Chapter Seven

Last Days of the MASH

In Garrison after Iraq: Training, Exercises, and Readiness

Each part of Lieutenant Colonel Canestrini's goals for the 212th—"trained, equipped, and deployable"—was vital to completing the mission in Iraq, establishing and operating the hospital, and saving lives. Reviewing events of the deployment, he felt the focus on maintenance and field equipment training was crucial:

> The bottom line is having doctors, nurses, involved and using our equipment prior to deployment makes them trained, giving them the confidence that they needed in action. All I can keep saying, from my heart, is trained, equipped and deployable is the mantra. We've got to be that. You've got to be totally mobile. If you're not 100 percent mobile, then you're not there for the warfighter, you're a problem child.

Morale and unit cohesion were very high in the 212th. It was a small unit that trained together, but it also absorbed and welcomed personnel from other units. Everyone knew that their job—glamorous or not—was directly related to caring for patients. Part of this cohesion and morale resulted from officers trusting their enlisted personnel. As First Sergeant Luciano remarked, "The leaders of the MASH understood their lane, stayed in their lane." Of course morale ebbed and flowed, largely in relation to whether personnel were bored or thought their work was meaningful. Other factors such as the arrival of mail and supplies were also important.

During the deployment, the 212th's soldiers were ready, trained, and working. The equipment worked. The unit deployed quickly, moved on the battlefield, and supported the combat troops. It did what it needed to do. After returning, it had to recover its equipment and maintain its readiness for the next mission.

The Rear Detachment

The MASH's rear detachment (referred to as the "Rear-D"), a handful of soldiers who could not deploy plus soldiers who had just been assigned to the unit, was in Germany, supporting the deployed unit and preparing for future tasks. Eventually totaling 18 soldiers, the Rear-D handled routine paperwork and reports, answered questions from various headquarters, conducted maintenance on equipment remaining in Germany, and trained. Newly arrived personnel received routine training as well as training for additional jobs such as vehicle driver or armorer. Through the Family Readiness Group, the Rear-D also served as liaison with the families of deployed soldiers. The family work was often tedious and thankless, but it was important for the morale of the deployed soldiers to know that someone was available to help their families.

If the 212th's deployment in Iraq had continued, the commander could have called soldiers forward from the Rear-D. The MASH, nominally a battalion, had several subordinate units. Two of these, the 160th FST and the 254th Combat Stress Control Detachment, received deployment orders. The 254th's orders were rescinded, but the Rear-D had to coordinate activities for both units.

Sergeant First Class Corwin Clark, the operations NCO for the Rear-D, recalled:

> The day-to-day mission requirement for me was basically supporting the 212th MASH forward and turning in any taskings or reports that were required from Brigade- or Corps-level here in the rear. Day-to-day operations were just like if the unit was here. Higher HQs had multiple taskings. They wanted to know manifests, reports, how many personnel, but it was basically accountability, to make sure that we were tracking all of the soldiers.
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> We had an FRG [Family Readiness Group] established, and prior to the deployment it actually kicked in, and we had one NCO designated to work hand-in-hand with the FRG leader, who was a dependent spouse of one of the soldiers. During our FRG meetings our battalion commander would actually call back on a speaker phone and brief all of the spouses on what was going on, where they were in the battle, patient flow, all of that stuff. We basically coordinated a telephone and computer roster, a database, where we could touch base with all of the family members—OCONUS and CONUS—so we pretty much kept people in the loop like that. The commander would send stuff back to the Rear-D first sergeant to send along through this e-mail roster, phone roster, because you had some people who didn't want to be contacted by telephone, so we sent those people stuff by e-mail. We also had computers here at the unit set up for those spouses who didn't have e-mail access. If they wanted to learn anything about the computer, our first sergeant was actually double-hatted as the information management officer, and he basically taught them the little stuff they needed to navigate on the Internet and stuff like that. We had all of the soldiers establish Army Knowledge Online accounts prior to deployment for spouses and significant others so there was always an open flow of communication.
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> There were soldier-family issues. It's not a perfect world and the soldiers try to be perfect, but we know Murphy's Law. There were some issues. I think we made every effort to resolve any issue that we could at our level. A lot of the soldiers left powers of attorney here so we could deal with the legal situations that they couldn't resolve prior to deployment. There were some things, issues that were brewing, that we still needed to work. But we chopped away at the mound as much as we could to bring it down to a mole hill. We had one dependent spouse that really was having a hard time with the deployment of her spouse,

because of the number of kids they had. They hadn't been in Germany that long, things of that nature. But the rear first sergeant made several trips, because this person was assigned to us but they were actually from another part of Germany. He would make an hour and a half, two hour drive, go up there and try to comfort the spouse and shed some light on what was going on.

If you're ever tasked on Rear-D, basically everything you've learned as a soldier will be put to the test. I can honestly say from your administrative skills, to your leadership skills, to your interaction with different people, especially dependents. You've got to be hypersensitive to what they're going through versus being in uniform. You know how we go: we get that heading and we go straight in that direction. You have to be able to sidestep some obstacles, and get back on the heading, especially when you're dealing with loved ones. Because any little thing you say, if somebody is under stress (and you don't know what their home life was like prior to a deployment, because not everybody's home life is peaches-and-cream) you never know, one little thing you say may spark off a conversation with them and they give you everything that you really didn't want to know, but you really did need to, you need to know to help them better and help them with their time over there.

First Days Back in Germany

After the unit's main body arrived back in Germany, the return to the normal work schedule was deliberately slow. For about a week soldiers worked half days, turning in gear and doing maintenance. The half-day schedule allowed a gradual transition to the normal working environment as well as normal family and personal life. It was also a way for leaders to keep an eye on troops and make sure that everyone was adjusting, that nobody was having particular trouble or needed professional intervention.

For the soldiers living in barracks, there was an irritation. They had packed their furniture and belongings into storage before deploying to Kuwait because a reserve unit that was augmenting the Landstuhl hospital would be staying in the barracks. Now the 212th was back and the reservists were still there, so MASH soldiers temporarily stayed in hotels and lived out of their rucksacks. At first, soldiers had only what they had brought back with them, but they were soon able to get their clothes out of storage.

While most of the unit came back in a group, some individuals had returned earlier, including the clinical staff. For these individuals the return experience was a bit different, and left some a bit lonely.

The unit also went through the postdeployment health assessment implemented after Operation Desert Storm. Some MASH soldiers thought the screening process involved everyone seeing a doctor, and were disappointed when they learned it was a paper-based system. A briefing from the psychiatrist explained that nightmares in the short term were normal, which helped reduce worries in those who had developed nightmares in association with deployment.

Part of the redeployment process were briefings about the changes that took place back in "the world" while the soldiers were away. Families adapt to the absence of a loved one, whose return requires adaptation again. Some single soldiers thought the briefings were overly focused on their married comrades.

Return to Routine

Even before everyone was back in Germany, the new command group began planning their training program. Repairs could start once equipment was back, and new supplies and equipment would be ordered. For instance, Sergeant Hufana hoped to get a new laundry machine, "But if not, then we're just going to work on [the old one] until we get it 100 percent." Gradually the 212th put together old and new equipment, old and new people, and readied itself for another deployment. As Staff Sergeant Nguyen commented, "The whole process starts over. Clean up, reorganize; all the spare chemical suits got taken away from us. So we have to do inventory, find whatever we need to order, because I'm assuming in the next year or so (maybe even earlier) we will probably be going somewhere."

Lieutenant Colonel Bitterman had thought about how to handle his command. Because he was the new commander of a veteran unit, he planned team-building activities instead of making numerous changes in his first days on the job. The first few months were limited anyway; most troops were on leave in July 2003. The welcome-home ceremony for the soldiers and their families took place in mid-July, and the medical staff did a routine month of medical work at Landstuhl Regional Medical Center in August, treating patients from Iraq and Afghanistan, so there was not much opportunity for unit training. (The 212th's medical personnel, officers and enlisted, routinely worked at the Landstuhl hospital as "hospital in hospital" exercises in February and August. When possible, they worked in the same teams as they would when deployed.)

In late July and August the vehicles and equipment returned in two groups, with the vehicles arriving first. Almost all the MILVANs were damaged, either from rough use in the desert or from routine accidents in loading and unloading. Eleven of the fifteen dolly sets had developed major structural cracks from bouncing through the desert and required welding. Since the 212th was the lightest, most mobile hospital in the Army, getting it ready to deploy was a high priority for USAREUR, and contract mechanics were hired to strip down all the vehicles and fix anything that needed attention. Vehicles that could not be fixed locally were sent to a nearby depot at Kaiserslautern, where major items could be replaced. The Army had kept medical maintenance personnel in uniform, but much of the depot-level vehicle maintenance was now done by contractors.

More importantly for the unit, the three critical ISO shelters (the operating room, radiation, and medical storage units) were damaged, and the hospital could not function without them. Bitterman's priority was fixing the medical equipment; if necessary, the 212th could deploy with vehicles borrowed from other units. The first step in repairing the shelters was emptying the containers. Emerging in clouds of dust, equipment was cleaned and inventoried before repairs could begin. Section by section, the troops worked through the equipment, and as items were readied, the hospital was gradually erected in the motor pool. Cleaning the tents was perhaps the most trouble; there had been nowhere in Ku-

wait to clean them, and everything had been brought back filthy. About a third of the tents were too worn to reuse, but replacement pieces were delayed.

Fortunately, the 226th Medical Logistics Battalion was collocated at Miesau and assigned many of its maintenance personnel to help the MASH repair equipment. Ultimately, refitting the 212th cost roughly $1.4 million, a mix of new equipment, new vehicles, restocked medical supplies, and restocked spare parts.

Cleaning, repairs, and replacements took about 3 months. By early November the 212th was once more a functional hospital and immediately began a field exercise. Patients were brought in and treated, including surgeries; guard posts were established; and everyone rehearsed their various roles. This period was also an opportunity for troops to emotionally process their experiences; the EMT that was set up at Miesau was the same one that had been at Bushmaster, and it brought back memories. A 1-hour session had been scheduled for the chaplain and combat stress personnel to address the troops, explaining some of the ways people experience stress over time; the event turned into a 3-hour session of listening and revisiting memories. Some soldiers had trouble adjusting after the high-speed/high-stress deployment, not necessarily in the first few months when they were busy with equipment and training, but a few months after their return. Bitterman helped soldiers with domestic problems or who were using alcohol or drugs as release mechanisms to get treatment, not just for their substance abuse problems but for the causes as well.

Individual training also required time. About 30% of the unit's soldiers were replaced in the second half of 2003, the normal turnover for an entire year. The new personnel had to be trained with the existing staff, and Bitterman thought the "old hands" did a good job of bringing the "newbies" into the spirit of the MASH. Soldiers also had to meet the normal training requirements, including the Army-wide routine of common task training.

In December 2003, the 67th CSH and 226th Medical Logistics Battalion were both ordered to Iraq. The 212th handed over equipment and lent personnel to help the deploying units. MASH soldiers ran firing ranges, cooked meals, and drove equipment for the two units so they could focus on final training. Preparing the 67th and 226th for deployment took 2 months, and in January 2004 the 212th was also ordered to provide medical support for the upcoming 60th anniversary commemorations of the invasion of Normandy. Bitterman took as many of his soldiers to this event as he could, plus a task force including dental, veterinary, preventive medicine, and combat stress personnel. The commemoration was a high-profile mission, supporting what was clearly going to be the last large assembly of D-Day veterans. The mission was exhaustively planned (soldiers were told not to wear clothing with crude messages or anything that would insult the French) and was conducted smoothly, with no seriously ill patients. Being present at the ceremonies at Omaha Beach ("Bloody Omaha," where roughly 3,000 American soldiers were hit in the first few hours of the Normandy invasion); visiting Utah Beach (where the 12th Evac had landed in July 1944); and

meeting the veterans who had liberated France all made strong impressions on the soldiers of the 212th.

In late summer 2004 the 212th augmented an FST that deployed to Bulgaria for the first US-Bulgarian training exercise at the new Novo Selo training area. Only about 10 personnel participated, however, and the mission did not interfere with the August "hospital-in-hospital" training, nor the planning for the major unit exercise at Grafenwohr in November. The November exercise started with an all-night drive to the hamlet of Speichersdorf, followed by 2 weeks of testing the unit's military skills and hospital operations, with patients flown from Landstuhl as practice for an air ambulance unit. New tests reflected the realities of likely deployments: civilians approached the gate, testing whether the 212th could calm a crowd and maintain security. Additionally, an opposing force simulated an attack on the hospital, using the latest generation of laser combat simulators. The attackers managed to penetrate the 212th's headquarters tent before being "shot."

Back at Miesau, the original target date for the 212th's conversion to a CSH had quietly passed. The 67th CSH was supposed to inactivate as part of the Army's constant realignment of forces to meet its changing missions. Medical staff were reduced along with overall forces in Europe, leaving only enough to staff one deployable hospital; since the 212th was both the senior unit and had more decorations than the 67th, its flag would survive. But with the 67th deployed in Iraq, transferring its personnel and equipment was impossible, and the conversion was postponed from October 16, 2004, until some later date.

Angola

Since the 212th was not going to be overhauled, it was available for USAREUR's next task, a MEDFLAG mission to Angola, the first US exercise with that formerly communist country. Planning began in January 2005 for an operation that would take place in July. While Angola would be a major exercise, routine training and routine turnover continued, including the arrival of a new commander, Colonel Angel Lugo. Because of the scheduled conversion to the larger CSH, the new commander was a more senior officer. The exercise outline agreed upon with the Angolans involved four points: (1) The MASH would train Angolan medical personnel (both government civilians and military) on how to respond to a natural disaster, including some general medical training. (2) Some MEDCAP missions would be held, as in Vietnam: seeing patients in their villages, dispensing drugs, eyeglasses, and advice. (3) The 212th would donate substantial quantities of medical supplies and equipment, so several Angolan clinics would be better equipped for years to come. Ultimately $200,000 of equipment and supplies came from the State Department to help rebuild the Angolan medical system, ravaged by almost 30 years of civil war. (4) The 212th would handle surgical and dental cases, although MEDCAPs had usually been outpatient care.

The decision to do surgery during the exercise drove the decisions on what equipment and personnel the MASH would need. Obviously the operating room and most of the nurses and surgeons were vital. Yet the daily activity at Landstuhl, where every day another aircraft brought patients from Iraq or Afghanistan, also required medical staff. Therefore, some of the 212th's specialist physicians were left behind; not only were they needed at Landstuhl, but specialized facilities were unavailable in Angola, and they could not see their patients through to a full recovery. In many ways the exercise in Angola was similar to the situation the MASH had seen in Zagreb.

The months-long planning process involved not only the Angolans but also other parts of the US military: an Air Force water purification unit; Army National Guard engineers (to drill wells for Angolan villages); Army reserve translators; a dental detachment; and an Air Force optometry team. A communications team was also added, the SMART-TeleHealth group from Europe. SMART (Special Medical Augmentation Reaction Team) was an initiative of Lieutenant General James Peake, the previous surgeon general, to have teams from fixed-facility hospitals available for quick-response deployments, mainly humanitarian or disaster relief missions. Various medical commands

Figure 7-1. 212th MASH personnel set up tents in Ambriz, Angola, during exercise MEDFLAG 2005. One purpose of the exercises is experience in real deployments.
Reproduced from: www.defenseimagery.mil, image 050908-F-VS677-010. Accessed May 16, 2013.

fielded various SMART teams, and European Regional Medical Command kept a six-person telemedicine group ready. In addition to signal personnel, SMART teams included medical staff to treat patients and provide medical information. For the Angolan mission, the team would practice its mission while providing the MASH with signal links to Europe. After an Angolan outbreak of Marburg virus, a highly lethal virus related to Ebola, canceling the mission was considered, but the outbreak was remote from the MASH's operating area and soon ended. In addition to logistics planning, MASH personnel attended briefings about Angolan history and culture, the environment (including advice to drink lots of water due to the heat), and the diseases they would likely encounter.

The trip to Angola was the first time since the Albanian deployment that the MASH had flown the bulk of its equipment. The use of civilian contracted aircraft made the trip easier since the experienced crews did the bulk of the load planning, telling the 212th's soldiers which pallet or container to load where. On arrival, after a short break to move to a remote region, the medical care began; 80 dental patients were treated (despite a generator failure one day) and 340 pairs of glasses were dispensed. The MEDCAP groups saw over 1,800 patients,

Figure 7-2. An optometrist attached to the 212th conducts an eye exam on an Angolan woman at the medical clinic in Ambriz, Angola, during exercise MEDFLAG 2005, September 15, 2005. Reproduced from: www.defenseimagery.mil, image 050915-F-VS677-015. Accessed May 16, 2013.

mostly with dermatological or respiratory problems (including the common cold or bronchitis). There were also vaccinations, and the 212th dispensed its entire supply of antibiotics.

The operating tables were in constant use for 4 days, as the surgical teams worked in shifts to perform 191 surgeries. Minor surgery was even done in a corridor. Most of the surgery consisted of simple hernia operations or reducing thyroid glands swollen by goiter. The orthopedic staff also worked on some patients with old bone fractures that had not mended properly. Unfortunately, not everyone could be cured, such as a sickle-cell sufferer with an incurable inherited disorder, who was given a blood transfusion that temporarily improved the problem. Another patient, with a goiter so severe it interfered with her swallowing, was turned away because she needed to take drugs for several weeks before surgery would be safe; she was likely to die from lack of nutrition, but there was nothing else to do. Other patients were more rewarding: a portable ultrasound machine let Angolan women see their unborn babies.

The local health facilities were little more than cinder-block buildings with thatched roofs, lacking running water and electricity. The soldiers unpacked the donated hospital beds, and also left behind as much durable medical equipment as possible, such as examination tables and stainless-steel surgical equipment. Although the latest generation of US medical equipment is disposable, to reduce the risk of infection, stainless steel, which can be sterilized and is durable, was the best option to help the Angolans. Lasting from August 21 to September 23, the exercise went smoothly, with training for Angolan medical staff, including both disaster response and hands-on training for nurses and medics, accomplished according to plan.

Earthquake Response in Pakistan

After returning to Germany, the plan was to spend the next 30 days getting the equipment ready again: cleaning it, checking to make sure it was functional, and sending in an order to refill gaps. The only events on the horizon were the scheduled conversion into a CSH and an anticipated deployment to Afghanistan in early 2007. However, there was a sudden change of plans. At 0852 in the morning of Saturday, October 8, 2005, a strong earthquake struck northeastern Pakistan. It was a shallow quake, which amplified the damage: about 80,000 dead, 130,000 injured, and 3,400,000 homeless over 11,500 square miles. It was the worst earthquake ever to hit Pakistan, and one of the deadliest in recorded history. Making matters worse for the population, it struck a remote, mountainous region (the state of Azad Jammu and Kashmir, or AJK), with limited access on narrow mountain roads, delaying information on the extent of the damage. Colonel Lugo was notified to prepare to deploy. Fortunately, much of the equipment was easily repacked. The disaster training in Angola also proved useful.

Figure 7-3. An earthquake survivor inspects damage to buildings on a street in Muzaffarabad, Pakistan, on November 10, 2005.
Reproduced from: www.defenseimagery.mil, image 051110-F-JI573-002. Accessed May 16, 2013.

The Mission

A US ally since 1954, Pakistan is a major contributor to UN peacekeeping operations, and it was a coalition partner against Iraq during the Persian Gulf War. After the attacks of September 11, 2001, Pakistan had aided US efforts in Afghanistan. The improved working relationship had led the United States to formally designate Pakistan as a major non-NATO ally (a legal status with enhanced military and financial ramifications) in 2005, but Pakistan was an overwhelmingly Muslim country and, as the military operations in Iraq continued to be controversial, a fair amount of the Pakistani public was dubious about American government policy and motives.

"Operation Lifeline" was the US response to Pakistan's request for aid. The operation had both humanitarian and public diplomacy motivations, intended to influence foreign public opinion. The military term is "information operations," which medical units frequently perform, although seldom with the high profile the MASH had in Pakistan. The US military regularly conducts over a hundred humanitarian and civil assistance missions each year—some years that number can double—with the dual purpose of providing realistic military training and influencing foreign public opinion. These missions can range from a few sol-

Figure 7-4. VIP visits, such as Vice President Richard Cheney, garnered media attention and thus helped spread the information operations message.
Reproduced from: http://www.defense.gov/home/photoessays/2005-12/p20051220a9.html. Accessed January 7, 2013.

diers offering technical assistance to a large task force helping after a natural disaster. But to be effective in influencing public opinion, these missions must be visible to the public, an important role for public affairs staff and media.

Embedded media, reporters that deployed and lived with the unit, accompanied the 212th's deployment to Pakistan. Colonel Lugo also took public affairs personnel. The 90 visiting media organizations, as well as local Pakistani media, spread the news that Americans cared about the earthquake victims. The embedded media played their role, and up to 20 prominent official visitors per day helped draw attention to the story.

At the individual level, Americans gave small gifts to Pakistanis, such as snapshots in frames with twined US and Pakistani flags, or caps and scarves with flags. In cynical moments, troops called these "door prizes," but the convoys that went to refugee camps or the airfield were directed to report how many people were wearing the flag-logo items. Questionnaires about what the patients thought about the United States were also distributed. Some patients had never heard of the United States before visiting the 212th, and some thought the Americans secretly intended to occupy Pakistan, slipping troops in starting with the MASH. Yet over time perceptions changed. Only about a quarter of

Figure 7-5. Vaccination trips, such as this one to the Konsar School, not only vaccinated thousands against disease but also helped show US interest and support.
Reproduced from: www.defenseimagery.mil, image 060107-F-JI573-010. Accessed May 16, 2013.

patients had a positive view of America when they arrived, but that percentage doubled by the time the unit left. Captain Liza O'Neal met a local man working as a translator at another relief hospital who was initially cynical and hostile.

> There was a time when he needed to send a patient to us, and he walked down and he saw our team working like crazy on this patient. Anyway, over time, he thawed; he gave me a Christmas card for heaven's sake—a Muslim making sure he had a Christmas card. You know that guy is going to have good things to say about Americans now, and there were a lot of people that are going to have good things to say. I think maybe we made a difference in that area of the world where a lot want to do us harm.

Individuals had little ability to judge what effects the public diplomacy efforts were having on the Pakistani people; the effects of the mission may never be visible. The MASH would treat over 20,000 patients, affect the lives of many more, improve the perception of the United States, and donate $4.5 million in hospital equipment and supplies. The MASH would later be awarded the Pakistani Sitar-i-Eisaar, or Star of Sacrifice medal, by President Pervez Musharraf for its work in Muzaffarabad. This award symbolized the Pakistani government's recognition of the mission, but the people who had been helped and those who had heard positive things about the United States could not be counted.

Terrorist groups were known to operate in Pakistan, including some in the earthquake-hit region, which prompted careful security measures. However, a requested guard platoon was overruled because of the high profile of the mission: it would send the wrong message if American troops seemed heavily armed, or were hiding in bunkers behind barbed wire. Instead, the Pakistani military provided security, escorting all foreign relief groups, civilian and military alike. Task Force 212 personnel took weapons, but the weapons stayed out of sight, helmets were rarely worn, and flak vests were typically worn under parkas or other outer gear. Protecting the force and protecting the mission had to be balanced. For instance, the MASH tried to obtain chicken wire for its perimeter fence instead of using barbed wire, but the necessary quantities of chicken wire could not be found on short notice. While outward security measures were carefully calibrated to the mission, training was not neglected. Soldiers were trained on spotting and responding to improvised explosive devices, the roadside bombs that were a major cause of casualties in Iraq. They also had to complete the routine predeployment paperwork that would help identify them in case they were captured.

Getting to Pakistan

The Pakistani request for aid was channeled through the US embassy. European Command responded with the 212th MASH, while Pacific Command sent an ad hoc Navy/Marine Corps group from Okinawa that was later called Combined Medical Relief Team 3, built from elements of the 3d Marine Division's logistics units. The MASH needed to be tailored into a task force for this particular mission for several reasons. First, it was not a doctrinal mission: the MASH would not be following combat operations or evacuating patients to the rear after emergency surgery; it would be treating a mix of patients different from the battlefield wounded. Second, the United States had permission to land only eight aircraft per day in Pakistan because there were many other flights and a finite number of runways. Pakistan's ports were open to receive cargo, but deliveries by sea were slow and ill-suited for emergency relief.

The 212th largely planned its own deployment. Seeking information on earthquakes, staff turned to the Internet and found guides to types of injuries (crushing injuries, which meant a need for orthopedic surgeons) and diseases (from life in refugee camps) they would likely treat. They also learned more about the region, including its medical facilities and the level of damage from the quake. Because it would not need 36 ICU beds, the unit left one ICU ward but took a 20-bed intermediate care ward, as well as several tents to establish a 40-bed minimal care ward in case it was needed, especially if diseases developed in the refugee camps during the winter. Extra physicians were taken, emergency room doctors to sort and treat patients quickly, family practitioners and a pediatrician, and an internist to handle disease cases. An orthopedic surgeon was added for

extremity injuries, and a general surgeon for abdominal injuries. An obstetrician/gynecologist was also added. Changing an ICU for an intermediate care ward meant changing some of the nurses, and 36 soldiers were brought in from the 67th CSH. Since the MASH would be deployed essentially by itself, without other logistical support units, it needed some mission-specific augmentation. Extra maintenance personnel were needed, since equipment would have to be repaired on site; preventive medicine personnel were requested, as were behavioral health, signal, water purification, public affairs, and civil affairs personnel, as well as translators, a guard platoon, and the SMART team that had gone to Angola. Only five military translators were available, four of whom were of Pakistani descent.

Gathering supplies, equipment, and staff made for an extremely busy week—made all the busier because the details of the mission were changing. The Angolan experience was utilized as a baseline since it had included both surgery and medicine in a developing country. The headquarters was a beehive of activity, keeping abreast of developments, juggling priorities, checking status and progress. Even after it seemed the orders were clear, there were changes. Initially, the MASH was supposed to take 30 days of supplies—not just medical supplies, but food, water, and fuel. The volume and weight of water would have been immense, and a water-purification team was substituted. The MASH also did not have enough tankers to carry fuel, so that requirement was dropped in favor of buying fuel in Pakistan.

The advance echelon left Germany on October 17, and started working with the Disaster Assistance Command, Pakistan (DACPAK), the headquarters that coordinated American assistance in Pakistan, as soon as it arrived the next day to locate a site for the hospital. However, DACPAK had few medical staff officers and little idea of the MASH's requirements, and the Pakistanis had to approve the site as well. The decision was made that the MASH would be located in Muzaffarabad, only about 15 km from the earthquake epicenter and the capital of AJK, where it would remain.

Meanwhile, the main body of the 212th flew to Pakistan gradually because of the eight-flight-per-day limit for all US activity. Troops and equipment traveled on 17 different aircraft. Individual pallets had to be juggled between flights, partly as priorities changed, partly as space changed, partly for safe loading of the aircraft. The uncertainty got to the point where some soldiers were happy to finally take off: they no longer had to sleep with their cell phone, wondering about their wake-up call. Various additional teams added layers of complexity; not only did they take extra space, they needed to stay together or both personnel and equipment were useless, and priorities were unclear. Eventually, the transportation bottlenecks caused mission parameters to change: instead of 30 days of rations and all the vehicles, the MASH left behind roughly half its trucks (partly because it would not move from Muzaffarabad) and 10 days of rations (to follow later).

The unit's main body was on the ground in the early morning darkness on October 23. The move to Muzaffarabad started only a few hours later, around 0600. Most troops traveled in small civilian buses, carrying 20 troops packed in with their rucksacks and gear. Soldiers joked that the buses had been built for smaller people. Pakistani troops provided convoy security, but not as many troops as most MASH soldiers expected. The Pakistanis provided what they saw as adequate security, and were using as many of their troops as possible to continue rescue and relief operations. Local drivers cut in and out of the American convoy, and from a security perspective, any vehicle might be a car bomb. Ultimately the convoy arrived at its destination with no explosions or collisions, only jangled nerves. The heavy traffic also caused the convoy to try to stay tightly closed up, and the 80-mile drive from Chaklala Air Base to Muzaffarabad turned into a 27-hour overnight drive. Part of that delay was due to simple safety: there was no point trying to push through the night on narrow mountain roads with drivers who had been awake in Germany to load the aircraft, then been awake through the long flight, and now had been through a start/stop convoy.

Staff Sergeant Eddie Green, chief wardmaster of the advance echelon, recalled handing out MREs to civilians and playing with children while waiting for the main body to arrive. The 80-mile drive was supposed to take only 6 hours, and while it ended up running a day late, there were no other delays. The final site selected was open ground in a Pakistani government compound, rather than in buildings, which had all suffered structural damage in the earthquake and faced danger from aftershocks. The compound also had a built-in security perimeter, and the Pakistani Rangers (a paramilitary force under the Interior Ministry) kept the whole area secure. However, potential attackers needed only to lob a mortar round toward the government buildings, which were local landmarks, to make headlines for their cause.

The site had been used for several purposes in recent days. Part was a helicopter landing zone, used mostly by government officials for convenient access to the office buildings. Part had been used by refugees, who left behind trash and small pits they had scooped for relieving themselves. Getting authorization to use the site was a chore when the MASH wanted to start treating patients. In the end the 212th had to move in and spread out rather than wait for full authorization for enough space in one place. Helicopters continued to land until MASH trucks were dotted around the landing zone, and bulldozers from a Navy engineer unit leveled the site, scraping away the top layer of dirt and trash. The standard staking plans for a MASH had to be scrapped in the constricted space available, but staff still had the IOC functioning within 12 hours, the 44-bed hospital in 48 hours, and 3 days later the entire 84-bed hospital. The first patient was being treated within 6 hours of starting to erect the tents, the first surgery was completed within a day (a woman who needed emergency surgery following a miscarriage), and the same day an entire ICU filled up. Disruptions were caused by squeezing all the Task Force 212 elements into less

Figure 7-6. Major Choi helps assemble the EMT of the 212th at Muzaffarabad, October 24, 2005. Reproduced from: http://www.defense.gov/home/photoessays/2005-10/p20051026a11.html. Accessed January 7, 2013.

space than the MASH normally occupied, and by the deployment bottlenecks delaying equipment.

Caring for the Earthquake Victims

The first month was hectic as earthquake survivors were admitted. By the time the MASH arrived some victims had died, but many survivors had broken bones, including grossly infected open fractures, and gaping wounds, including a man who came in with an open fracture 45 days after the injury. Orthopedic injuries were typically crushing injuries, arms and legs that had been smashed by falling buildings. Some patients had been untreated so long that severe infections meant amputations were necessary to save lives. The operating room was being used up to 18 hours a day, and with the time needed to clean and prepare for more operations, that meant 24-hour work. This pace could not be maintained, and the 212th instituted shifts for operating room staff. Some elective surgeries were also performed, and the scheduling became complex as staff hours, emergency surgeries, elective surgeries, and maintaining some reserve capacity were all balanced.

The MASH was the most capable hospital in the area—the only one with ven-

tilators and intensive care capability—so it received the most serious patients. Because of this equipment, the Army doctors offered to take the worst patients when the UN "health cluster" meetings (of leaders of various healthcare facilities and organizations) were initiated to balance healthcare resources. Other facilities had different capabilities; the MASH had no ophthalmologist nor an oral surgeon, despite requesting both. (An oral surgeon arrived after a few weeks, but without enough equipment to do substantial surgery. After extracting some teeth, he was sent back to Germany.) The health clustering also allowed sharing of facilities and supplies, including pediatric and geriatric supplies that the Army did not routinely stock. The MASH offered operating room time to other surgeons, for instance, the Turkish neurosurgeon.

The cluster also shared information, and the MASH learned where it could send patients once they had stabilized or were recovering well. This system substituted for the MASH's usual battlefield patient evacuation procedures. US helicopters were helping move relief supplies in the area, and the 212th also became the de facto coordinator of evacuation flights, ultimately arranging over 100 flights to hospitals in Islamabad.

Figure 7-7. An earthquake survivor receives medical treatment at the US 212th MASH at Muzaffarabad, Pakistan, November 6, 2005. The 212th had the most capable hospital in the area. Reproduced from: http://www.defense.gov/home/photoessays/2005-11/p20051107a5.html. Accessed January 7, 2013.

Figure 7-8. The MASH received patients with a wide range of medical problems, not all connected to the earthquake.
Reproduced from: www.defenseimagery.mil, image 060105-F-JI573-013. Accessed January 7, 2013.

Treating the most serious patients kept the staff busy and productive, but also brought the stress of patient deaths. The behavioral health team held debriefs, usually including the chaplain, to help soldiers manage their feelings. The ward nurses had somewhat lighter duty than the operating room and primary care staff. There was considerable turnover of patients, but the overall census seldom rose much over 50% of capacity, and most patients were held less than 10 days.

The MASH accepted patients from 0800 to 1700, allowing some rest for the staff and for greater nighttime security, and patients swamped the small hospital. The EMT had only eight stations; it quickly became backed up and a triage tent was added within a week. However, the triage tent, a modular unit, was subsequently expanded and turned into a primary care clinic. Staffed with primary care personnel and stocked with simple drugs such as vitamins, cough medicine, antibiotics, and pain medications, the clinic was used to perform minor procedures such as draining abscesses. The new clinic handled as many patients as possible and reduced the pressure on the EMT; however, the load kept the primary care staff, translators, and hospital administration busy. Swamped clinical staff began experiencing compassion fatigue as each day brought hundreds more sick and injured. At times the chief of surgery and chief of medicine argued

about what the 212th should be doing and how much it could afford to devote to particular patients, partly caused by the stress of overwork. Both officers tried to schedule time off for their staff, but time off was always subject to a critical patient arriving and needing care.

The PAD, which ordinarily logs patients in and out and keeps track of their medical files, faced a variety of challenges. The documentation system was set up to handle US patients with surnames, known birthdates, and a Social Security number, and had trouble with foreign nationals, who might use only one name and had no Social Security numbers. The system fallback was to create a "pseudo-Social" based on a birthdate, but some Pakistanis did not know their birthdate. The paperwork had to be completed as patients were seen, then was entered into computers overnight—usually by staff from other departments because the few PAD clerks were overworked. PAD was also responsible for discharging patients, which brought its own challenges. Many people had lost their homes, even their entire village; the Pakistani government was running some refugee camps, relief organizations were running others, and some people had set up their own spontaneous camps. How could PAD find the rest of a family?

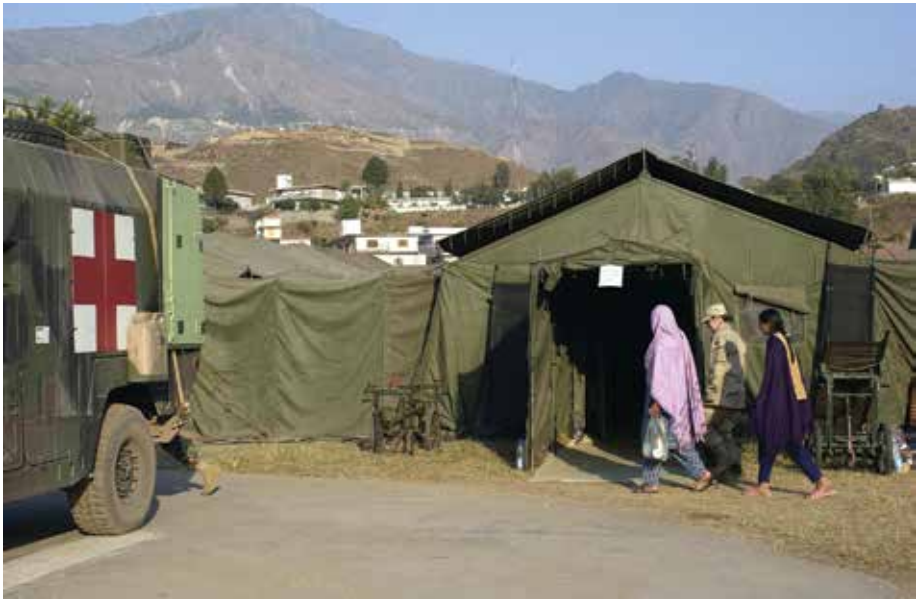

Figure 7-9. Women enter the 212th MASH at Muzaffarabad, Pakistan, November 6, 2005. Once patients were cleared by security at the gate they were escorted to their destinations.
Reproduced from: http://www.defense.gov/home/photoessays/2005-11/p20051107a1.html. Accessed January 7, 2013.

What should be done for orphaned children? What camp had space that day? Where were food and clothes available?

The patients arrived through a sturdy, multilayered perimeter. The Pakistani Rangers formed the outer layer, with sentry posts and sandbagged firing points, passing individuals through a metal detector and inspecting vehicles. Then a US checkpoint checked the visitors and logged them in. Having the male Pakistanis perform security checks on female patients avoided cultural problems. Guides within the compound directed vehicles and took patients to the appropriate place, which reduced the language barrier and prevented potential attackers posing as patients from wandering around. The MASH soldiers soon recognized how competent the Rangers were, and relaxed guidelines as the situation became more routine. Junior soldiers were used on the supply runs, but no one went out alone or at night. No security incidents occurred during the mission.

After a month to 6 weeks, the pace changed, as was expected. Instead of first-order patients (those injured by the event), second-order (with diseases or problems from living in refugee camps) and some third-order (with problems stem-

Figure 7-10. Air Force Major Fareed Sheikh, a doctor, and his father Doctor Mushtaq Sheikh, a civilian physician, discuss a patient's chart. The MASH was augmented with extra physicians, and civilian doctors volunteered to work there, greatly augmenting capabilities.
Reproduced from: www.defenseimagery.mil, image 051111-F-JF472-009. Accessed January 7, 2013.

ming from a dislocated local health system) patients began arriving. The number of surgical cases dwindled, although overall hospital workload, including laboratory and pharmacy tasks, did not. The medical cases, however, became more severe as people developed pneumonia or tuberculosis, or just colds from living in tents. Fewer surgeons were needed, and some were sent back to Germany where there was plenty of need, especially as combat was flaring up in Iraq.

At this period the MASH required more primary care staff, but because the 212th's authorized quotas of physicians could not be altered, the unit recruited six Pakistani civilian providers. The internist at the MASH was of Pakistani descent, and his father was also a physician, with links in the Association of Physicians of Pakistani Descent of North America (APPDNA). APPDNA worked with the State Department and Pakistani government to provide doctors, who not only spoke Urdu and other local languages to help with patient care, but also publicized the MASH's work with interviews to local media. The Pakistani government itself, and the Islamic Medical Association of North American, also provided doctors. The civilian doctors provided a significant service because they could each see 10 or more patients per day, they did not need translators, they were aware of local customs and patient expectations, and they knew where to refer the patients for continuing care.

Even with this help, translators were a bottleneck for the whole operation. Few were available from Germany, and while many Pakistani soldiers spoke English reasonably well, few villagers, the majority of patients, did. It took several weeks to get more translators, because while locals volunteered to translate, for security reasons all translators had to be approved by the US embassy in Islamabad. The translators were typically well-educated, and although they knew little medicine or medical terminology, they succeeded in speeding patient care.

Despite the shift to primary care, many patients unexpectedly arrived with burns. Many refugees lived in tents, which they coated with paraffin for additional weatherproofing, adding to the fire risk caused by cooking stoves. An entire family whose tent caught fire might be brought in at once. The MASH was the only hospital able to handle patients with burns on more than 20% of the body, but even with an ICU, the unit could not handle their entire recovery and had to find room in an Islamabad hospital for follow-up care. Without specific MEDEVAC helicopters, the MASH had to improvise inflight care, sending a nurse and at times a doctor along to monitor and care for the patient. Lieutenant Colonel Linda Lebedovych was escorting a baby to Islamabad, using a Jackson-Rees breathing circuit, when the oxygen tank on the ventilator suddenly registered empty:

> I had to do mouth-to-tube for that baby for 45 minutes, and I did it and I just said my silent prayers, "Please God, help me not run out of strength or energy. Please God help me ventilate this baby for as long as this baby needs it, and I will take a deep breath for myself in between, but I'll keep going." And I kept going, and going, and going. Got to the hospital and that baby made it. I needed to sit down. They were so kind to me when I got there. They got the baby

> ventilated and gave me some apple juice, because I remember being really thirsty after that. But I recovered and I was glad that that baby made that transport.

Another case ended differently: a badly burned child was brought in after being turned away from another hospital as likely to die. All staff could do was administer morphine to relieve pain as the child died.

At times the Pakistanis had a fatalistic view that troubled the American doctors. As Major Robert Piotrowski recalled:

> A man brought his wife, who was nursing a 3-month old child. She [the wife] had an open fracture of her hand, and the finger needed to be amputated; otherwise we wouldn't be able to control the infection. She also had a bad burn on her leg that needed to have some surgical debridement. The husband only wanted some antibiotics to make her hand better, because he was concerned she would not be able to work in the fields, and if she didn't work in the field they wouldn't have food, and she had to get food so she could nurse their son. We said no problem, but she's going to need to have that finger surgically taken care of. He initially agreed to that but when we saw the bad burn on the leg we said, "That leg also has to be taken care of." Well, we pushed his comfort zone. He said, "No, just one." We said, "No, we need to take care of both." Well, he decided that he wasn't going to have either taken care of. Without taking care of those two open infections she was going to die. The hand was getting swollen, very purulent. Well, between the husband and the brother-in-law they decided, "We'll just trust Allah's will. If Allah wants her to live she'll live. If she dies she dies. If the baby dies because there is no one to nurse the child, the baby dies, too." It really wasn't a big issue for them. It was very hard for our surgeons to let them leave, but we had to respect their culture, their wishes, so we gave him some antibiotics and said, "Here you go. If you want to come back we'll fix whatever you want to have fixed."

Such attitudes were not the only cultural difference the 212th found in Kashmir. The 212th was deployed through the month of Ramadan, when most Muslims fasted, and as a gesture of goodwill the chaplain suggested that the Americans not eat in front of Pakistanis.

Although some patients came to the MASH specifically for US healthcare, staff faced some difficulties handling patients and family members, just as in Iraq. Families tried to feed inappropriate food to recovering patients; there were different standards of handling trash; and some Pakistanis relieved themselves inside the wards, not knowing where the bathrooms were and unable to communicate with American staff. Nor was the 212th supposed to be running a miniature refugee camp, so visiting hours were introduced, which limited visitor numbers although families were allowed to leave someone overnight with children. Treating female patients in a Muslim country, however, did not cause any problems.

Families also brought endemic local diseases that were unfamiliar to the American doctors. Telemedicine capabilities helped provide diagnoses, including some unusual skin conditions that nobody at the 212th could identify. From being a fifth wheel during the 1996 Bosnia deployment, telemedicine had become useful: every few days photographs were sent to Army hospitals in the United States, and in most cases the information that came forward caused a

significant change in diagnoses and an improvement in treatment. Another unexpected problem (unconducive to remote diagnosis) was intestinal worms. Perhaps 60% of the local population had worms, mostly from eating food containing parasite eggs. Although easily treatable with pills, worms could cause abdominal pain, which was difficult to diagnose, and an occasional unnecessary exploratory surgery was performed as a result.

As 2006 began, the patient mix continued to change. The winter had fortunately been mild, mitigating the risk of diseases in the refugee camps. The surgical average was down to one patient per day, frequently an elective case of gallstones. Local hospitals were being rebuilt, diminishing the need for the MASH, although some staff had concerns about how local hospitals would handle the long-term care of patients, or indeed whether the local facilities could sustain the care. Staff also became frustrated from being under-employed, just as 212th soldiers had been in Zagreb. One senior doctor remembered that lack of work made them "cranky." In January the MASH drew down from 84 beds to 32, keeping an ICU and the intermediate care ward, and sending surplus troops back to Germany.

The changing categories of patients, from surgical, to inpatient diseases, to

Figure 7-11. The MASH did not normally stock pediatric drugs or equipment, but improvised until supply lines could be established.
Reproduced from: www.defenseimagery.mil, image 051112-F-JI573-009. Accessed May 16, 2013.

outpatient conditions, caused some shortages of supplies; however, the effects were not severe and mainly resulted in substitutions of less preferred medications and equipment. The 212th did not stock any children's orthopedic equipment, so Navy engineers helped make crutches for young patients. Without the MASH's usual battlefield support units, the medical maintenance personnel stayed busy, especially working on ventilators and their filters. Staff managed to do almost everything on site, despite the scarcity of spare parts, which was exacerbated by security firewalls on the computers in Afghanistan that administered the supply flow to Pakistan. To bypass the firewalls, staff flew to Afghanistan with the supply order on a computer disk—similar to how the 12th Evac handled computer systems used in Saudi Arabia during Desert Shield.

Living Conditions

With a functioning hospital the unit's first priority, living quarters were inevitably a bit cramped in the small compound. In the early days sleeping tents, showers, latrines, and dining tents were overcrowded, being used by augmentation teams as well as MASH troops, totaling about double the normal MASH personnel numbers. Over time more useable space was found as containers were moved to the perimeter (where they also acted as a security measure), military trucks were sent back to Islamabad because civilian trucks were handling most deliveries, and tents were moved to optimize the available space.

Amenities also improved over time. Early "burn-out" latrines were replaced, rations were improved, and a civilian company was hired to run the dining facility. Laundry, ironing, and shower cleaning were also contracted out. Each of these contracts freed a few soldiers, but other duties kept them busy: mechanics kept the generators running, and other service and support personnel were put in the pool for guard duty and other tasks. Additionally, a barber shop opened (although it closed almost immediately after a small water heater accidentally exploded), as well as a small post exchange selling snacks, DVDs, and other items. Some amenities had become routine: satellite television was available, and another television was available for soldiers to play video games. There were also movies, dances, card tournaments, and dominoes. The Navy engineers built handy items such as tables, shelves, and bridges across the dips in the ground. Fortunately the winter was not severe, and broken tent heaters were an annoyance rather than a crisis. Temperatures dropped to about freezing at night, but reached the 40s and 50s during the day.

Even in the middle of Pakistan, there was plenty of communication with the outside world. In addition to the satellite television, individuals had radios, and some commercial cellular telephones worked as well. The SMART-TM group provided sufficient bandwidth for e-mail as well as video conferences, for both the command group communications with headquarters and the Family Readiness Group. Although letters and parcels were sent and received by mail, fre-

quent delays generated rumors that mail was deliberately being held back in Islamabad for unspecified reasons. In reality, delays were caused by the legal requirement for US mail be accompanied by an American escort (who was then escorted by Pakistani military) when US helicopters were unavailable. Other rumors circulated, including the belief that the MASH would be sent straight to Afghanistan rather than going back to Germany when the Pakistan deployment ended.

Communications with the outside world both caused and relieved stress: soldiers were not insulated from the problems and frustrations of family back home, so a car accident, a child's bad grades, or just a spouse's rough day could be relayed to Pakistan as soon as it happened. Colonel Lugo had asked for, and received, two behavioral health personnel to help with stress relief. Probably the most intense stressor was seeing a child die, and the behavioral health team's work spiked when that happened. Otherwise, the team mostly handled routine problems of family life, although one soldier had a recurrence of posttraumatic stress disorder related to his experiences in Iraq, and had to be evacuated from Pakistan.

Another source of frustration, and then stress, was the unknown length of the deployment. While the 212th was ordered to deploy for up to 180 days, most soldiers expected a far shorter stay, ending after the earthquake's victims had been treated. Although most staff recognized that second-order effects, the diseases from crowded conditions in refugee camps, were earthquake-related problems, the MASH, as a surgical hospital, was not considered the solution for these diseases and routine primary care. Some soldiers expected to stay in Pakistan only 60 or 90 days; when the deployment was prolonged, morale suffered. MASH leaders had drawn up a series of event-driven triggers, changes in the both numbers and types of patients from those the 212th was best suited to treat, that would lead to redeployment. These triggers came and went, but the State Department felt that withdrawing a US hospital in the middle of winter would send the wrong message. Officials decided to keep a US hospital in Muzaffarabad until March 21, which disappointed some soldiers. As at Dogwood after Baghdad fell, there was disappointment and frustration after a high-intensity mission dwindled but did not end. First Sergeant Diamond Hough, a seasoned soldier, saw the deployment in Muzaffarabad as comparatively comfortable, but many of the junior soldiers complained.

The holiday ball and VIP visits failed to keep all the troops busy and interested, and some soldiers left the compound on trips in the local area, to make supply runs to the airfield and to support the preventive medicine team. Force protection guidelines kept troops from mingling with locals in Muzaffarabad. Local merchants were brought in a few times to sell their wares in weekend bazaars, providing some exposure to Pakistani culture. Soldiers and NCOs of the month were selected, sports were played within the 212th and against other units, and there were ceremonies for promotions, reenlistments, and NCO induc-

tion. A limited R&R program allowed a few soldiers at a time to spend a few days at the embassy in Islamabad, where they could see new faces, eat different food, and come back refreshed.

Leaving Pakistan

In late January 2006 another piece of public diplomacy began: the handover of MASH equipment to the Pakistani army. This policy was both a humanitarian donation of medical equipment and supplies worth several millions of dollars (the 212th had also taken around $400,000 of humanitarian medical supplies from State Department stocks to Pakistan) and an effort to bolster Pakistani medical capabilities for future disaster relief: the new Pakistani 67th Medical Battalion would be more capable than existing local field hospitals. The handover might also increase the likelihood of an early return from Pakistan, if the Pakistanis were running the hospital effectively and the MASH was no longer needed. As the winter progressed and stayed mild with few illnesses, the transfer date was advanced from the end of March; ultimately Pakistani troops arrived

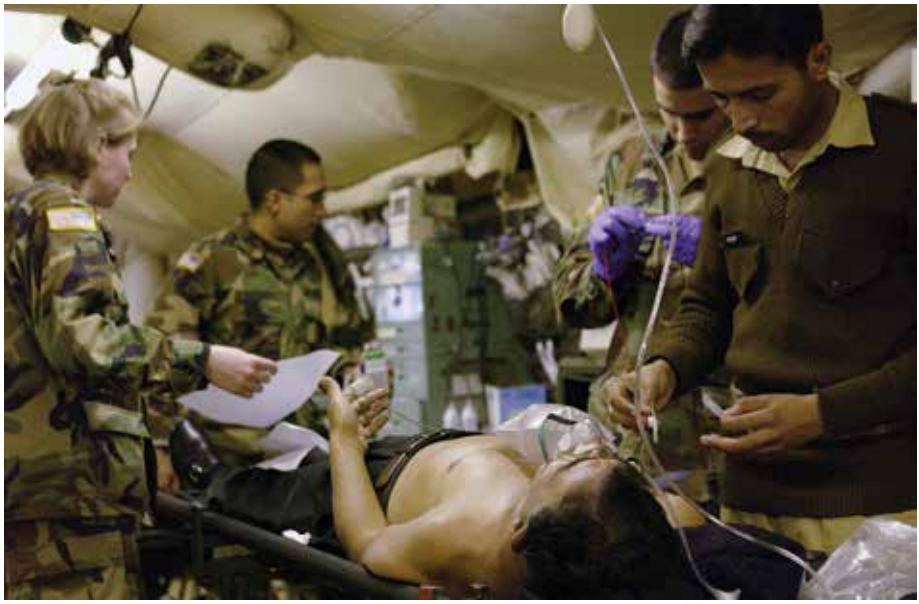

Figure 7-12. MASH and Pakistani medical personnel treat a patient at the 212th MASH, January 5, 2006. Pakistani military personnel worked at the MASH before the formal training for the handover.
Reproduced from: www.defenseimagery.mil, image 060105-F-JI573-010. Accessed May 16, 2013.

to start training with the MASH equipment in early February. Detailed planning for the transfer-of-authority ceremony revealed cultural differences between the two militaries: the Pakistani army expected to work with Colonel Lugo as the commanding officer; instead, the sergeant major was assigned that responsibility.

The MASH worked with the Pakistani military to design a 2-week training program, which moved sequentially from simple inventory through section training to on-the-job training for the Pakistanis operating the entire hospital. It culminated with the transition-of-authority ceremony, a final opportunity for public diplomacy, on February 16. Simply by departing, the unit stopped the rumors that the United States intended to occupy Pakistan. After the transition-of-authority ceremony, equipment was gradually moved back to Islamabad and personnel were flown out on helicopters. On February 21 the unit's main body flew back to Germany, with a small party staying through March 1 to ship back remaining equipment, which was sent by sea since it was less expensive and lives were no longer at stake.

As soldiers arrived in Germany, most went on leave since it would be another 2 months before the equipment returned. As after so many other deployments, equipment had to be inventoried, repaired, and replaced, under the constraints of the available budget and staff. This provided even more incentive for transferring equipment to the Pakistanis; everything handed over was one less item to be processed back at Miesau. The spring and summer of 2006 was spent incorporating both personnel and equipment from the 67th CSH, which was being inactivated as part of the gradual reduction of forces in Germany. The 67th had recently been to Iraq, and much of its equipment was worn, needing repair and overhaul. New equipment was needed to complete the inventory, and the Miesau barracks required expansion to accommodate the returning soldiers, with most of the space taken by expanded Landstuhl staff handling its increasing numbers of patients.

A Legacy and a Future

On October 16, 2006, the colors of the 212th MASH were cased, and the 212th CSH became the Army's newest deployable hospital. But the 212th is also the Army's oldest deployable hospital, serving in five wars, over 18 campaigns, and numerous peacekeeping and humanitarian missions. Just as the people of the 212th MASH became the people of the 212th CSH, the lineage of Evacuation Hospital No. 12 and the 12th Evac lives on in a unit that is "Skilled and Resolute." Within a week of converting, the 212th conducted a field training exercise to test their readiness for deployment, for the unit was already scheduled for its next campaign in Afghanistan the following summer.

Figure 7-13. Casing the colors of the 212th MASH.
Photograph courtesy of: US Army Garrison Kaiserslautern Public Affairs Office.

Sources

This chapter was based on interviews of unit personnel, including successive commanders (see appendix), plus Operation Lifeline daily briefings, after action reports, mission completion briefings, and documents and photographs provided by the unit. General information came from Army magazine and news service articles:

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