SHRAPNEL WD/ GSW TO (L) UPPER
BACK CAUSED HEMOTHORAX

- CHEST TUBE PLACED - 500cc blood ^{out}

- CENTRAL LINE PLACED

- INFUSED 3 LITERS

- TRANSFUSED W/ 3 UNITS BLOOD

- WOUNDS RE-DRESSED

- MORPHINE GIVEN

- ANCEF GIVEN

35% BSA BURNS TO FACE, HANDS

SURGICAL AIRWAY PLACED
TO PROTECT AIRWAY AFTER
FACIAL SWELLING; FAILED
INTUBATION

2 PERIPHERAL IVs.

2 LITERS FLUID GIVEN

MORPHINE, VERSED GIVEN

FOLEY PLACED

WOUNDS RE-DRESSED

SHRAPNEL WDS!

25% TBSA BURNS TO BILAT LOWER EXT

FASCIOTOMY TO (L) CALF

FOLEY, NG, SILVADOENE, DRESSINGS, I.SLR.

Lieutenant Colonel Vetter recalled:

Another patient that impressed me was the first burn patient I took care of. This particular soldier had about 70 percent body burns, but I was very impressed at how calm he was, talking, awake, conscious. He wanted to know for sure if he was going to be OK. We thought he probably would be, although his burns were very serious. I remember holding his hand to kind of reassure him. His hand was so cold and so moist; I never felt anything like that before. And then all of the skin of his hand just sort of came off in mine. But a very calm patient, very cooperative. Unfortunately he died shortly after he left our facility, on the MEDEVAC flight out.

Major King helped as well.

We had one fellow who had like 60-80 percent of his body burned, a devastating wound and he was developing a hemopneumothorax, blood and air into his chest cavity. Dr Cho placed a chest tube in, and as soon as the chest tube was in you heard the gush of air and he lost about maybe a liter of blood. I've done bedside chest tube placements and, boy, they hurt. Patients scream. The doctor will numb it with a local anesthetic as best they can. So this man who was developing the hemopneumothorax really did receive a lifesaving procedure, but he had devastating wounds on his body. He was so cheerful.

Dr Cho said, "We have to put a chest tube in because your lung is deflating, and we have to reinflate it so you'll breathe better." He went, "OK, let's do it." Dr Cho put a little numbing medication on, put the chest tube in. Patient never groaned, never winced, never blinked. So I was thinking, "Man, that numbing medication really works." I asked him, "Did you feel that?" The patient goes, "Hell, yes, I felt that. It hurt like hell." Even though it hurt like hell he didn't scream or cry. He knew it had to be done in order for him to live.

He didn't survive. They gave him close to 100 percent chance of not surviving his injuries. He also had a lacerated liver and spleen, other injuries that, even without the burns, probably would have been fatal. But during that short time in the ER when he was alive, he was talking to us. "Do whatever you do." We had to do a head-to-toe assessment, so we had to move him on his side which must have been painful for him.

The 212th had to adjust to battlefield conditions, just as generations of surgeons had before. Dr Jatoi reflected:

Dr Alarcon was probably the busiest because he was the orthopedic surgeon. We needed his expertise in a lot of things. But general surgeons can get into that mode as well, because a wound is a wound. You clean it, and you go ahead and evacuate the patient for definitive care in the rear. So a lot of those things the general surgeons were able to deal with, with him looking over and saying, "Yes, that's fine. You can go ahead and do that." We're used to civilian settings where we do very detailed histories, and physicals, and so forth. When you get out in the field you don't have time for that, you basically have much abbreviated forms and documentation because you're getting huge numbers of injuries coming in at one time, and you've got to move them quickly.

Another adaptation was wartime priorities for operating on patients. It was not an option to hold a patient for several days before deciding whether or not

Figure 6-10 (at left). Lieutenant Colonel Canestrini's note card about the burn patients. Photograph courtesy of Lieutenant Colonel Kenneth Canestrini.

to operate. With only three operating tables and 36 ICU beds, the 212th faced an unpredictable flow of patients. Delays before operations reduced the capability to handle more patients. That unpredictable flow of patients also caused the doctors to review their operating strategies. If a long operation that might or might not salvage more of an organ or limb occupied an operating table, newly arrived critical patients could not receive care. The physicians had discussed the subject in Kuwait, and continued reviewing priorities and policies in Iraq. Another departure from routine was driven by diagnostic equipment. With x-ray and ultrasound equipment limited to preserve mobility, the MASH surgeons had to operate on more patients. Dr Booker King, a general surgeon, described the results:

My first casualty was a US soldier that had a gunshot wound to the neck, on the right side. He came in, was pretty stable, but had an obvious entrance and exit wound. We made a decision, me and Dr Cho, took him to the operating room and explored him. It was a negative exploration, but I think it was something that needed to be done, because if he actually had an injury then he would probably die later. In a medical center you have the ability for CT scans and other things. . . . But it was our thinking that we needed to be aggressive and explore these wounds because we didn't have the equipment to say whether this guy had an injury or not. Explorations were about half and half; some of them negative, some of them positive.

I think the most important thing I learned was that you've got to be aggressive and you can't be afraid to take a patient to an operating room. There were a few patients I personally wavered on, and ended up taking them to the OR, and they ended up having injuries that would have been missed. Probably would have been catastrophic, because the critical patient you can pick up on easily. These were more subtle patients. I think in that environment you have to be really aggressive in terms of who you operate on. X-ray won't necessarily tell you everything. We had a little portable ultrasound; that won't give you all of the clues. You've just got to go on your overall feeling and say, "Hey, I think this guy has an injury and needs to go." You can't be afraid to do that.

A key to keeping the hospital functional was keeping the surgeons rested. Colonel Jatoi had initially wanted to be briefed on all incoming wounded, but after being awakened three times in the first 2 days, he realized how fatigued he could get and stopped that requirement. Work schedules and call schedules also were discarded when they proved both unnecessary and unworkable. American forces with night vision goggles operated at night, and thus many wounded arrived at night. But wounded arrived during the day as well, so the surgeons rested when they could. The internist, Dr Vetter, handled most postoperative care and discharges, leaving the surgeons to handle surgery, something Dr King thought was an excellent example of teamwork. The gynecologist contributed where he could, mainly in abdominal cases, but he also participated (under supervision of a thoracic surgeon) in chest surgery.

Supplies dwindled as the initial stocks were used and resupply was delayed, but care was always at a high standard. Some of the first-line items ran out, but there was always a backup, for instance, reusable anesthesia equipment instead of disposables. Surgeons had to be urged to scale back; there were many pro-

cedures where two surgeons were not necessary. OR nurse Captain Dale Vegter recollected:

To their credit they wanted to help out. But they would disagree with us, and we would disagree with them sometimes, about the need for some of them to scrub in, the need to conserve the surgical gowns, gloves, what have you.

Dr King remembered using staplers several times on the same patient despite the risk of contaminating a wound in one area with bacteria from another area, an acceptable risk. Sutures were also conserved, and when only one surgeon



Figure 6-11. Preparing a patient for surgery. *“The anesthesia equipment is outstanding. The ICU equipment is outstanding. The operating room equipment, the instruments are great, but we don’t have a lot of it. We don’t have bone saws, so we used a specialty knife that you use to cut through the bone. Twice I had to cut through the bone in the midline area, and I did that without the use of a bone saw. It was an acceptable solution. In the event of trauma, you do what you can to make things happen. It would have been better to have some of that additional equipment, it may be helpful, but it didn’t affect the end result. In the intensive care unit the equipment was new, the ventilators, the Propaq monitors. It was just like being in the ICU at Walter Reed. For me, I was very pleased with that. The standard of care was met.”* —Lieutenant Colonel John Cho

Photography courtesy of the 212th MASH.

was necessary, only one would operate, which doubtless helped reduce fatigue and increase rest. When disposable gowns ran out, cloth ones were available, which required the laundry to function. That led to two more effects: the laundry soldiers had less time available for guard duty, and the laundry needed water so showers were curtailed for a few days.

On the Wards

After EMT and surgery, patients were moved onto the wards. The MASH had three 12-bed ICUs. ICU1 was intended for medical patients, ICU2 for surgical patients, and ICU3 for both medical and surgical Iraqi patients, so only one ward needed guards. Since the numbers of patients fluctuated greatly, the plan had to be flexible. Some nurses in each ward thought they had the more interesting patients: Captain Gregory Hubbs thought that the surgical patients were more important, while Major Rhonda Newsome remarked that the non-surgical patients could talk about their experiences. Most of the nurses had already seen wounded patients from Afghanistan at Landstuhl.

There were strong bonds of duty and loyalty among the enlisted soldiers. Medics from the 212th were frustrated when they were on guard duty and not helping patients, and Captain Joe Wilson answered their concerns by saying they were helping by guarding everyone. Wilson was also touched that, when cots had to be brought out to prepare for an influx of patients, some patients helped, knowing that soldiers from their units would be occupying them. Patients felt strong bonds to their buddies still in combat as well. Captain John Keener recalled a platoon sergeant whose unit was ambushed:

He had all these young kids and he was trying to organize them, getting off the vehicle and into fighting positions, and he extended his arm, meaning "move forward," and when he did that, he got shot through the elbow, and he was very distraught. He said, "Have you heard anything about my soldiers or anything? I've got to know. I've got to know." We couldn't calm the guy down. He was just so worried about his soldiers, and he didn't want anything, any pain medicine. "No, if my soldiers don't get pain medicine, I don't." I said, "Well, we don't know, but we're pretty much the only hospital around, and they're not here so they're probably OK." He didn't want to eat regular food, he wanted to eat MREs because that's what his soldiers were eating. He was there overnight, and he got evac'ed back to Kuwait, and the very next day all his guys came in, some of them injured. Not really with life-threatening injuries, but the poor guy was pretty much up all night. He was very emotional, worrying about his soldiers, and he missed seeing them by a few hours.

Captain Hubbs had two patients experiencing two aspects of group loyalty:

We had a guy that was in an ammo carrier. They'd done their mission during the day and were all excited about it, I think four of them in the vehicle. Well, they were driving and they drove into a ditch, and all of these thousands of pounds of ammo started to fall. One guy tried to catch it, but he couldn't do it, it just buried them all in ammo. Then the worst part was it's under water. We took care of a guy whose legs were crushed, which is bad enough, but he's dealing with the shock of his buddies being there and then, all of a sudden, now they're gone.



Figure 6-12. Dr. Jatoi briefs Lieutenant Colonel Canestrini, with Majors Linck and Richardson in the background. *“Every night that we were out there at Bushmaster I made it a point to go around in the evening, full Kevlar and flak jacket, and walk through the wards. Colonel Jatoi was available and we did patient rounds. I would go through and he would give me an assessment, in layman’s terms to some degree, “This is what we’ve got.” I knew what was going on in that facility, if they had any issues, but primarily it was so that the American soldiers could see a commander. That made a big difference. The American soldier that’s in the bed liked seeing a commander. They appreciated the fact: here’s a soldier coming through who’s a commander and he’s assessing, checking, and making sure I’m taken care of. Even though Colonel Jatoi’s doing what he’s supposed to do, and it’s clinically correct, they just like to hear that there’s some type of a report, that someone is checking on my care.”* —Lieutenant Colonel Kenneth Canestrini

Photography courtesy of the 212th MASH.

That was pretty tough for him.

The fighting spirit of some of the guys was amazing. We had one guy come in; a bullet went right through his arm, through the other side, didn’t hit anything. He said, “Got anything broken?” “No.” The next morning, “Hey, I want to go back to my unit. I want to get back there up to Baghdad.”

American patients seldom stayed at the MASH more than 2 days before they were evacuated to Kuwait. Most went by helicopter, but C-130 flights could fly large groups (over two dozen) at once. At first an air ambulance company was based next to the 212th, and it was easy to coordinate with them; their flight

CURRENT CENSUS = 29

ICU 1 = 8

2 = 7

3 = 6

ICW = 8

PENDING EVACUATION =

US = 17 (ALL VIA C130)

IRAQI = 6

NEXT EVACUATION BY C130 @
~ 0900Z today

Patients to begin loading @
0530Z from EMT. Leave

212th via FLA 15-ton @ 0530Z

YESTERDAY

36 Admissions

59 EVACUATIONS

4 INPATIENTS RTD

> 56
CENSUS

27 PATIENTS (12 LITER, 15 AMB)

EVACUATED ON 1st C130 LIFT

THIS FAR NORTH. 1st ENGINE

RUNNING ONLOAD THIS DEPLOYMENT

ONE OF THE LARGEST IF NOT THE

LARGEST ERO EVER DONE. PROCESS

WENT EXTREMELY WELL. GREAT

ARMY / AF INTERFACE, TEAMWORK

medics also helped at the MASH when able. Later that unit moved forward and coordination declined. Captain Gregory Hubbs helped with evacuations from his ward and recalled:

The air ambulance company was almost embedded with us; that was great and worked very well. When we needed to move patients, they could work something out. They could work within their sleep-rest cycle and all of that kind of stuff. It didn't work so well when they weren't with us, because we didn't have communication and [the second unit] didn't work as well with us.

Captain Nina McCoy, a nurse, briefed her patients on what they would be experiencing:

I would tell all of the evacuating patients, "OK, this is what you should expect. It's a two-hour trip back by helicopter. After an hour they're going to have to stop to refuel. You might get air sick. It's going to be dark. Do you need anything?"

One little guy said, "I need my wallet and my St. Christopher." So I went to look for it, came back, "I can't find it." He said, "Ma'am, I don't care about my wallet. I can replace all that, but I need to have my St. Christopher's medal." So I went back and asked Smitty, one of the PAD guys. He says, "Ma'am, why didn't you come and ask me first?" So he had his dog tags with the medallion, but he didn't have his wallet. I went back; he's like, "Oh, thank you." You could just tell that this was the only thing that was going to get this poor kid back to the rear with his peace of mind intact.

REACTING TO DEATHS

Only one person, an Iraqi civilian, died at the 212th, but a number of American dead were brought to the hospital. Some had been killed in action, others had died in accidents. In theory a Mortuary Affairs unit rather than a medical unit should have received them and gone through the somber last steps: emptying pockets, inventorying possessions, closing the human remains pouch, and rendering honors as the remains were evacuated to the rear. However, there was no Mortuary Affairs unit forward, and the MASH had the only refrigerated trailer available. Some dead soldiers were flown to the 212th on the same helicopters

Figure 6-13 (at left). One of Lieutenant Colonel Canestrini's note cards for daily briefing. "*Lieutenant Colonel Canestrini is an MSC officer and I'm a clinician. But we had a very good relationship. When it came to clinical kind of questions, he would defer to the clinical side of the house. When it came to a lot of these operational issues, which I really didn't have that much experience with, he was far more familiar. One of the good things that I like about him is that he basically had the willingness to incorporate the clinicians into the decision-making for how things should be managed. I think for that reason things worked very well, so I don't think there were any real problems. I know some people have said it's very different for a non-physician to really command a hospital, and I didn't find that to be true. I found that it was very easy to work with an MSC commander. In fact, he had a lot of expertise in a lot of those things, because I was just brought on as a DCCS late. It was something that I really had to kind of defer to him on. I think the relationship worked out very nicely.*" —Colonel Ismail Jatoi

Photograph courtesy of Lieutenant Colonel Kenneth Canestrini.



Figure 6-14. Major Newsome and Captains Wilson, Prieres, and Fry bring a patient for helicopter evacuation.

Photography courtesy of the 212th MASH.

as their wounded comrades. Sometimes it was not clear if an arriving patient was dead; some wounded died on the evacuation helicopter, and the triage teams worked on them before realizing there was nothing anyone could do.

For many in the MASH, it was their first time seeing a dead body. Sight was not the only stressful aspect; many commented on the smell, and on cleaning up the blood afterwards. There were cases where the MASH was also treating the wounded buddies of a dead soldier, adding to the strain on everyone. Having a chaplain and a psychologist in the unit helped; they could talk with soldiers and help them decompress. The chaplain helped by delivering rites appropriate to the soldier's religious preference.

Specialist Sarah Hoffman was one of the trained behavioral health personnel. Her training helped her understand and cope, but she too reacted to the first body that arrived.

I never saw him, but I saw the litter that he was on, and that was one moment that I honestly thought, "I don't know if I can handle this." I was outside cleaning litters so we could have

some for the next people, and that's when they brought that one over and set it down next to me. The litter was completely covered in blood and had a green blanket on top of it that also was completely saturated in blood. I got over it, but that sticks out in my head. That was one of those days where you think, "OK, I don't know why I'm here." But I got over it, and kept doing what I had to do.

I had a confrontation, sort of, with one soldier who actually carried the body to the refrigerated van. He was angry, and that's how he was dealing with it, and I was upset because that's how I was dealing with it. So when we kind of ran into each other, it didn't really work out too well. But we sat down and talked about it and got over it together. But that was definitely an emotional day for a lot of people because it was the first one we got, and a lot of people hadn't been exposed to that.

Specialist Tashiana Graves, a medic, described her reactions:

When I saw my first death I really didn't know how to handle it, because I hadn't ever seen anything like that before, and it looked like something straight off the movies, ten times worse. We had a pregnant civilian, we had a 15-year old girl there with her sister who was like 24, and they had gunshot wounds, and stuff to the chest, and everything. Then we had this old guy, and his arm and stuff was blown off, only hanging from a piece of skin. He had holes in his feet and legs and stuff, and, I don't know, the sounds of everything and the smell of everything, the smell of the flesh, it just really got to me within a couple of minutes. I didn't want to cry right then and there, so I just had to step away and go back to my ICU and go in the back room, and I cried for about half an hour. A couple of people tried to come up and hug me, but I didn't want a hug. But afterwards I talked with those people. A couple of people came by to see me afterwards. It was just something that I had to get over. It was my first time seeing it and I really didn't know how to deal with it right then and there.

Captain Arthur Finch, the psychiatrist, described the effect of starting to treat a patient, only to discover he was dead:

Some of the most poignant incidents were when we got our first American DOA. He died en route and it was a very somber moment because one of the doctors didn't realize that he was dead yet and started working on him and had the whole team working for probably a couple of minutes before they realized the guy was actually not responding at all. The impact of that, psychologically and emotionally, is pretty intense on most folks as they had to transfer the body to a body bag and escort it out of the emergency room.

The other hard part about that is he was part of a Bradley crew that was continuing to receive treatment, there in the emergency room, while all of this was going on. Those guys were pretty shaken up, understandably, and having to work with them and talk to them over the next couple of days while they were there kind of gave you a real feel for what these guys go through up there on the front line. It was pretty humbling to talk to them.

We had to deal with that three or four times, where the medics and doctors were working on them and lost them en route. It was always a kick in the stomach when those folks showed up, because once we get them we can usually keep them alive. But if they don't come in alive we can't do anything for them, and it's very sad.

Colonel Jatoi described the differences for the younger troops and how the leadership responded:

A lot of the very junior enlisted were probably having the hardest time with KIAs, because they're young, they'd never had much experience in a major trauma center. A lot of us, espe-

cially trained surgeons, had seen lots of deaths in the emergency room and the trauma room. During my training I saw a lot of people come in who died. But for the very junior people, 18, 19 years old, all of a sudden they're seeing this for the first time. They've got no real extensive medical background. On top of that, they're in the middle of the desert. They're away from the loved ones. But nevertheless I think they did fine.

We did spend some time talking to them. You need to talk and communicate. You need to go up to somebody and say, "How are you doing?" "Any problems, issues?" "Have you heard from your family?" and so on and so forth. Let them air their feelings, and kind of talk things over with you. I think all of us basically stepped up to the plate and did a little bit of mentoring at that point. Especially in that setting, when you're out in the field and you've just seen somebody—they're wearing your uniform, they look like you, they're your similar age group—also you see them dead; it's not an easy thing.

COMBAT STRESS CONTROL

Lieutenant Colonel Canestrini augmented the MASH with two behavioral health personnel. One was a psychiatrist, Captain Arthur Finch, the other an enlisted behavioral health technician, Specialist Sarah Hoffman. Beyond the



Figure 6-15. The MASH's refrigerated van. Photography courtesy of the 212th MASH.

two behavioral health staff, the MASH had a chaplain. Canestrini expected the MASH would receive some combat stress patients and reckoned the combat stress control detachments assigned to the divisions and brigades would be busy enough with their normal work. Finch and Hoffman had no formal duties in the hospital. Finch moved around as needed, through the EMT, the wards, and wherever the soldiers were, talking and listening. He was also called in from time to time when doctors and nurses thought someone needed his help, and moved to other units to observe potential patients. Hoffman worked in the EMT section and also on the wards, informally screening patients and also being available for a quiet word.

Leaders in the MASH watched to see who was stressed beyond the normal strains of working in a hospital in combat, and talked with their people, arranging a chat with the chaplain or the professionals as needed. Captain Finch found that soldiers were not totally overwhelmed but only stressed about a facet of their duties; the MASH leadership could frequently shift those soldiers to other duties.

There were few pure combat stress patients, soldiers who just could not handle combat and broke down. Instead most were already wounded and reacting to their wounds, some already experiencing flashbacks. Colonel Jatoi remarked that the clinicians were too busy with their normal duties to try to help combat stress patients, and both the combat stress personnel and the chaplain were very important elements. Nobody can quantify how effective it was to have behavioral health help in the hospital, but it apparently helped some patients and staff. Canestrini thought taking the two behavioral health soldiers to Iraq was thoroughly justified:

Their contribution was great. But in addition they really helped the staff out. They were on the spot. [Finch] really made a lot of evaluations in the emergency room which he was not used to doing. He'd been used to being with the soldiers. He clearly saw a need for his ability to work as health staff and also help the soldiers as they're going through a traumatic period.

Captain Finch actually treated the MASH's first patient.

That first morning we also took our first casualty, ironic in my mind because our first casualty was a psychiatric case. He came presenting with atypical chest pain. The EMT took him and did all of their poking, prodding, x-rays, and everything else, and then shrugged and said, "We don't see anything wrong with him." It ended up he was having panic attacks. So the first case that the MASH actually had was a psych case, which I guess is a good way to start, because they don't require a lot of nurturing at that point. We ended up just putting him to work, we had him help us set up tents. He was a medic so he knew a lot of medical stuff, so we put him to work and about 48 hours later he decided he probably wasn't as bad as he thought he was and he went back to his unit.

Having Specialist Hoffman in the EMT section was probably the very best thing that could have happened, because that meant that I had an insider in the emergency room, working with the patients as they came in, helping to identify who were combat stress type casualties. Most of these guys were combat injuries of some kind or another, but a lot of them were experiencing the combat stress reactions that come with those. So being able to have her

in the emergency room, actively part of the team that was working, but also being my eyes and ears on who needed to be talked to later, was much better than just me trying to stand around like a vulture figuring it out in a crowded and busy emergency room, which never would have worked. To our knowledge it has never been done before, but having [her] in the emergency room, we identified soldiers that were exhibiting initial signs of acute stress reactions, kind of the precursor to posttraumatic stress disorder. As we identified those patients, we went one-on-one and had debriefing sessions with each of them. I have no numerical data that says that's a good idea, but it seemed like the thing to do at the time and so we gave it a shot. We were trying to give them a heads-up, let them talk about their experience, these are guys that we'd watch sleeping and they'd jump awake, and you asked them what was going on. "Oh, I can feel the bullet still going through me." They would sit down and talk to us, 10, 15, 20 minutes about what had happened to them. We'd just let them talk and then ask how they're reacting, try and let them know that that's a normal reaction, not pathological. Trying to give them a heads-up that if it's still happening two months from now to get some help because we can fix it early, but later on it's really hard to fix. Hopefully the 9 or 10 percent of folks that might end up with PTSD from a situation like this, maybe we caught a few of them. We'll never know.

As a therapist you're used to dealing with intense conversations, and these were as intense of conversations as I've ever had. A crew chief for a Bradley sobbing for an hour while he tells his story because two of his guys are dead, and him feeling very responsible for that and very guilty that he's the one that survived and they didn't, and knowing their families well back home, and what they were going to do without their Dad there anymore. Very, very intense and emotional moments. I'd never seen anything like it. So it felt helpful in the moment. We ended up seeing over 350 people in that two-week period.

Dealing with Iraqis on the Wards

A large number of the 212th's patients were Iraqis. Under the Geneva Conventions an army has to treat any enemies it takes prisoner. In addition, CENTCOM had a theater-wide policy of treating local civilians at risk of losing their life, a limb, or their eyesight, while lesser injuries to Iraqis were to be treated by the local healthcare system. V Corps planned for Iraqi patients to be evacuated to an element of the 86th CSH outside Tallil, about 60 miles into Iraq, and the 212th had been told that it would be treating American soldiers.

Almost immediately, however, Iraqi patients arrived. They were evaluated and treated just as any other patient would be; it turned out they were captured soldiers and had to be treated. Adding complications, they arrived shortly after a group of American wounded, and the Iraqis may have been involved in the fighting that wounded those Americans. There was little planning on how to handle Iraqis, and procedures changed as the 212th gained experience. Iraqi men had to be treated as prisoners of war—searched, restrained, and guarded—whether they were in uniform or not, because Saddam's Ba'athist and Fedayeen fighters did not necessarily wear uniforms. Also, most Iraqi men claimed, regardless of circumstances, they were not soldiers. Even those wearing combat boots claimed to be farmers or shepherds. Searching patients sometimes delayed their treatment so that everyone would be safe. When patients arrived by ambulance the ambulance would be stopped at the gate so there was no chance of a suicide bomb. As Major Richardson noted, "If we had suspicious people coming up, they were going to get shot."



Figure 6-16. Specialist Tomokane on guard in ICU3. *“We had no incidents with EPWs. EPW guards were another five to seven people you’d have to give up every day. We had guards on them tight. We treated them just like we had to by Geneva Convention rules, but we let them know we weren’t being friendly. We’re going to treat you, you’re going to be fine, but this attitude can’t happen. We had to watch these people. Especially Fedayeen, which we knew were die-hards. But we had a few who we just had to put in their place, just let them know what’s going on.”* —Sergeant Joseph Filipiak
Photography courtesy of the 212th MASH.

If the guards judged it necessary, prisoners were tied up and/or blindfolded. Sergeant Joseph Filipiak, in charge of force protection, recalled no incidents with prisoners. Saddam’s anti-American propaganda had included dire warnings about Americans executing prisoners, and many wounded men probably denied they were fighters in hopes they would be spared. Almost all lost their fear as they were cared for. Dr Vetter saw a pattern: “For the first twelve hours or so they were a little apprehensive, then when we would feed them, and give them water, and treat them like human beings they really became appreciative.” Even a sergeant major from the Republican Guard, an elite Iraqi unit, realized that everything he had been told about Americans was a lie.

At first Iraqis and Americans were mixed on the wards, but that caused concerns among wounded American soldiers who did not want Iraqis on the same wards, and it also increased the number of guards needed.

Many MASH soldiers had mixed feelings about treating Iraqis. There was compassion for hurt and scared people of whatever nationality, yet the 212th were Americans supporting American soldiers. Senior leaders in the MASH had the chaplain lead two sessions to explain and discuss the medical rules of treatment, explaining them and giving younger soldiers (and those not from medical backgrounds) the chance to learn them and ask questions. Those sessions largely cleared the air. Major Stephen Linck, in charge of ICU3, set the tone for his soldiers and for the prisoner patients. The soldiers had to do their best, and the prisoners were told they were prisoners and could be shot if they tried to escape or overpower the guards. Leaders also rotated staff so that nobody had to care for Iraqis all the time, and both the chaplain and the psychiatrist visited daily to observe if any of the soldiers needed relief. POWs were eventually transported back to other Coalition hospitals, but Iraqi civilians had to be returned to the Iraqi civilian healthcare system. Some patients healed and they could simply be released to relatives, but MASH staff scouted a hospital in the city of An Najaf for the several dozen who needed further care.

The Iraqi civilian dead posed another challenge. Chaplain David Bowerman admitted there was little he could do beyond using the Chaplain Corps's ecumenical handbook. There was no civilian government to receive them, and it took days to find somewhere to return the remains. At times the family could not be found, and there were also problems finding home villages.

Language was a major problem. An interpreter, Nasir al Nasir (called "JJ"), arrived after a few days, and was invaluable, but he could not be everywhere. "JJ" was a Kuwaiti high school principal who had studied in the United States and volunteered as a translator after seeing a newspaper advertisement. His family was worried, but he felt he owed the United States both for liberating Kuwait in 1991 and for his education. He did not have a medical vocabulary, and would sometimes editorialize. After one patient was giving a lengthy description of his problems, JJ commented, "This one, he talks more than your grandma." Eventually flashcards were written for common questions.

Cultural differences, especially about male and female roles, caused some problems. Male prisoners, even with their hands bound, did not necessarily want female medics to help them go to the bathroom. Female patients had a chaperone present when a male physician examined them, because all the 212th's doctors were male.

Specialist Tashiana Graves worked on ICU3 and described the practical problems:

It was pretty difficult at first dealing with the EPWs, because, for one, they didn't speak our language. They had religious barriers. They were screaming and hollering, and we really didn't know how to ask them what exactly was wrong with them, or what could we do for them because we couldn't understand them. We did get an interpreter, but he wasn't on the floor all the time, so when he left, we were basically on our own to try to figure out what was going on with the patients. They would get upset with us because they would want food or water or something like that, and if they had to go to the OR, or anything, we couldn't give

them food or water, and we couldn't explain that to them so that they could understand. So they would get angry and everything. After a while we got pretty much used to taking care of them. We even made flashcards, Iraqi writing on the back and English writing on the front, so the major questions that we needed to ask them, we could just show them the card. If they could read it, they could answer yes or no to the different cards. That made it a little easier. We started learning what certain words meant.

First Lieutenant Molly Shifferd, a nurse, recalled other problems:

I did not have any problems with being a female healthcare provider in a male-dominated Iraqi culture. I think the people who worked in the EPW ward had some problems, but I personally didn't have any problems. When it was a trauma, it was a trauma. If I needed to put on a Foley catheter, or if he needed to urinate or something, they would do it. I don't think they were any more uncomfortable than an American male would have with a female dealing with that.

Now sanitation was a problem for me. The little children all pooped in my tent. They just walked on to the back of the tent and I walked back there and there were little piles. Things like that were a challenge. I tried to teach them how to take medicines, "Every six hours you need to take the medicine," but eight hours would go by. The females would never ask for food or water for them, I really didn't see a lot of initiative. So I definitely had my doubts about whether the instructions would be followed.

Some Iraqi civilians came to the MASH because it was a nearby hospital, and American healthcare has a worldwide reputation. However, under the life/limb/eyesight rules, few patients could be accepted. The MASH, as a small hospital, also lacked capabilities (such as a neurosurgeon) to help some patients. One young girl had spinal injuries; her family brought her to the 212th and Canestrini tried to find proper care, but had to send her back to the available Iraqi hospital because the MASH could do nothing. Civilians also came to visit family members. Some were admitted, but a prisoner's family had to be turned away.

SUPPORTING THE HOSPITAL

It takes more than doctors and nurses to run a hospital. The rest of the unit, from pharmacy to nutrition care, to the motor pool, to guards on the perimeter, all contributed to the 212th's success. Generally the auxiliary functions ran fairly smoothly, although they were certainly busy. When the fighting wound down, Canestrini told many of the officers, "I want you to get out there and walk around and grab a mechanic, and grab hold of a laundry and bath guy, and a supply clerk, and an admin guy. All of those guys that have been guarding the perimeter every day the last 19 days, or the guys that are hauling water for you. As you sit here and do the glory mission and feel good about yourselves, go out there and hug those guys. They too need to feel needed, because they're doing a very important mission."

Working conditions were hardly ideal for pharmacy, lab, or x-ray. In Germany, the decision was taken not to bring all the ISO containers, but to save shipping space and work from tents. The sandstorm wrecked those tents, and a sleeping

tent was appropriated for the pharmacy. It could be hooked into the DEPMEDS equipment, and thus the temperature moderated, but it had about one-quarter the normal amount of space. Thus most of the medications were kept in storage, and only the most commonly used ones were kept adjacent to the EMT. Medications were mixed as needed rather than made up in advance because the MASH was moving patients out frequently and it made little sense to make an IV that might not be used. Dust also made it difficult to keep IV solutions sterile, but constant cleaning overcame the problem. Pharmacy staff also had to improvise, for instance on pediatric supplies. When a child needed antibiotics, Sergeant Shannon Malloy worked with a doctor: they crushed penicillin tablets to make a suspension, then added Kool-Aid to make it palatable. Major Tou Yang, the pharmacist, had to remind physicians that tests required finite resources, including reagents that might not be in stock; Yang felt that doctors ordered tests that might not affect how a patient was actually treated at the MASH. Pharmacy technicians normally worked beyond the pharmacy, not just bringing items to EMT, OR, or wards, but treating patients; one pharmacy technician inserted a catheter. Pharmacy stocks of some common medicines (for instance, ibuprofen and antifungal creams) dropped because medics came to the hospital to get more supplies, and Yang had to limit his sharing. He also commented that resupply was poor: over 200 items were ordered and about 10 resupplied, and most of those were only partially supplied. Occasionally some items arrived in super-abundance, for instance morphine, which was needed and used, but Malloy remarked that the roughly 10,000 doses received were far more than needed. Part of the resupply problem might have been poor communications because the computer systems were not well coordinated. Canestrini felt the frustration as well: "We are out on the battlefield; we are the point of the spear for the whole Medical Department right now. I should not have a problem with getting medical supplies." The MASH always had acceptable replacements for short supplies at hand, and patients were never put at risk.

Over time, the 212th always had enough supplies although some reserves grew perilously low. Transportation was the real problem: the theater had plenty of stock, but there was not enough transportation to move everything forward. Blood supplies traveled through a separate supply chain (mainly moved by the helicopter ambulances when they were flying forward after dropping off wounded), but other medical supplies competed for space with all the other supplies the troops needed. However, while the MASH left some supplies behind by deliberate choice, taking more than 3 days' worth of basic supplies proved vital.

The Nutrition Care Department prepared special meals for patients. Some patients were on liquid diets, soft foods, or other special meals, and there were special ration packs for them with soups, nutritional supplements, and substitutes. Iraqis had Islamic dietary restrictions, and department staff were able to substitute kosher meals. Sergeant Albert Gaskins recalled that trying to identify items that a child would like from among the various items available caused

some concerns. Again, supplies ran low but did not run out.

Refrigeration was a concern not just for the pharmacy but also for laboratory and x-ray: many drugs and reagents and some machines were temperature-sensitive. Another concern was the number of enlisted technicians that were needed for guard duty, but that problem improved over time as other units filled in around the MASH's perimeter. Sergeant Mario Rivera-Mendoza, NCO in charge of the laboratory, commented that the experience his soldiers got working at Landstuhl paid off, because the lab was able to function short-handed.

The Patient Administration Division (PAD) was in charge of logging in arriving patients, keeping their records, and sending medical files with all discharged patients showing their condition and the treatment they had received. PAD was also responsible for performing medical regulation (arranging the transfer of patients between hospitals), and of taking care of patients' personal effects. Standard procedures were for a patient's unit to keep his or her equipment and weapons, but in the rush of combat, procedures were sometimes overlooked. Sometimes units also recognized that their wounded soldier was not going to return to duty and decided to ship all his or her equipment back on the MEDEVAC helicopter. That caused backpacks and other gear to accumulate at the MASH because helicopters heading back to Kuwait would not take these items. Personal effects were put in a locked MILVAN until there was a lull, and weapons (and other sensitive items) were turned over to an appropriate unit.

A PAD clerk was part of the standard reception of patients, getting identification and then creating a medical record and a tag. Many patients arrived with only minimal information. As Captain Sean Lankford, the PAD officer, noted, units in combat often had better things to do than fill out forms, especially for Iraqis. Lankford had previously conferred with the clinicians about what forms would be used, pruning out ones that were not absolutely necessary and standard. By switching to standardized forms he was able to reduce his space requirements from a filing cabinet plus five footlockers of material to a compact disk and blank paper for the printer. There was no copier, so the 212th did not attempt to create complete patient records. Patients arrived with negligible paperwork, and the MASH documented the care it gave, then it sent that paperwork along with the patient. There was neither time nor personnel to do more.

The Air Evacuation Liaison Team located with the 212th helped coordinate evacuation flights on Air Force fixed-wing aircraft and helicopters. V Corps had decided that helicopters would be the main means of evacuating casualties, and most patients were flown out by Army helicopter ambulances. Back in Kuwait the PAD section had contacted the Theater Patient Movement Requirement Center and checked exactly what information was needed to get a flight, which proved invaluable. Helicopters might be available as promptly as 15 minutes, although 60 to 90 minutes was more common. Such delays allowed time to gather all paperwork and personal items. Sometimes nurses had to accompany seriously injured patients; the nurses would return on another helicopter. Weather

was the biggest problem; when sand and dust were blowing, helicopters and aircraft were unable to fly patients out, but patients could still arrive by ground vehicles. It was during a sandstorm that the MASH had its highest number of patients, almost twice as many as it had beds for, but since most were not seriously injured it was only a problem, not a catastrophe.

The PAD section also had the responsibility for getting in touch with the units of wounded soldiers, to let them know their comrade was safe and being cared for. Lankford tried, but communications were often poor. If the weather allowed radio or telephone contact, the combat unit might be moving, or a message might get through to a battalion but not get to the wounded soldier's platoon within the battalion. A casualty liaison team had joined the 212th in Kuwait, but it arrived with no warning and it had never worked with a hospital, so it was only moderately useful.

The 212th also needed food, water, and non-medical supplies. Inside the MASH's perimeter were a few other small groups: a signal team, an air evacuation liaison team, and the forward headquarters of the 30th Medical Brigade, which was with the 212th for several days. As other units arrived, they tied their



Figure 6-17. Major Yang at work in the temporary pharmacy tent. Photograph courtesy of the 212th MASH.

perimeters around the 212th, freeing up some of the MASH's guards. Those soldiers then became the work detail, maintaining sanitation, collecting trash and trucking it out of the compound, stringing more barbed wire, and doing the dozens of other chores.

The motor pool performed maintenance despite a virtual absence of spare parts. Since the MASH might, at any time, have to move forward to support combat operations farther north, the motor pool had to keep vehicles ready. By using stockpiled parts and scavenging non-functional vehicles at a cannibalization point, the MASH maintenance team kept its vehicles running. Cannibalization led to theft; a nighttime roving guard was instituted after the starter was removed from a MASH truck. The generators were running constantly, using more oil and air filters than normal, and some air filters had to be cleaned and reused rather than replaced.

The operations section tracked and coordinated all the unit and hospital functions so that resources could be shifted around within the 212th. "Ops" also had to know what was going on outside the unit, not just in the cluster of support units at Bushmaster but also in the 30th Medical Brigade, to keep abreast of what it might want the MASH to do next. This meant meetings, constant phone or radio calls, and monitoring headquarters websites to stay informed and to pass information along. Unfortunately, communications were frequently a problem. The 212th usually had contact with higher headquarters, but weather could knock communications out or lower the quality of the connection, and the MASH switched between various systems. There was tactical satellite radio, long-distance radio (which required so much auxiliary equipment that units tended not to use it), and satellite telephones. A signal team from Germany had been identified to travel and work with the MASH, but another team was substituted instead; it was trained and equipped, but for several weeks in Kuwait it lacked identification codes to log into the network.

A much bigger problem was computer links. Many Army systems rely on computer networks that worked well between bases and for units with high-speed connections, but not all units had the necessary equipment. The MASH frequently either lacked computer connection or had only a very slow connection. Secure military systems often provided slow access, while the civilian Tachyon system provided fast but only unclassified access. Headquarters sometimes assumed units received something as soon as it was posted on the command website; units with spotty communications, or on the move, might not receive the news, and headquarters tended not to follow up and make sure information was received.

LIFE IN THE DESERT

Being busy distracted soldiers from the living conditions; Specialist Meghan Slater recalled a week or more without more than 2 consecutive hours of sleep. There were nine sleeping tents, divided between officers and enlisted personnel



Figure 6-18. Working in the Tactical Operations Center at the 212th. Photography courtesy of the 212th MASH.

but not by sex. Each person's living space was only about 4 by 8 feet, and that space had to hold a cot, footlocker, dufflebag, rucksack, body armor, and personal items. For the first few days everyone had to sleep in chemical suits and body armor, then just the chemical suit, and ultimately that could come off. The air conditioners were needed for the hospital, so sleeping tents got quite hot during the day. In fact, many soldiers stayed in the hospital during the day and slept on the floor or in unoccupied beds because it was more comfortable than the sleeping tents, and also closer to work when the next group of wounded arrived. Powdery dust got everywhere.

While there was plenty of food, there was not much variety. For roughly a month only MREs were available, and while nutritious, they quickly grew boring. Troops knew that other units and contractors had better food, which was an annoyance. Sergeant First Class Angel Zepeda, NCO in charge of nutrition care, recalled the first hot meals were a huge morale booster. He did his share of wheeling and dealing to trade what arrived for what his customers wanted.

Drinking water was not a problem, but the laundry section had first priority for bulk water for the 10 to 15 bags of laundry generated every day. The soldiers kept the old washing machine going (although the dryer never worked), washing sheets, blankets, and hospital gowns. Clothes were washed when the hospital's needs had been met, and showers were taken if water was still available, generally every 2 or 3 days. The only recourse was baby wipes and hand sanitizer.

The MASH's latrines were the envy of many other units. The field sanitation team had bought toilet seats in Germany and built a wooden frame in Kuwait. Covered with canvas and set over a deep trench, it was one of the nicest latrines in Iraq. A helicopter once landed just so the crew could use the MASH's latrines. Despite the flies around the latrine, the MASH did not have trouble with diarrhea or upset stomachs because the soldiers followed simple sanitary steps, including using the hand-washing stations purchased just before deploying. Sergeant Michael Cheeseborough was a medic assigned to work on a ward, but an additional duty was field sanitation:

I barely worked on the floor, I barely did patient care. I was mainly the sanitation guy. I had to take care of the hand washing stations, the latrines. At first it was a pail latrine, but we didn't really like that idea. It was really messy because when you had to dump it, you had to find a place to bury it, and it was a lot of stuff. So we had engineers come out there and dig these really deep, roughly 10-ft holes. Then we took the toilets that we had constructed, set them over those holes with support beams, and we had some of our timber hold the cover for it. It worked out really well, because everybody liked it. A lot of people from different areas came and used it.

The latrines did not take care of all waste: the Army had contracted for Kellogg, Brown & Root to dispose of medical waste, but the pace of operations meant the 212th had to cope themselves. They burned not just bloody bandages but amputated body parts, and buried non-flammable items (such as needles) to reduce the risk of infections.

To keep the soldiers informed, Canestrini held a daily briefing for unit leaders, who could then pass information along. The first sergeant did the same for senior NCOs. Major Linck thought that passing information along eased everyone's minds and quashed rumors, while Sergeant First Class Tony McDonald, a medic, thought he got a lot of information but the situation changed so quickly it was soon out of date. Canestrini passed information back to the Family Readiness Group in Germany. Security put limits on what he could say, but he tried to call back at least once a week (while e-mailing more often) and keep the families informed about what was happening.

DOGWOOD, BAGHDAD, AND THE RETURN TO GERMANY

The 212th had moved to Bushmaster to support the ground assault through the Karbala Gap and subsequent combat operations around Baghdad. Its future movements would be determined by the course of the ground campaign. As events transpired, Baghdad was quickly isolated from the rest of Iraq, and the Army began probes into the city on April 5. The probes found weak resistance and grew more aggressive, driving into the city and staying there. It was clear that the Ba'athist regime could not hold the city. There was no formal surrender or even a clear fall of the regime, but the toppling of Saddam Hussein's statue in Al Firdos Square on April 9 was effectively the end of the ground campaign to take Baghdad.

Because of the rapid collapse of Saddam's regime, there was no second phase of the ground campaign for the 212th to support. The MASH spent roughly a week at Bushmaster after Baghdad fell, with fewer patients coming in as combat became sporadic. By April 17 the 212th was ready to move, but V Corps seemed to have no plan for the next phase. The MASH was ordered to load up, preparatory to moving. The destination was first Mosul, but it was rapidly changed to Balad, then Ibn Sina hospital in downtown Baghdad, or Baghdad airport. The mission was equally changeable, perhaps working as a hospital, but the 212th also was warned it might be needed for hospital assessment missions in Baghdad, something it had not planned, prepared, or trained for. Rumors also circulated that the MASH might go home, since there were several other Army hospitals in Kuwait that had done less in the maneuver phase. Canestrini recalled the brigade commander slapping him on the back and saying other units would do the remaining work. While higher headquarters considered various options, MASH soldiers caught up on sleep and readied their equipment.

Assessing Iraqi Hospitals

The 212th moved from Bushmaster to LSA Dogwood, located in the desert roughly 30 miles southwest of Baghdad. Even as it moved, the 30th Medical Brigade was changing the MASH's mission. It was not going home but would

stay at Dogwood and send hospital assessment teams into Baghdad. Small teams of two vehicles and about six personnel were to visit hospitals and clinics, talk with the Iraqi staff, and assess the facilities and their needs. The teams were neither providing any assistance nor promising anything; rather, they were “showing the flag,” demonstrating American interest in the Iraqi healthcare system and gathering information.

This mission was controversial among MASH staff. They sensed risk on the chaotic streets of Baghdad, and it was hard to see any particular results from the hospital assessment visits. They had no training in hospital assessments; the information generated no visible action or results; and the assessments gradually became predictable since almost all Iraqi hospitals were short of electricity, water, money, and security. Iraqi reactions varied. Some were happy to see Americans, some were indifferent, and some were angry. The MASH soldiers were traveling with ambulances, and the Red Cross markings seemed to reduce tensions. The troops were under orders not to hand out food and water, which many Iraqis sought, to avoid having vehicles swarmed and surrounded. Major



Figure 6-19. MASH personnel visiting an Iraqi hospital. Photography courtesy of the 212th MASH.

Jeffrey Hermann, the obstetrician-gynecologist, remarked that he did not volunteer because colleagues who were going into Baghdad reported little point to the trips. However, the Army needed a thorough assessment program and wanted to generate goodwill and support through meeting Iraqi healthcare professionals and the Ministry of Health. Canestrini requested a written order to make sure his commanders had thought the mission through, then got volunteers to do it. When his soldiers reported the risks, he verified that higher headquarters still felt the risk was worthwhile. Hospital assessments would remain the MASH's main mission for several weeks, with daily trips into Baghdad. Ultimately over 50 hospitals would be examined, plus other medical facilities. Major David Vetter led most of the assessment missions.

We left Baghdad airport, drove into the city, a very eerie place at that point. A city of several million people and we drove around the city for hours. There was sporadic gunfire everywhere, buildings still on fire with secondary explosions, but we saw absolutely no Iraqis driving anywhere in the streets. Actually, I don't remember seeing a single Iraqi civilian in the entire city the whole day we drove around. The first hospital we looked at was on the grounds of one of Saddam's palaces. There was a statue of Saddam outside of the hospital, and a Republican Guard uniform abandoned at the foot of the statue, along with the black boots that you saw everywhere.

No one was in the hospital, most of the windows broken. But we were struck by the equipment we found there. It was really a state-of-the-art facility. For example, there was an Excimer laser machine for doing Lasik eye surgery. From patient records, up until the middle of March they were doing corrective eye surgery there. There was a CT scanner, MRI scanner, surgical rooms with operating microscopes, corneal scanning machines, hearing booths, pulmonary function testing equipment, really everything you could want in a hospital. There were private ICU rooms, everything in very good condition, with air conditioning. So it was obvious that Saddam and his family had pretty good medical care at that facility. We left there and went to some of the other regime-associated hospitals. Saddam Cardiac Surgery Center, which is the only center in Iraq for cardiac surgery, things like congenital heart defects, valve replacement surgery. Since that hospital was also associated with the regime, and outside of the protection of the palace compound, it was totally destroyed by looters. All of the equipment burned, medical supplies scattered all over the place. Actually it was sad to see the country lose an asset like that, which may take years to rebuild.

At the first public hospital we visited the docs there had not yet returned to work. There had been a lot of looting there also, air conditioners stolen, parts of MRI and CAT scanners stolen. Anything that looked like a computer or a monitor ended up being stolen from most of the hospitals. They'd seen patients during the war, had a lot of dead bodies brought into the hospital, and those they just buried in a shallow grave in the hospital courtyard. They showed us the identification cards for all of those patients, a dozen or so. They had a little bit of war damage. On the third floor of the hospital an Iraqi army or police unit had set up, so US soldiers had targeted that floor of the hospital, pretty much destroyed it. Destroyed the hospital generators in that vicinity. But, overall, in Baghdad I was surprised at how little collateral damage there was. I think our government obviously took a lot of care to avoid targeting any of the infrastructure, the hospitals. Also I was surprised to see how much damage Iraqis themselves did to the hospitals. The hospitals would have been able to function immediately had it not been for all of the looting and the vandalism that occurred.

THE RETURN TO GERMANY

The 212th's leaders paid attention to "redeployment" (the Army's term for return to garrison) opportunities, and did their best for their own people, also bearing in mind the value the clinicians had for the Army's hospital system and the number of other medical units available in Iraq and Kuwait. MASH personnel left Iraq in batches. First a few surgeons left because the Army could use them at hospitals in Germany or the United States. Then it was reasonable to send the bulk of the remaining clinical staff back so they could resume work at Landstuhl. At that point the 212th could not operate as a hospital, so it made sense to send it back, although a small team stayed behind to travel back by sea with the vehicles and equipment. Coming back as a unit would have allowed a ceremony, but it could have taken weeks to arrange.

There were a number of administrative steps to go through, and some bottlenecks, but the soldiers were excited to be going home and solved the problems. On the way back to Germany, Lieutenant Colonel David Bitterman took command on June 2. The trip started by road, south through Iraq amid local factions violently settling scores. There had been administrative hassles both leaving Germany and arriving in Kuwait; now there were administrative hassles getting out of Kuwait. There was a rigorous customs inspection for all individuals, and equipment and vehicles also had to be screened for contraband. For instance, Sergeant Michael Cheeseborough was delayed as customs inspectors went through clothes, books, and CD cases. Few units had left the theater, and there were conflicting lists of what needed to be done. Major Troy Mosely, the new executive officer, recalled looking at requirements from various sources, assembling them onto one master list, then determining what had to be done when and assessing available resources. Once vehicles and equipment had been cleared, fuel tanks were emptied to avoid explosive vapor in confined space on ships, and exteriors were cleaned. Since everything was dusty and dirty from the desert, cleaning required high-pressure hoses and there was only one wash rack. Originally the MASH was to have 2 days to wash up, but when another unit was moved up the priority list, the 212th had to finish in a single day. The trail party spent the next several weeks getting paperwork sorted out to finally load the equipment on a ship.

Troops also had to go through various steps, for instance what Specialist Hoffman described as a quick behavioral health debriefing, about what was a "normal" experience versus what warranted professional help. As she pointed out, "A lot of people saw things that they never thought they would see, and dealing with some of the visual stuff that they had been exposed to, that's the main thing really." The main body flew out on a plane shared with a Marine Corps unit. Meanwhile, the trail party stayed behind, working with soldiers from the 10th CSH, a unit that had not gone into action but was now helping out-process other units from Kuwait.

Sources

Background came from Gregory Fontenot et al, *On Point: The United States Army in Operation Iraqi Freedom* (Ft Leavenworth, KS: Combat Studies Institute Press, 2004) and Kevin Woods et al, *Iraqi Perspectives Project: A View of Operation Iraqi Freedom from Saddam's Senior Leadership* (US Joint Forces Command, Joint Center for Operational Analysis, 2006); specifics of the diplomatic/political road to war came from speeches by President George W Bush on the White House website and from Bob Woodward's *Plan of Attack* (New York: Simon & Schuster, 2004).

Information on the 212th is based on interviews with a majority of unit members as listed in the appendix. Unit files include the modified Table of Organization and Equipment, the after action review, several briefings, and e-mails with unit personnel. Major Ronald Krogh, Major Suzanne Richardson, Lieutenant Colonel Kenneth Canestrini, Captain John Keener, and First Lieutenant Molly Shifferd shared their journals and diaries. Clinical data came from Captain Arthur Fry and Lieutenant Colonel John Cho et al, "Operation Iraqi Freedom: Surgical Experience of the 212th Mobile Army Surgical Hospital" (*Mil Med*; April 2005: 268–272). Photos were taken by various unit members and provided by Captain Nina McCoy and others.

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.