Chapter Ten

Aviation Transformation and Domestic Operations, 2002–2005

"What does assigning Dustoff to the aviation battalion do for the patient's needs?"

Maj. Gen. (ret) Patrick Brady, U.S. Army[1]

The Aviation Transformation Initiative

Background

In the spring of 2002, Lt. Col. Pauline Lockard was serving on the Office of The Surgeon General (OTSG) staff as the assistant executive officer when she was notified of her selection for promotion to colonel. As part of that selection, she was queried as to whether she wanted to be considered for colonel-level command. She decided against it so she could do one more tour in the Army and then retire. Subsequently, the Army Medical Department (AMEDD) executive officer, Col. Bill Thresher, asked her to assume the dual positions of the MEDEVAC proponent, replacing Lt. Col. Gino Montagno who was leaving for battalion command, and the MEDEVAC consultant to The Surgeon General.

Lockard discussed this with Lt. Col. Scott Heintz, the current consultant, Montagno, and his Proponency deputy, Lt. Col. Van Joy. Heintz was already reassigned to U.S. Special Operations Command (USSOCOM) headquarters in Tampa, Florida, but asked to remain as the consultant to the Surgeon General for MEDEVAC matters. Lockard and Heintz agreed that they could work together with her as the proponent and him as the consultant, and Thresher concurred.

The Medical Evacuation Proponency Directorate (MEPD) was still at Fort Rucker, Alabama, and still reported to the AMEDD Center and School at Fort Sam Houston. Thresher and Heintz were concerned that MEDEVAC needed

more visibility in the Washington area, and they told Lockard that she could set up her office in the OTSG complex in Falls Church, Virginia. Her MEPD staff would remain at Fort Rucker with its day-to-day functions directed by the deputy, Joy.

After his tour at the Joint Readiness Training Center at Fort Chaffee, Arkansas, ended in the summer of 1993, Joy had served in medical units in Panama, as an advisor to Reserve Component units at Fort Leonard Wood, Missouri, and at Fort Bragg, North Carolina, with the 56th Medical Battalion (Evacuation) and the 44th Medical Brigade. At Fort Rucker, Joy established strong relationships with his counterparts on the Aviation Center staff and handled affairs there as the MEPD deputy.

This all sounded reasonable to Lockard, and she accepted the job and arrangement. She believed that she could continue to work effectively on the OTSG staff while maintaining control over the MEPD Office and affairs at Fort Rucker through teleconferences, occasional visits, and her working relationship with Joy.[2]

She threw herself into her new job and became engaged in a plethora of medical and MEDEVAC issues including the ongoing Aviation Transformation Initiative (ATI), which included the proposals to reduce MEDEVAC companies from 15 to 12, 10, or even eight aircraft to help reduce the overall Army aviation budget. Wholesale inactivations of units—both continental United States (CONUS) and overseas—were being considered, and the AMEDD Center and School commander, Maj. Gen. Kevin C. Kiley, proposed to align MEDEVAC companies with the divisions similar to the 50th Med Co (AA) with the 101st Airborne Division.[3]

Larger efforts developed. Gen. Eric Shinseki retired from the Army in June 2003 and his successor was Gen. Peter Schoomaker, a career Special Forces soldier who had already retired from the Army and last served as the commander of USSOCOM. However, the Secretary of Defense, Donald Rumsfeld, had not been satisfied with the pace of change being set by Shinseki. With a desire to transform the Army, he had asked Schoomaker to return to duty as the Army Chief of Staff. Assuming office that summer, Schoomaker was very aware of Shinseki's initiatives and almost immediately instructed the Army Staff to convert to a modular brigade-sized force. He and a transition team developed a set of focus areas highlighting aspects of the Army that needed immediate attention to facilitate the change. Several key items emerged:

- The Army needed a better public relations program;
- Commanders had to be better prepared for the "long war"; and
- The post–Vietnam policy of putting most support elements into the Reserve Components had to be reversed.

However, the most prominent need was to reorganize the fighting forces under the modularity concept. Each of these key items became a focus area. Schoomaker directed the Training and Doctrine Command to develop a set of essential tasks for each area.[4]

Lt. Col. Jon Fristoe as the commander of the 421st Multifunctional Medical Battalion in 2007. While assigned to the OTSG Staff, he played a key role in the Aviation Transformation Initiative.
Source: Author

Process

Responding to the chief's tasking, the commander of Training and Doctrine Command, Gen. Kevin Byrnes, organized Task Force Modularity, under the direction of Maj. Gen. Robert Mixon. The team of 50, with another 35 analytical support personnel, was drawn from across the Army to address all viewpoints. It also had representation from the regional combatant commanders and the other services. Task Force Modularity had several parallel task forces with specific areas of interest. One was Task Force Aviation, which had the lead for developing concepts and designs for aviation in the modular force. Its autonomous nature reflected the complexity of designing aviation units and concepts of use. The earlier ATI was ongoing and eventually absorbed by this effort. Its report was due by early November 2003.[5]

Lockard heard about Task Force Aviation. She called the action officer in charge, an aviation officer, and discovered that the actual task force leader was Brig. Gen. (P) James D. Thurman, an armor officer who had flown AH-64s. His assigned deputy was Brig. Gen. Edward J. Sinclair, a career Army aviation officer. They were charged to do a "holistic review of Army aviation."[6]

Before this temporary assignment, Sinclair had served as the assistant division commander for support with the 101st Airborne Division and had been with the unit during the initial phases of Operation IRAQI FREEDOM. His next assignment was as the commander of the U.S. Army Aviation Center and chief of the Aviation Branch at Fort Rucker. Sinclair maintained a close liaison with the senior aviator in the Army, Lt. Gen. Dick Cody, and had recommended Thurman to Cody as the head of the ATI project. Sinclair and Cody spoke directly several times a week, and Cody shared with Sinclair his thoughts on transforming Army aviation, especially the configuration of aviation brigades and maintenance structure.

Cody was also concerned about the integration of MEDEVAC into aviation and the fact that the MEDEVAC aircraft fleet was older than the overall Army fleet. He would act as a behind-the-scenes sounding board as the ATI progressed. Sinclair had Col. Ellis Golson working with them as the head action officer.[7]

Lockard attended the initial meeting at Fort Rucker in September. The group was too large and unwieldy, so a smaller, more select group, which included Lockard as the AMEDD representative, was identified and sequestered at Fort Monroe, Virginia, for several weeks to discuss the issues in focus teams. She was one of six colonels on the Fusion team. Her Proponency deputy, Joy, was assigned to the doctrine and training team where he worked as the only MEDEVAC person with several other aviators and a few ground officers. Of the 43 members of the overall group, they were the only MEDEVAC personnel formally assigned.[8]

Word of Task Force Aviation quickly spread through the MEDEVAC community. Several senior cohorts who wanted to be apprised of developments contacted Lockard. As a requirement for her assignment to the group, she signed a nondisclosure agreement. Consequently, although she called on her compatriots for information and advice on several occasions, she withheld discussing the task force's developments with them.

She had many other experts within the MEDEVAC community, including Lt. Col. Pete Smart, on whom she called for assistance. Smart had recently left his position as the Commander of the 45th Med Co at Ketterbach, Germany, and had moved to the Army Aviation and Missile Command at the Redstone Arsenal at Huntsville, Alabama. He was the director of the Utility Helicopters Project Office and gave her data on the composition and projected structure of the MEDEVAC fleet.[9]

Maj. Bill Goforth was also available to assist. Goforth, another career MEDEVAC officer, worked in the Army National Guard (ARNG) Surgeon's Office as its senior evacuation staff officer and executive officer. He was aware of the transformation issues and unit size reduction proposals and examined them from the ARNG perspective, ever mindful that the 16 MEDEVAC companies in the ARNG

were a key part of the overall MEDEVAC force. Already ARNG MEDEVAC units were used in Bosnia, Kosovo, Afghanistan, and Iraq, and as backfill at several bases for active duty units deployed overseas. Goforth knew that any significant changes resulting from the ATI would have a great impact on the ARNG force.[10]

Maj. Jon Fristoe, the aviation staff officer in the Force Management Division on the OTSG staff, assisted Lockard on the task force. Following his tour as the commander of the 236th in Germany, Fristoe attended the Army Command and General Staff College at Fort Leavenworth, Kansas, and then reported for his staff tour.

Lockard got to know him well because he was the primary action officer for many of the issues that she tracked as the MEPD director. He had already written several of the preliminary plans for the reduction of the MEDEVAC units to as few as eight aircraft. When the ATI process started, Fristoe was concerned. He had not found any solid historical data about MEDEVAC unit operations. His instincts told him that such data were probably critical to any rational discussions of MEDEVAC matters with aviation officers. But he concluded that no process or methodology existed whereby the Department of the Army staff was informed of what was going on with the MEDEVAC units. He found an expectation that—when necessary—the MEDEVAC units "would just be there." As a former commander, he intuitively knew that the units were trained and ready to perform. However, he did not find any enthusiasm on the Army staff to modernize the MEDEVAC UH-60 fleet or any strategic analysis ongoing to determine the required size of the MEDEVAC fleet to support current or projected Army operations as directed by the wide array of contingency plans.[11]

Lt. Col. Randall Anderson, a MEDEVAC officer serving as the Aviation Staff Officer in the OTSG, had completed an excellent MEDEVAC study in May 2002. The Army G-3 directed the study under the auspices of the earlier ATI to determine which CONUS Army training sites still required Army MEDEVAC coverage and how many aircraft were necessary to provide coverage at each site. The plan also suggested alternative methods to provide quality of care and draft a CONUS installation prioritization list for the Army G-3. However, it only looked at units in the United States rather than units overseas or the overall concept of MEDEVAC operations.[12]

The exhaustive Anderson study scrutinized the previous three years of domestic MEDEVAC operations. A prioritized list of 18 forts and training sites requiring MEDEVAC support and a baseline for installation MEDEVAC coverage was developed. Such peacetime coverage required 128 aircraft, with three basing courses of action, and a four-aircraft detachment option presented. This study did not consider obligations under the Military Assistance to Safety and Traffic (MAST) program that were still in effect at several locations but steadily reduced as civilian companies took over the mission.[13]

Fristoe unsuccessfully tried to find the necessary operational data to initiate a larger strategic effort. He was determined to assist on the aviation task force as best he could and collected operational and safety data. Coincidentally, he knew Golson from his deployment with the 236th to Kosovo.[14]

Lockard, Joy, and—periodically—Fristoe attended the meetings at Fort Monroe. All aviation communities were represented:

- Attack forces;
- Scout units;
- Cargo; and
- MEDEVAC.

The list of issues ranged from air traffic control to logistics, training, and unit organization. Lockard also noticed that at many smaller meetings only select individuals were invited. She sensed that other agendas were being discussed. Aware of the long history of attempts by aviation to control MEDEVAC, she reviewed some of the history from Vietnam and the attempts made during the creation of the aviation branch, which she discussed with Col. (ret) Tom Scofield. She became aware that some aviation brigade commanders in Iraq complained through safety reports that the MEDEVAC units there were not properly tied in with their units and the medical chain of command did not provide proper command oversight for their flight operations. The report suggested that the MEDEVAC units should align under the control of aviation brigade commanders.[15]

Thurman had a few private meetings with Lockard where she clearly presented a strong case for maintaining MEDEVAC as it was with the 15-ship companies. Her deputy, Joy, had a different opinion. In his MEDEVAC assignments both in units and as an observer/controller at the Joint Readiness Training Center, he had developed a strong belief that the MEDEVAC units needed to be under aviation control. He had long talks with the aviators on his committee who concurred. When he made his views known to Lockard, she told him that he could have his own opinions, but during these meetings he represented the AMEDD and needed to maintain the AMEDD position.

Subsequently, Thurman heard of Joy's discussions with his committee compatriots and approached him directly for his opinion. As per Lockard's instructions, Joy gave him the AMEDD position. The General waved him off. "I know the AMEDD's position," he said, "I want to know what you think." Joy told him:

> My position on it was that it needed to be up under the aviation brigade… Arguments can be given for both sides of it. My personal view of it is that we hold that aviation brigade commander responsible for everything that flies. Therefore, if that's the case, and they are looked at and he is responsible for that, what does the MEDEVAC do that is so special that that aviation brigade commander cannot oversee? And really, it is nothing. If you look at what a MEDEVAC pilot does, and what a lift pilot does, there is no difference. They transport items from point A to point B. What makes the MEDEVAC different is that mission equipment package that is in the back of the aircraft. And it is that medic and the equipment that is on board that aircraft that makes it special.
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> Otherwise, the pilots up there are no different. We put warrant officers in the front of the aircraft and go off single ship and perform that mission and they have no additional training other than their flight training. That's no different than a lift unit can do.[16]

Thurman thanked him and walked away. He discussed it with Sinclair and then decided to include Joy's concept as a proposal that all MEDEVAC units be reorganized as divisional assets along the lines of the 50th Med Co (AA) assigned to the 101st Airborne Division. Under the modular concept, all divisions would expand to four brigades. Each brigade could have an Forward Support MEDEVAC Team (FSMT) of three aircraft and crews that could then form a habitual relationship with them. A restructured 12-ship MEDEVAC company could be assigned as a subordinate unit to the general support aviation battalion (GSAB) and under aviation control.[17]

When Lockard learned what had happened, she had a firm conversation with Joy. She also immediately argued against the proposal. To Thurman and the others on the working group, she pointed out that a pure divisional/brigade allocation left no units to provide area general support. She questioned how pure divisional units could provide all of the CONUS support that the MEDEVAC units provided. She discussed the evolving doctrine that required MEDEVAC to be available for a much larger patient base, such as joint/coalition forces, Department of Defense personnel, contractors, and local populations as opposed to just providing for the parent divisions. She highlighted all of the almost uncounted missions that MEDEVAC units performed domestically, such as the hugely successful MAST program. How would all of that be provided for with small units focused on a divisional identity? She patiently explained to them the key role that the helicopters and crews played in the medical continuum of care. She buttressed all of her points with reports from the 36th and 56th Medical Battalions and the 50th, 54th, 57th, 82d, 126th, 159th, 507th, 571st, and 1042d Medical Companies detailing their experiences in ongoing operations in Iraq and Afghanistan. She was now deeply concerned that the path that the working group was drifting toward would restructure the MEDEVAC force into one incapable of meeting current or projected mission requirements.

Lockard also showed that the concept of the GSAB was flawed. Under the current 15-ship Medical Force 2000 structure, an air ambulance company could essentially operate independently as long as it could locate with a larger aviation unit for logistics support. In being assigned to a GSAB, the MEDEVAC company's support elements would be dramatically reduced, and it would not be able to deploy independently. It would need to deploy with the GSAB properly to operate. Lockard argued vehemently against these proposals. She said:

> This was briefed over and over again, yet the aviation community really felt that they could put their arm around us and do a lot more of the management, consolidate the maintenance, do some other type of organizational structure changes that would work better for us all, and keep the modularity or the transformation going ahead.
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> …I can give them all of these "what if" situations and I can create so many vignettes and give them examples of how successful MEDEVAC has been and how well we worked together in Somalia—that I wasn't *assigned* to aviation, I was *attached* to the maintenance and logistics. But I had the operational control by the medical field because we knew where to go when. We were tied at the hip to the evacuation process from the guy on the ground to the aid station to the hospital. We weren't just an aviation element calling a taxicab.[18]

Lockard asked Heintz for his thoughts on how to proceed. He believed that the study group had purposely been stacked with aviators who both outnumbered and outranked the MEDEVAC attendees. He also felt that Cody, the G-3 on the Department of Army staff, supported moving MEDEVAC into aviation and closely watched the efforts of Task Force Aviation through his close relationship with Sinclair. Cody had served in the 101st Division on several tours, including as the division commander, and thought the example set by the "Eagle Dustoff" was the proper way to organize MEDEVAC. Heintz, in turn, did all he could as the consultant to explain the issues to The Surgeon General and his contacts throughout the MEDEVAC community in an attempt to sway the arguments. Heinz had even suggested to the Surgeon General that failure to fight this proposed change to doctrine was tantamount to abdicating fundamental Title 10 responsibilities to properly and responsibly clear the battlefield. Heintz also enlisted the support of MEDEVAC Medal of Honor recipient, Maj. Gen. (ret) Pat Brady, to petition the senior Army leadership to reconsider these recommendations.[19]

The aviators on the working group listened politely to Lockard, but the 12-ship proposal under GSAB and aviation was written into the transformation package. She noticed that she was being left out of more and more meetings and—on several occasions—was told that she was "too parochial" in her views.

Fristoe also became involved as much as he could in the discussions. As a relatively young officer, he did not have much influence with the group. He was challenged on several occasions to produce hard data showing the efficacy of the 15-ship company or to buttress the Lockard's arguments. He could not find the information and concluded that it did not exist. Fristoe remembered that "Every time we brought up a course of action or potential change, anything at all, the response was 'until and unless you have the data, you are being parochial. You need to just get on board, just be part of the team.'" In a more candid moment, an aviation colonel pulled him aside and told him:

> You guys are doing the right things. What's not happening is your leadership isn't engaged. You're right; you guys got the mission right. It's just that your leadership is not engaging; that's why you are losing this battle. But we are not going to say anything; we have our marching orders.[20]

Neither he nor Lockard could do anything about that. She did feel that the working group had been stacked to achieve a preordained outcome. But she did persevere. In another session, Lockard pointed out that recent events in Iraq reconfirmed that MEDEVAC was communications intensive. Every patient had a unique condition requiring different and perhaps specialized medical care that could require intense and focused communications that had no business being passed through aviation C2 channels because the pure volume of calls could block out all else.

Both she and Fristoe also realized that the reassignment of the MEDEVAC companies to the GSABs would eliminate the rationale for the medical evacuation battalions. They tried to argue the key role that the battalions played in

orchestrating the overall evacuation process and providing for medical regulation. Again, however, they were dismissed as being too parochial. Sinclair believed that recent operations in Iraq showed that the MEDEVAC units did not have the necessary connectivity under the medical evacuation battalions to maintain the situational awareness to operate over the modern battlefield. The personnel billets in the medical evacuation battalions could be reprogrammed into the proposed new aviation force structure.[21]

Sinclair also believed that the MEDEVAC company commanders exercised far too much launch authority and were not in compliance with Army standards. He said:

> Per Army Regulation 95-1, an extremely high risk mission has to be approved by a general officer; high risk has to be approved by an O-6. In the MEDEVAC world, they were delegating that down to captain level. I understand that they have experience but there was a lot of concern because as a result, you had, for example, these single ship MEDEVAC missions going out into combat areas where there was heavy fire.[22]

One of the aviation officers also suggested that all 67Js should be "re-branched" into aviation with a specific 15 series AOC sub-identifier. Lockard and Fristoe responded vigorously and argued vehemently for the 300 plus 67J MEDEVAC officers and the unique training and knowledge of both medicine and aviation that they possessed. Fristoe recalled:

> There was discussion about just making [the 67J] a 15 Series with additional skill identifier for MEDEVAC, but we carried the day because the way we are tracked in the Medical Service Corps, we all have secondary [area of occupational concentrations]. They can be logisticians, they can be comptrollers, they can be health care administrators, they can be all sorts of stuff. The AMEDD's position was: "We can't afford to lose that; those secondary AOC [area of occupational concentration] areas of expertise and functionality within the structure." The whole health care system would collapse if we just all of a sudden one day said, "All of you [67Js] now belong to aviation."[23]

Lockard had a one-on-one discussion with now Maj. Gen. Thurman and obtained his support to keep the 67Js unique and in command of the companies. Deputy Surgeon General, Maj. Gen. Kenneth Farmer, who also discussed this issue with Cody, supported Lockard in this effort. However, the question of career development opportunities for the 67Js as aviators beyond company command if the medical evacuation battalions were inactivated was not discussed.

Fristoe sculpted a concept to assign the MEDEVAC companies to the aviation brigades as separate units that would have retained the unit structure and autonomous operations capability. As such, the companies would have retained their distinctive "AA" suffix unit identification codes that allowed them to be individually tracked by the AMEDD. Fristoe felt that this was absolutely critical for continued medical oversight of the units, but did not get support from senior medical officers to fight for this issue.

Lockard took a different tack and suggested that the best way to integrate MEDEVAC into aviation was to attach rather than organically assign the MEDEVAC

companies to the aviation battalions and brigades. She stressed that it was simply the best way to combine the best of medicine and aviation. In analyzing this action, Fristoe did not think it was a viable option. Sinclair listened to the presentations, but neither suggestion was accepted.[24]

Reluctantly, Lockard realized that among the aviation officers who ran the task force a historic assumption that MEDEVAC belonged under aviation existed. The opportunity to absorb it when the branch was created was missed. She later lamented that:

> I think it has been a theme. If you go back in time with Tom Scofield, all the way back to when they wanted us to be in aviation branch, there has always been a certain intent by the aviation community that MEDEVAC needs to belong to aviation. Some people will say they agree with it and some will say "No, don't." But I will say the current leadership that we had during the current transformation process versus the leadership that we had during the '80s had a different opinion and the current leadership felt strongly that MEDEVAC should be part of aviation, and that aviation branch guys can command a MEDEVAC company. MEDEVAC should just be one of the many missions associated with aviation. Just like picking up bullets and supplies and milk and water. And that they can manage it; they can operate it; they can send it out where they need to; they can command and control it. …In some people's minds, they think that this would be more efficient—to have MEDEVAC under aviation. …It looks great on Power Point slides.[25]

Still not ready to concede, Lockard pointed out that making the MEDEVAC units letter companies under aviation battalions required them to give up their medical identities and lineages. The MEDEVAC veterans groups had also heard about this potential change and were distressed about such a dramatic step. Fristoe raised this issue more than once. He and Lockard were again told that they were being "parochial" and that the redesignation of the companies as aviation units was not a subjective decision, but just the way the Army organizes and operates. The same thing was happening to most of the air cavalry units that were also being realigned under aviation. The new designations would be determined by the Army Center for Military History that maintained unit lineages and designations. This was a bitter pill to swallow because—as separately identified companies—most of the units had long and distinguished heritages reaching back to Korea. All of that would end as the MEDEVAC units inactivated and their personnel and equipment were reassigned to letter companies in the GSABs.[26]

Lockard and Fristoe frequently briefed the Surgeon General, Lt. Gen. James Peake or his deputy, Farmer. Peake's attitude was, "If it isn't broke, why fix it?" On a few occasions, he and Farmer weighed in as they could on the issues, although they were dealing with other huge battles concerning transformation initiatives for other medical units and ever increasing numbers of critically wounded soldiers filling Army hospitals. As she continued to struggle with the working group, Lockard was overwhelmed with a growing sense of inevitability about the outcome. The 12-ship company under GSAB and aviation control stayed in the aviation transformation package with all of the other decisions about the reorganization of attack, lift, cargo, and scout aviation units. All of that then became subsumed in the overall modularity package.[27]

Report

The Army Aviation Task Force Study Report was completed and submitted in early November 2003. The report, which exceeded 140 pages, was restricted in distribution and included numerous recommendations that affected the entire aviation community. Only a few pages addressed MEDEVAC. The results were as Lockard had feared.

In response to the Chief of Staff's tasking, the Aviation Task Force conducted a comprehensive review and assessment of aviation forces, considered different courses of action, and developed recommendations for the development of a new aviation modernization plan to support the Army as it continued to transform into the future force. One of the recommendations was to "Consolidate Aviation Proponency for MEDEVAC aircraft and make MEDEVAC units organic to the Aviation UA [units of action] with an SRC of 01." That recommendation would presumably improve capabilities, flexibility, maintenance, safety, standardization, airspace management, and resourcing. AMEDD would retain proponency for special mission equipment. MEDEVAC companies would reduce from 15 to 12 aircraft and be removed from the medical chain of command. Proposed personnel reductions could reduce the MEDEVAC company to as few as 50 soldiers. The heritage MEDEVAC units would be inactivated and their assets and personnel would be used to create new companies that would then be identified as subordinate letter companies of GSABs.[28]

Decision

In reviewing the report, Schoomaker approved much of it, including the MEDEVAC portion, stating that, "Army aviation has more potential than any other branch—we just have not maximized its potential. My commitment to you is we are going to make Army aviation the best damn outfit on the battlefield. We owe it to our soldiers, our Army, and the nation." The report reaffirmed the restructuring of MEDEVAC units with 12 aircraft and their reassignment from medical to aviation command. It also directed the task force to develop an implementation plan and develop a charter for overall MEDEVAC proponency.[29]

The Surgeon General, Lt. Gen. Peake, was not happy with the result. At Lockard and Fristoe's suggestion, he met with Thurman and Sinclair on 18 December. A subsequent memorandum from Peake to Thurman, with a copy to Cody, captured the issues:

- Proponency;
- Future structure design;
- Mission; and
- Resourcing implications.

Peake agreed to share proponency, with the AMEDD responsible for doctrine, organization design, force structure development, AMEDD personnel

management, and the issues that were fundamental to the mission set for patient evacuation. Aviation would be the proponent for aviation training, aircraft procurement and modernization, airspace coordination, maintenance, logistics, safety, and standardization.

Operationally, the MEDEVAC companies had to be fully integrated into the aviation scheme of maneuver to operate safely and with the same standards as the aviation troops. Organization of the units and proper command and control required another look. The MEDEVAC companies needed to remain as SRC 08 [medical] units versus SRC 01 [aviation] units. Placing the MEDEVAC units under the aviation brigades addressed the support requirements, but there still needed to be medical command and control in the linkage because MEDEVAC clearly remained a part of the integrated medical support to the force.

Peake addressed the 50th Med Co (AA) of the 101st Division as an outstanding example of a unit directly supporting a division. He also pointed out that it relied on varying levels of aeromedical evacuation support from corps-level assets at different phases of current operations, especially for missions outside of division boundaries or for support of joint or coalition partners. He also, again, pointed out that direct support units could not provide general support to other units at the same time. Other SRC 08 MEDEVAC units not under division control could provide for all of these needs.

Peake did not support the 12-ship proposal for the four-brigade division. He did support procuring a new light utility helicopter to be assigned to Table of Distribution and Allowances units so the UH-60s could be freed up for assignment to Modified Table of Organization and Equipment units. He also asked if UH-1s could be used in Kuwait—again—to free up UH-60s for service in the higher threat areas.

He once again stressed the critical role that MEDEVAC played in the continuum of care and mentioned that the U.S. Army MEDEVAC force was always in high demand and the envy of the world.[30]

Implementation

Task Force Aviation now switched functions and transformed into a series of implementation conferences. Lockard, Joy, and Fristoe stayed engaged as Medical and Aviation Branch staffs began to work through the various residual issues.

Still not satisfied with the flow of events, Peake wrote a memorandum for Gen. Jack Keane, the Army Vice Chief of Staff, on 5 February 2004. Keane had supported keeping MEDEVAC under the AMEDD. In Peake's memorandum to Keane he expressed his continuing concerns about MEDEVAC, emphasizing that, "The mission of clearing the battlefield and providing en route care is intrinsically and fundamentally a medical mission and not simply transportation. It is integral to maintaining the continuity of care, and its retention within the medical battlefield operating system supports the principles of unity of effort and command."[31]

Peake indicated that since the Medical Reengineering Initiative of the 1990s FSMTs were formed and deployed far forward to support maneuver elements or

in general support for echelons above division in support of joint/combined tasking or even domestic support operations. Current MEDEVAC company structure provided a small support package to go with each FSMT. Under the GSAB, those packages would be lost and such support would have to come out of the battalion. If the battalion was supporting multiple aviation operations, then MEDEVAC support could suffer.

Under the proposed plan, overall theater coordination of MEDEVAC would also suffer because there would be no one headquarters like the existing medical (evacuation) battalions to provide it. The proposed reorganization would necessitate the creation of a medical operations cell to augment the aviation brigade staff to provide for overall coordination and synchronization so that casualties could be moved, tracked, and regulated as expeditiously as possible.

Peake also indicated that no evidence suggested that flight safety would improve with the reassignment of MEDEVAC units to aviation. He cited statistics for fiscal year 2003 showing that the Army rotary-wing community suffered Class A, B, and C accidents at significantly higher rates than the MEDEVAC community, specifically:

Rate of Accidents per 1,000 Flight Hours in UH-60A/L Aircraft

		MEDEVAC	Nonmedical
Overall			
	Class A	.03067	.11873
	Class B	.01533	.07476
	Class C	.09200	.29024
Operation IRAQI FREEDOM			
	Class A	.08880	.37802
	Class B	.00000	.11937
	Class C	.08880	. 37802[32]

Peake was very passionate about MEDEVAC for personal reasons. As a young lieutenant in Vietnam, he had been wounded and then evacuated by a MEDEVAC helicopter and he retained vivid memories of that event. In a later interview, Peake recalled that as he was being flown out, he could still remember the calming effect of the morphine and the smell of the secretions from the patient in the rack above as they dripped down onto him. As he watched the ATI process move forward, though, he finally conceded that, "I don't have any heartburn about it [MEDEVAC] being part of the aviation brigade."[33]

For the most part, his concerns were disregarded, as Task Force Aviation continued to transform aviation. On 4 March 2004, Thurman briefed the results of his overall review of Army aviation to the Tactical Air and Land Forces Subcommittee of the Committee on Armed Services of the U.S. House of Representatives.

Citing his derived tasking from Schoomaker, he explained the results of his review and stated:

> We need to have trained, standardized modular units that are fully connected to the combined arms team and joint forces…Army aviation is a unique combat element whose requirements extend across all Joint Functional and Operating Concepts. The task force analyzed required capabilities from Joint doctrine down to company level in order to develop a basic building block for units. These company building blocks permit the creation of a truly capable Aviation Unit of Action (UA) with standardized formations. Aviation UAs are multifunctional aviation brigades that will support four to five brigade combat teams. The Aviation UA incorporates the lessons learned from recent operations and corrects deficiencies in our current structure by moving aviation assets closer to the warfighter.
>
> The Aviation UA is able to organize by task, purpose, and mission…Combat medical evacuation aircraft are directly organic to the aviation brigade commander to better support our forces…We developed a Brigade Aviation Element (BAE) organic to every ground maneuver unit equipped with long range joint communications packages to better synchronize and deconflict airspace for responsive planning and execution of combat operations.[34]

Included in the briefing were the plans to include within each divisional aviation brigade a GSAB that included the 12-aircraft MEDEVAC company equipped with UH-60s that would be modernized as the overall aviation fleet was modernized. ARNG divisions would also convert to the 12-aircraft companies, although many would be equipped with UH-1s, and overall plans were not yet firm.[35]

Three weeks later, Fristoe briefed the plan for transforming the MEDEVAC company to the implementation committee. Heretofore, the company had 15 aircraft, organized into three FSMTs with three aircraft each, and an area support section of six aircraft. The FSMTs would directly support tactical units while the area support section would provide back-haul or area coverage on a general support basis, or could provide spare aircraft for the FSMTs if one of their assigned machines was down for maintenance. The company also had its own refueling trucks and troops and an Aviation Unit Maintenance section that could perform all unit level maintenance and provide small support teams to move forward with the FSMTs. The unit was manned with 10 officers, 26 warrants, and 113 enlisted troops. Its basis of allocation was one company per division.

The proposed 12-ship company was much leaner. Still allocated as one per division, it provided three aircraft each for four FSMTs that would directly support the four Brigade Combat Teams being fielded by each division. It did not have an area support section, and its total manning was only 85 soldiers, consisting of 10 officers, 25 warrants, and 50 enlisted troops. The company no longer had refueling trucks or troops or an Aviation Unit Maintenance section; both would have to be provided by the parent GSAB.[36]

Still working with the ARNG Command Surgeon, Goforth watched the unfolding ATI process with some dismay. He was beginning to understand the significant challenges that the process presented to the ARNG MEDEVAC community. The realignment of units from 15 to 12 aircraft would cause wholesale reorganization issues for almost all ARNG units as they realigned their company commands and detachments to meet federal and state missions. Many MEDEVAC units were

commanded and staffed with aviation officers on waivers instead of 67Js because of personnel recruiting challenges. Many of those officers were receiving bonuses for their MEDEVAC duty. Goforth was concerned that these bonuses might now be at risk. These issues and many more would have to be resolved as ARNG units were activated for overseas duty and backfill at CONUS bases for deploying active duty units.[37]

Through the spring months, Lockard and her compatriots continued to work with the implementation committee as they slowly worked through the intricate details. In March, she prepared a package for Cody requesting that the AMEDD be allowed to retain proponency of the MEDEVAC units and the 67Js and 91Ws. He approved the requests that meant that the MEDEVAC units would continue to be identified as SRC 08 instead of SRC 01 units and the AMEDD could properly manage its specialized personnel.[38]

In May, the committee crafted a compromise charter agreeable to the AMEDD and the Aviation Branch/U.S. Army Aviation Center (USAAVNC). The document delineated responsibilities for each organization, specifically:

AMEDD

1. Develop the organizational design (SRC 08) air ambulance organization to support command and control and evacuation requirements. Present change to design within the Force Design Update process.
2. Develop medical doctrine that supports the Combat Health Support System to include roles and responsibilities in joint and coalition environments.
3. Retain personnel proponency for AMEDD personnel (91W and 67J MOS/AOC). Command aeromedical evacuation companies with O4/67J. Establish training and medical mission manpower requirements.
4. Develop field manuals supporting integrated health care operations in a joint, interagency, multinational theater of operations.
5. Be responsible for AMEDD-specific mission/equipment package development and training. Coordinate with the USAAVNC and vice versa, regarding materiel requirements (airframe, medical and nonmedical support, communications requirements).
6. Conduct the essential medical training course (2CF7) for aeromedical evacuation personnel. Include in the course the training on appropriate subjects in medical evacuation doctrine for commissioned, warrant, and noncommissioned officers.
7. Develop an Aeromedical Evacuation Operational and Organizational Plan that fully integrates medical evacuation operations within the Aviation Operational and Organizational Plan across all echelons of care.

USAAVNC

1. Integrate medical doctrine into USAAVNC Operational and Tactical Doctrine and Operational and Organizational Plan for full-spectrum operations.
2. Develop aviator and nonrated crewmember training programs and associated training documents except for those skills specific to AMEDD personnel.

3. Provide leadership development of Aviation Branch Military Occupational Skill/Career Management Field (less 91W & 67J).
4. Determine (proponent-specific) materiel requirements and input to modernization strategies/plans for aviation systems. Implement emerging aircraft requirements to include AMEDD and medical mission support/equipment package requirements.
5. Incorporate aeromedical evacuation organizations, medical doctrine, and operations into all aviation safety and standardization documentation and training.
6. Develop appropriate aviation field manuals outlining/supporting integrated aviation operations.
7. Develop operational and organizational plans that integrate aviation operations within the full spectrum of operations. Implement AMEDD employment concepts for aeromedical evacuation ensuring the continuity of health care functions and medical base operating systems from the tactical to strategic levels (levels 1–5).
8. Coordinate with other Army proponents providing vision and set the foundation for aviation operations within the Army.[39]

The charter went through a few more iterations before it was finally approved by Gen. George Casey, the Army Vice Chief of Staff, on 14 May 2004.[40]

In April, Peake tried to raise once more the contentious issue of unit identification and status reporting. Statutorily, he was still obligated to maintain visibility of the readiness of his medical units. Aviation had agreed to allow the MEDEVAC companies to retain their SRC 08 designations. However, the decision to reorganize and identify the units as letter companies of the GSABs was final. His request was not honored. The units would be inactivated and reconstituted as letter companies of the battalions even though they would still be coded as SRC 08 units.[41]

Post-Decision Debate

In July 2004, Lt. Col. (P) Dave MacDonald joined the OTSG staff as the Deputy Chief of the Force Management Division, with a follow-on assignment to replace Lockard as the Director of the MEPD. Unlike her though, he would move to Fort Rucker.

Settling into his assignment on the OTSG staff, he reviewed the progress of the ATI and felt compelled to write a magazine article about the dramatic changes about to unfold. Titled "Is MEDEVAC Broke?" his article took that open-ended and oft-repeated question and turned it on its head, stating peremptorily, "The perception that the MEDEVAC system is broken is misguided and unfortunately shared by many non-medical military professionals who do not understand the medical evacuation system. The fact is MEDEVAC professionals have executed their missions superbly, despite being under-resourced since aviation became a branch of the Army in 1983."[42]

Col. Dave MacDonald in 2006.
Source: Author

He explained that MEDEVAC had proven to be a combat multiplier in every military action since Vietnam. From Operation URGENT FURY to IRAQI FREEDOM, it had proven itself a key component of a world class medical system that supported the young men and women sent into harm's way and was now seeing a 97% plus survival rate for wounded soldiers. MacDonald highlighted the role that MEDEVAC units played in supporting almost every humanitarian and peacekeeping operation that the United States supported, and indicated that in many cases, MEDEVAC teams were the first elements deployed. He also mentioned the almost continuous involvement of MEDEVAC units in domestic relief operations, base support, and the historical support for the still ongoing MAST program. MEDEVAC units did all of this while flying a mixed fleet UH-1 and UH-60 helicopters, maintaining an accident rate well below the Army average, and receiving a preponderance of commendable ratings on Army Resource Management Survey inspections.

Why then, he queried, was there such a negative perception of MEDEVAC? He offered two reasons:

1. There was a widespread misunderstanding of the MEDEVAC system and a misapplication of MEDEVAC assets by both the Army and the joint community. To support this, he stated that both communities consider MEDEVAC to be a solely Army asset designed to support primarily Army missions and other service components secondarily. The reality was that

Army MEDEVAC was a core competency that supported the full spectrum, interdependent, joint and coalition fight in a theater of operations as defined by current joint and service doctrine. Its patient load could consist of joint or coalition forces troops, displaced civilians, enemy prisoners of war, or personnel from interagency, nongovernmental, or civic organizations. Army MEDEVAC was part of the intra-theater joint patient movement system, as directed by Joint Publication 4-02.2. This misunderstanding resulted in the failure of planners to integrate Army MEDEVAC into the theater joint patient movement plan. Consequently, Army planners only focused on Army requirements while overlooking the larger theater requirements. This disconnect appeared in both Operation ENDURING FREEDOM and Operation IRAQI FREEDOM (OIF).[43]

2. There was continual controversy over who should own and control MEDEVAC assets between Army aviation and AMEDD. This political posturing had been ongoing since the Aviation Branch was formed in 1983. Army leaders then recognized the inherently joint nature of MEDEVAC, and while the units had to coordinate and integrate airspace usage with both the Army and Air Force components, ultimate control of the mission had to remain under AMEDD to ensure evacuation (as part of the joint health care continuum) remained responsive to the needs of the wounded soldier or patient. Not understanding the evacuation part of the care continuum, senior Army aviation commanders attempted to reverse that decision, and this conflict has migrated down the command chain to tactical commander resulting in the misapplication of MEDEVAC assets.[44]

To correct these two problems, MacDonald suggested that the Army needed clearly to recognize that MEDEVAC was a joint asset that served the intra-theater joint patient movement system. Joint leadership needed to establish MEDEVAC requirements under the Joint Operations Planning and Execution System and request funding through the Joint Requirements Oversight Council as a separate funding line in the Army aviation budget.[45]

The January 2005 edition of the *Army Aviation Magazine* carried a quick response from Col. Bill Forrester, Chief of Staff, U.S. Army Aviation Center at Fort Rucker. Forrester had served with Sinclair as the commander of the 159th Aviation Brigade of the 101st Division during OIF. Without addressing MacDonald's specific criticisms in any methodical way, Forrester mentioned that the modern battlefield was now a complex place, and, "The days of receiving a call for help and blindly launching in haste to save lives are truly over." He stated that MEDEVAC had a history of being logistics poor and always needed the fuel, maintenance support, intelligence, and tactical and operational awareness best supplied by the aviation battalions and brigades. The Army aviation plan to integrate fully the medical evacuation mission with the commander's scheme of maneuver and link them in through the brigade aviation elements was well founded from lessons learned from earlier conflicts and analysis of future fights. It was time to move into the future as a team, and not keep a parochial

point of view.[46]

As Heintz had requested, Brady, perhaps the patriarch of the MEDEVAC veterans, had followed the transformation efforts and increasingly fractious debate and had been active behind the scene contacting senior officers. In reading Forrester's comments he felt compelled to respond in an open forum.

Responding also in the *Army Aviation Magazine,* he stated, "There is not enough room in this magazine for me to say all that came to mind when I read Col. Bill Forrester's letter... [that] MEDEVAC … is not on track." He recalled his own experiences in Vietnam and had to wonder if the spirit of Charles Kelly was even being considered as MEDEVAC was being transformed. Lambasting Forrester for saying that MEDEVAC crews were prone to "blindly launching in haste," he indicated that Forrester's reference to "haste" suggested rash action. Brady turned the reference into a positive notion of rapid to swift action. He then completely reversed the argument back against Forrester by saying:

> The most serious 'rash action' that can occur during patient evacuation is when anything or anyone interferes with the patient's needs and the swiftness of evacuation. In his entire dissertation of bureaucratic changes, Col. Forrester does not mention patient needs once. And that is the question that should be at the foundation of any changes to the method of Dustoff…
>
> Col. Forrester opines that the aviation battalion is the answer to Dustoff missions, mission understanding, maintenance, and operational awareness. I never met a non-Dustoff aviator who understood my mission better than I did. But more importantly, what does assigning Dustoff to the aviation battalion do for patient's needs? I would bet that it will not add to the swiftness of launch, essential in life saving…Is Dustoff not performing? Have patient needs changed?
>
> If Col. Forrester represents current attitude, I sense the beginning of the end of Dustoff and I fear the patient will be the worse for it.[47]

This three-legged discourse was a recapitulation of the classic debate about MEDEVAC. Is it medicine or aviation? MacDonald, in arguing about the expanded patient load directed by joint doctrine and ongoing operations, addressed the larger medical imperative. Forrester, in arguing about the exigencies of operating over the modern battlefield and addressing the logistic needs of the MEDEVAC units, argued about the pressing realities of the physics of aviation. Brady brought the debate to a higher level. He slid by both of their arguments and asked plaintively, "What about the patients needs? Have patient's needs changed?" To him, the argument was misplaced. It all had to be about doing what was best for the patients out there who needed to be cared for. That simple but powerful and even eloquent statement came from a man who knew intuitively and instinctively what MEDEVAC was all about and had perfect moral authority to make it.

However, the decisions had been made, and the transformation committee continued to meet and work through the issues. The template for the new GSAB was drafted. The Table of Organization and Equipment (SRC 01305G100) called for 531 soldiers organized into a headquarters and headquarters company, a command aviation company equipped with eight UH-60s, a heavy helicopter company

equipped with 12 CH-47s, a MEDEVAC helicopter company assigned 12 aircraft, an intermediate maintenance company, and a forward support company. The additional personnel for these units were drawn in part from the manpower positions taken from the MEDEVAC companies. It was commanded by an aviation branch lieutenant colonel.

One of the first units to be so reformed was the 2d Battalion, 4th Aviation Regiment, assigned to the Aviation Brigade of the 4th Infantry Division at Fort Hood, Texas. Its MEDEVAC company was designated Charlie Company of the 2d/4th (C/2d/4th). It would be formed from the personnel and equipment taken from the soon to be inactivated 507th, which had so ably supported the 3d Infantry Division in the attack to Baghdad.[48]

Lockard realized that the fight was lost, and she just had to live with the decision. Subsequently, she moved into another job in Health Care Operations until retiring in 2006. MacDonald replaced her as the Director of the MEPD. Shortly after leaving Task Force Aviation, Joy returned to Fort Rucker and submitted his retirement papers. Lt. Col. Glen Iacovetta replaced Joy. Iacovetta inherited numerous issues generated by the ATI. Joy finally hung up his uniform on 1 December 2004 convinced that it was he more than anyone else who facilitated the transfer of MEDEVAC from medicine to aviation.[49]

The response within the MEDEVAC community was predictable. Those still serving were shocked and dismayed but resolved to carry on and do what they were told. But the seeds of bitterness were spread far and wide.

The Death of Maj. Gen. Spurgeon Neel

As these events occurred, the MEDEVAC community suffered a personal loss on 6 June 2003, the 59th anniversary of the allied landings on Normandy Beach in France in World War II, when retired Maj. Gen. Spurgeon Neel, widely recognized as the "Father of Army Aviation Medicine," and unarguably the patron saint of MEDEVAC, died of complications from pneumonia in San Antonio, Texas. He was survived by his wife of 63 years, Alice Neel. Widely recognized for his pioneering work in and tireless advocacy for MEDEVAC, he had also been the first Army Aviation Medical Officer and first commander of the Health Services Command. After his retirement, he remained active in Army medical affairs and was inducted into the U.S. Army Aviation Hall of Fame and the DUSTOFF Hall of Fame. He was buried under a bright Texas sun in the Fort Sam Houston National Cemetery, amidst a very large gathering of family, friends, and admirers.[50]

Unit Transformation Plans

After Schoomaker approved the plan for the aviation transformation, the Army staff published the list of estimated dates for inactivation of the legacy units and activations of the new units as 12-ship companies.

Unit	Inactivation Date	Activate as Unit/ /battalion/regiment	Location
377th	16 May 05	C/2d/52d	Korea
507th	16 Jun 05	C/2d/4th	Fort Hood
542d	16 Feb 07	C/6th/101st	Fort Campbell
57th	30 Sep 07	C/1st/52d	Fort Wainwright
498th	16 Jul 06	C/2d/3d	Fort Stewart
82d	16 Jul 07	C/2d/501st	Fort Riley
50th	16 Feb 07	C/7th/101st	Fort Campbell
571st	16 Jun 06	C/2d/227th	Fort Hood
54th	16 Jun 06	C/3d/82d	Fort Bragg
159th	16 Sep 07	C/3d/10th	Fort Drum
236th	16 Oct 06	C/1st/214th	Landstuhl
45th	16 Mar 07	C/5th/158th	Wiesbaden
68th	16 Jun 06	C/3d/25th	Wheeler

The five U.S. Army Air Ambulance Detachments at Forts Rucker, Drum, Irwin, Polk, and Soto Cano, Honduras, would remain as they were. The actual dates of inactivation and activation were preliminary and varied as operations continued in Kosovo, Iraq, and Afghanistan.[51]

The ARNG units would also transform and relinquish their heritage unit identities. Proud designations such as the 24th, 86th, 112th, 126th, 149th, 717th, 1042d, etc., would likewise be replaced with Charlie Company designations of GSABs. For them, too, the actual dates varied, and many would also change missions as regularly happened with ARNG units. Additionally, detachments from individual states would be realigned into new pairings to make up the 12 aircraft UH-60 companies.

Unit/battalion/regiment	Activate on	State(s)
C/2d/104th	1 May 06	West Virginia, Tennessee
C/2d/149th	1 Jun 05	Texas, Oklahoma
C/1st/111th	2 Oct 05	Florida, Arkansas
C/3d/238th	1 Jun 05	New Hampshire, Michigan
C/1st/189th	1 Jun 05	South Dakota, Montana
C/1st/168th	1 Jun 05	California, Nevada
C/2d/211th	1 Oct 05	Minnesota, Iowa
C/3d/126th	1 Jun 05	Vermont, Massachusetts
C/1st/126th	1 Oct 05	Maine
C/2d/238th	1 Oct 05	Indiana, Colorado
C/1st/169th	1 Oct 05	Maryland, Pennsylvania, Kentucky
C/5th/169th	1 Oct 07	Wyoming, Arizona
C/1st/171st	1 Oct 07	New Mexico, Kansas
C/7th/158th	1 Oct 07	Oregon
C/2d/135th	1 Oct 05	Nebraska, Colorado[52]

Four ARNG legacy units would maintain their heritage designations and remain equipped with UH-1Vs. They would remain as the base generation force and would eventually be reequipped with a new light utility helicopter yet to be selected and procured. The four ARNG legacy units were:

Unit	State(s)
148th Med Co	Washington, DC, Delaware
249th Med Co	New York, Rhode Island, New Hampshire
812th Med Co	Louisiana, California, New Mexico
832d Med Co	Wisconsin, Georgia, North Dakota[53]

The ARNG units were equipped with 180 UH-60s — mostly -As but with a few -Ls, and -Qs — and almost equaled the 18 active duty units equipped with 192 UH-60s and 26 UH-1Vs. Additionally, consideration was given to reactivate several U.S. Army Reserve (USAR) MEDEVAC units based on demographic studies and the availability of new UH-60Ms.[54]

From their introduction into the MEDEVAC force in the 1950s, the Reserve Component units remain a vital part of the MEDEVAC community. They were not used in Vietnam, but they provided great service in all subsequent conflicts, the MAST program, innumerable natural disasters, and as backfill for active duty units. They are an integral part of the great MEDEVAC heritage.

Moving On

Most officers within the MEDEVAC community watched the developments with transformation very closely, realizing that it would dramatically affect their careers and possibly personal lives. When Lt. Col. Bob Mitchell's tour as the executive officer of the 1st Medical Brigade at Fort Hood ended in the summer of 2004, he took command of the 36th Medical Battalion (Evacuation) collocated at Fort Hood. The implementation committee was grinding through all of the steps necessary to carry out the transformation. As Mitchell watched, he realized that The Surgeon General would lose control of all of the MEDEVAC companies. He had hoped that the medical evacuation battalions would possibly be rolled up under the aviation brigades but was saddened to see that they would instead inactivate or transform to something else. Yet he had seen early on when he served with the standardization and evaluation team at Fort Rucker that MEDEVAC intuitively needed to be better aligned with aviation because of its need for operational and logistical support that could only be provided by larger aviation units.

He recalled that, "From my perspective … I was on a Department of the Army level inspection team. I can speak for them. I have grown up in this field where we just don't do things with the aviation side. And I don't understand that."[55]

He also felt that all of the key decisions had been made too quickly without considering the current combat deployment cycle for MEDEVAC companies and

GSABs. The companies and battalions that absorbed them were on different deployment schedules, and it would take several iterations of deployments to realign them so that they could deploy together.[56]

His battalion deployed to Iraq in December 2004 and replaced the 429th Medical Battalion (Evacuation), a USAR unit from Savannah, Georgia. Located at Tikrit, the 36th battalion was the only evacuation battalion in the country and provided general area support and command and control of the three residual MEDEVAC companies and two ground ambulance companies. The battalion worked closely with three different aviation brigades that had the MEDEVAC companies located with them.

Commander and staff of the 36th Medical Battalion (Evacuation) in Iraq in 2005.
Back row, left to right: Maj. Bill Howard, 50th Med Co (AA), Capt. Anne Garcia, 141st Med Co (GA), Maj. Terry McDowell, 498th Med Co (AA), Maj. Keith Farrar, 1159th Med Co (AA), Maj. Eric Rude, 571st Med Co (AA), Maj. Pete Lehning, 54th Med Co (AA), Capt. Craig Strong, 313th Med Co (GA), Capt. Nancy Ginas, Capt. Ron McBay, 128th Med Co (GA).
Middle row, left to right: 1st Sgt. Norris Thomas, 50th Med Co (AA), 1st Sgt. John Stonoha, 141st Med Co (GA), 1st Sgt. Alonzo Dixon, 498th Med Co (AA), 1st Sgt. Raymond Persinger, 1159th Med Co (AA), 1st Sgt. Joseph Cevesco, 571st Med Co (AA), 1st Sgt. Ruth Byner, 54th Med Co (AA), 1st Sgt. Mark Carlson, 313th Med Co (GA), 1st Sgt. Jennifer Pirtle, 1st Sgt. Eddie Henshaw.
Front row, left to right: Cmd. Sgt. Maj. Brian Fahl, 36th Med Bn, Lt. Col. Robert Mitchell, 36th Med Bn.
Source: Lt. Col. Robert Mitchell

Shortly after arriving, Mitchell met with all three aviation brigade commanders to determine whether any issues existed that required his attention. He also met with his MEDEVAC company commanders and explained that he expected them to work closely with the brigades. He directed them to place liaison officers in the brigade tactical operations centers and also attend their intelligence and standardization briefings and the daily battle update briefings. He said to his commanders, "If you are operating in their sector, you are going to listen to what they have to say. You have two daddies here. So balance them out commanders. You figure it out."[57]

To another MEDEVAC commander, he was more specific. "I want the 1st Cav [aviation brigade] to think they own you. That's the only way we can win this thing and do it right." The commander followed his orders, and Mitchell noticed that the brigade commander was—within a few weeks—"doing cheetah flips" about how the MEDEVAC unit was well organized and disciplined.

Mitchell had another reason for pushing his MEDEVAC commanders to develop stronger relationships with the aviation brigades and their assigned GSABs. He knew that when his battalion left Iraq in late 2005, it would not be replaced. Instead, the companies would then be formally assigned to those brigades and battalions. The overall theater MEDEVAC program would be overseen and coordinated by Lt. Col. Bill Goforth, who was assigned to the G3 on the staff of the Multinational Corps Iraq.[58]

Mitchell had his reservations about transformation but knew that the Army had made its decision and it was time to carry on. His 21 years as a warrant officer and then MEDEVAC officer had taught him that all of the issues would be resolved. He was well familiar with the arguments on both sides, but his bottom line was well formed. "This is about the soldier on the ground that is counting on somebody getting in there and getting him out. If we don't do that and do it right… somebody has got to be able to answer for that. [We will do] whatever it takes to make sure that this is done right." Pat Brady could not have said it better.[59]

Unit Inactivations

Then the MEDEVAC companies began to transform to their new configurations and identities. The proud 507th at Fort Hood was the first. On schedule in June 2005, the unit formed up for the inactivation ceremony. By now, the news of the transformation of MEDEVAC had spread throughout the Dustoff veterans' community. They were not in favor of such a dramatic change, especially the change in unit designations from their heritage designations to the relative anonymity of the Charlie Company of the whatever. They rallied to lobby as they could against the transformation. But it was just wasted effort.

They also showed up to witness the ceremonies. As the maroon guidon of the 507th Med Co (AA) was furled for the last time and cased, and the blue guidon of the Charlie Company, 2d Battalion, 4th Aviation Regiment, was unfurled, a low moan rolled through the veterans. To them, it was the personification of their worst dream. Their beloved MEDEVAC was finally being consumed by Army

aviation. It was something that they and their predecessors had fought since the very beginning, all the way back to the bitter conflict in Korea. They now knew that the battle was lost. It was a bitter pill to swallow.[60]

Operations

MAST

When the MAST program was first initiated, its original intent was to demonstrate the efficacy of aeromedical evacuation to the civilian community with the fervent hope that private companies would assume the task. The response was slow but inevitable. One example sprang forth in Missouri. In 1985, Colin Collins started Air Evac Lifeteam in the small town of West Plains. It eventually grew into an organization of more than 1,300 employees in 11 states, utilizing 64 operational sites that served more than 600 hospitals. Its fleet of 85 Bell 206 Long Ranger helicopters was rated as some of the safest and most reliable general aviation aircraft in the world. Since its founding, the company transported more than 120,000 patients. It is a testimony to the trailblazing efforts of the Army MEDEVAC community that set the example and the vision of Neel.[61]

As the operational tempo for Army MEDEVAC units increased after the events of 9/11, those units that had not been replaced by civilian agencies slowly backed away from their MAST commitments. In 2005, the controlling Army Regulation for MAST, Army Regulation 500-4, was not renewed, and Headquarters, Department of the Army, sent a field message stating:

> "Current Wartime sourcing requirement and the operational tempo of the Army's MTOE [Modified Table of Organization and Equipment] aeronautical evacuation assets exceed their capacity to perform installation MEDEVAC support. U.S. Army CONUS MTOE MEDEVAC installation support ceases O/A 1 Jun 05 or upon the demobilization of Reserve Component MEDEVAC assets currently providing support."[62]

Exceptions were granted for the Table of Distribution and Allowances U.S. Army Air Ambulance Detachment units at Fort Drum, New York; Fort Rucker; the National Training Center at Fort Irwin, California; the Joint Readiness Training Center at Fort Polk, Louisiana; and a few other training sites that these units directly supported. This directive did not direct the termination of MAST for the units in Hawaii and Alaska because they were not CONUS-based.

Under Army Regulation 95-1, Army MEDEVAC helicopters could still be used to transport civilian personnel when they were involved in rescues or were involved in major disasters or catastrophes that required lifesaving aeromedical evacuation.

The intent was clear. MAST, so long a customer of MEDEVAC services and the trainer of many MEDEVAC crewmembers, was slowly being overcome by events and supplanted by overriding priorities. It was not being terminated, but most effectively curtailed or perhaps more accurately—suspended—and the program's

potential for future service to the nation remains.

However, since its initial prototype flying in July 1970, the MAST program has been phenomenally successful. The MEDEVAC companies and detachments who flew the mission — active, USAR, and ARNG — logged more than 55,000 missions and more than 116,000 flight hours, carrying almost 52,000 patients and rescuees. It is a great part of the MEDEVAC legacy.[63]

Central America

In Honduras, the 1st Battalion, 228th Aviation Regiment, continued to serve as the U.S. Army aviation component of Joint Task Force (JTF) Bravo and occupied new permanent facilities built after Hurricane Mitch devastated the area. The attached MEDEVAC U.S. Army Air Ambulance Detachment was reequipped with new UH-60L aircraft and continued to support the task force in a multitude of missions:

- Support for counter drug operations;
- Civic action projects;
- Relief operations for natural disasters; and
- Classic patient recoveries and transfers.

Operations there by the men and women of the detachment are ongoing.[64]

Hurricane Katrina

Background. The next challenge for MEDEVAC came from another completely different quarter. The traditional beginning of the United States hurricane season is 1 June. All southeastern states have—at one time or another—been pummeled by these devastating storms and have developed contingency response plans in conjunction with various federal agencies and the military services.

The summer of 2005 was an average season with 10 named storms by mid-August. Using weather satellites in geosynchronous orbit over the Atlantic Ocean, The National Hurricane Center began tracking a tropical depression well east of Puerto Rico in mid-August. By 24 August, it drifted west to the Bahamas and formed into a tropical storm named Katrina.

Continuing to strengthen into a category 1 Hurricane with sustained winds exceeding 75 mph, it crossed southern Florida on the 26 August, causing localized flooding, some damage to buildings and homes, and 14 deaths. It then slowly traversed the Gulf of Mexico—gaining strength—on a generally westerly track. By 28 August, the storm was almost due south of New Orleans and had strengthened to a category 5 storm with winds exceeding 155 mph. All Gulf Coast states closely watched the storm and activated command centers and National Guard units. On 28 August, the storm turned to a northerly track and seemed to be headed directly for New Orleans. Top winds were 175 mph and recorded lowest air pressure was 902 millibars (1,013 is normal), one of the lowest recorded readings ever.[65]

Helicopters and crews from the 249th Med Co (AA), New York and Rhode Island ARNGs deployed to support recovery operations after Hurricane Katrina.
Source: Maj. Mike Charnley

As he watched the storm closely the State Army Aviation Officer for Louisiana, Col. Barry Keeling, began pre-positioning aviation assets on 25 August and directed his flying units to form a team of four UH-60s and two UH-1s to be

Arkansas ARNG UH-60 over New Orleans after Katrina.
Source: U.S. Army

Rooftop recovery by an Arkansas ARNG MEDEVAC UH-60 after Hurricane Katrina.
Source: U.S. Army

available to fly in the wake of the storm for immediate rescue operations. The next day he activated several command centers and established Task Force Eagle. It consisted of all state aviation and aviation support assets, and had the capability to command and control deployed ARNG units from other states. He also directed the full manning of all affected command centers and the deployment of fuel and support equipment to the Baton Rouge and Hammond Airports. The state also had flight facilities at Lakefront Airport and Jackson Barracks, both located on the north side of New Orleans. However, if massive flooding were to occur, neither might be usable.[66]

Keeling also requested aviation support from other states under the provisions of the Emergency Management Assistance Compact (EMAC). Created by Public Law 104-321, the EMAC was an agreement among 48 states, Washington, DC, Puerto Rico, and the Virgin Islands to provide assistance across state lines when any type of disaster occurs. It was first used effectively in Florida in 2004 when that state was swept by four hurricanes. Within hours of receiving Louisiana's request for help, several states activated their Army Guard units for deployment.[67]

Federal agencies and the military services were also beginning proactive actions to deal with the looming storm. First U.S. Army headquartered at Fort Gillem on the southeast edge of Atlanta, Georgia, primarily trained units for overseas deployment and utilization. Headquarters U.S. Army had also assigned First Army a secondary mission to be prepared to support disaster relief operations in the eastern half of the United States. The commander, Lt. Gen. Russell Honore, and his staff had been monitoring the storm for several days. On 25 August, he

directed the activation of the command crisis action team at Fort Gillem and the deployment of Defense Coordinating Elements, with senior Defense Coordinating Officers to Florida, Alabama, and Mississippi. Additionally, Honore made contact with the Adjutant Generals of the National Guard forces of Louisiana, Mississippi, Alabama, and Florida, to begin the steps necessary to coordinate the flow of federal aid into the states.[68]

All aviation units from the Louisiana ARNG, including the 812th Med Co (AA) with 12 UH-1V aircraft, were activated for the storm response. Initially, they worked primarily out of their flight facility at Esler Field near Pineville—in the middle of the state—but also operated from the Baton Rouge Airport and the Hammond Airport just north of Lake Pontchartrain. The 812th and its state brother unit, the 1st Battalion, 244th Aviation Regiment, were experienced in hurricane response, having been called out many times for the storms that either threatened or hit the Louisiana coast each summer and fall. Contingency plans were robust and well practiced.

On 28 August, Keeling deployed a special reaction team to the Superdome in New Orleans. This team acted as a forward command and control center for operations in and around the city. It was fully trained, having deployed six times already to the Superdome in support of civil authorities, two of which were for hurricanes threatening the city. Additional personnel, assets, supplies, food, and water were also deployed to the Superdome, the Naval Air Station at Belle Chasse, and the other sites activated earlier. By that afternoon, evacuees began to flock to the various centers and an estimated 2,500 were already at the Superdome.[69]

The storm made landfall near the mouth of the Mississippi River at 0500 on 29 August as a category 4 storm with maximum sustained winds of 150 mph. Six hours later, winds lessened to 125 mph sustained as the storm eye passed just a few miles east of New Orleans and slammed into southern Mississippi.[70]

The storm devastated the area. New Orleanians and suburb residents were ordered to evacuate, and the roads were packed as the populace fled to higher ground. But tens of thousands had also been trapped in the city. They sought cover from the hurricane winds and more than eight inches of rain at preplanned public shelters like the Superdome in the middle of the city, where an estimated 10,000 to 12,000 had gathered.

The worst was yet to come. As the storm moved off to the north and the citizens stepped outside to survey the damage, several key levees that could no longer hold back the storm surge and the massive amounts of rain broke almost simultaneously, and the city flooded. Within hours, whole neighborhoods were under water, in some places as much as 20 feet deep. Looting erupted, and police and national guardsmen tried to restore order.[71]

Sixty miles to the northeast, the Mississippi coastline had also been devastated. Ships and boats were swept up out of the harbors by the wind and storm surge and scattered through the cities and towns along the coast destroying structures wholesale. Even huge floating casinos were pushed up on the shore. More than 100 deaths were reported in the first few hours, including 30 at one apartment complex that was smashed by storm surge. All roads and rail lines were blocked,

all area airports were out of commission, and the electrical power grid and all phone service was completely disrupted.[72]

As the storm passed New Orleans, President George W. Bush signed a Declaration of Major Disaster that authorized federal assistance for Louisiana, Mississippi, and Alabama. Headquarters Northern Command directed both First and Fifth Armies to begin crisis response operations. Honore ordered his forward headquarters to move to Camp Shelby, Mississippi.

Response

As the winds died down, military forces in the area sprang into action. Helicopters from the 812th and 1st Battalion, 244th Aviation Regiment, were airborne from Baton Rouge. Several aircraft from the 812th had also pre-positioned at New Iberia located 60 miles west of New Orleans. From there, these aircraft intended to launch into the devastated area behind the storm as soon as it was safe to fly. The next morning before sunrise, an 812th crew composed of pilot Capt. Ryan Faulk, copilot 1st Lt. Stuart Maxwell, crew chief Sgt. Jeremy Miller, and medic S.Sgt. David Jacob launched from Iberia for rescue duties in New Orleans. They logged 11.5 hours in their hoist equipped UH-1V as they responded to the desperate scenes below that day. Unable to land because of the flooding, they hoisted 30 stranded people from the roofs of homes, apartments, and cars. That total included a family with six children and several wheelchair-bound elderly. To facilitate the recoveries, Jacob went down on the hoist several times to help the frightened rescuees. All were then flown to recovery centers where they received water, food, and necessary assistance.[73]

The Louisiana ARNG facilities at the Lakefront Airport and Jackson Barracks—both on the north side of New Orleans—were completely flooded and unusable. To the men and women of the Louisiana units, it was more than a mission—it was personal. "I was thinking about my community, New Orleans, my home. I was taking care of the people who are from here," said S.Sgt. Eugene Bordelon, a UH-60 crew chief.[74]

Helicopters of all services joined them as soon as they arrived as did any civilians who could get airborne to conduct immediate search and rescue operations. They joined a growing fleet of boats, both military and civilian, beginning to motor through the city. Recovery centers were activated at the Naval Air Station just south of New Orleans and the international airport on the west side of the city. Rescued personnel were dropped at these two sites or at the Superdome in the middle of the city. Navy SEABEE units located in the area also used their heavy equipment to clear roads and secure live electrical lines. All public utilities were nonfunctional as were all land phone and cell phone systems.[75]

By 1800, several state command and control elements were consolidated at the Superdome as a key part of Task Force Eagle. The "Eagle's Nest," as the command center was called, began an earnest effort to gain some control over 150 plus helicopters operating over the city and suburbs. Maj. Matt Brocato, the S-3 of the 1st Battalion, 244th Aviation Regiment, was in the Eagle's Nest with liaison

officers from several services. With several operable radios of varying capability, they—defacto—began tasking any helicopters that they could contact for rescue missions. Crews from their own units who were familiar with the city were given street addresses to fly to. Crews from other units were given geographical coordinates. Brocato and his team improvised a simple expedient for determining the location coordinates. When given an address for rescue, they logged on to the *Google Earth* website and obtained the converted coordinates that were then passed to the crews. Countless rescues were mounted this way. At one point, Brocato received a huge list of 911 calls for assistance. When the storm raged through the city, all of the cell phone repeater towers were knocked out. However, the calls had all been logged onto the receiving system. When the overall cell phone system was restored, all of those calls were forwarded in a continuous stream. Brocato was presented this huge list and began systematically using it to dispatch the helicopters.[76]

At one point, a controller in the Eagle's Nest received a call from a retired Army colonel in Mississippi. An elderly lady trapped in her home in New Orleans had contacted the colonel. A crew was dispatched and flew to the home. They did not see the woman. Upon checking, they determined that the woman could not walk. The crew landed the helicopter a block away in a parking lot. The crew chief and medic proceeded to the house, found the woman, and then got her aboard the helicopter for recovery. Such events—although varied in detail—were very common.[77]

Within two days the team in the Eagle's Nest had begun to work out an overall rescue and recovery plan, and began distributing the equivalent of an air tasking order to all units to better coordinate the effort. The next morning, Louisiana ARNG engineers turned the Superdome parking lot into a massive heliport, and helicopters began to move 24,000 accumulated evacuees out of the city and shuttle in arriving support personnel. Later that day, Northern Command directed First Army to lead the recovery effort and to establish JTF-Katrina. Honore complied, designating himself as the commander. Under the EMAC agreement, all ARNG aircraft in Texas, Louisiana, Mississippi, Alabama, and Florida were declared immediately available for disaster relief. Many were airborne within four hours of Katrina's passing, and in conjunction with aircraft from all military services and other governmental agencies, they converged on the disaster area, over-flying massive ground convoys of active duty, ARNG, USAR, engineer, military police, medical, and other assorted support and even combat units, plus comparable elements from the other military forces and governmental agencies. As they arrived they were organized under a series of task forces. Active forces and activated Federal Reserve forces were under the operational control of JTF-Katrina. National Guard units were under the operational control of the State National Guard to which they deployed. Honore and his staff had the huge challenge of coordinating the actions of all of the disparate task forces.[78]

On 31 August, Honore made his first visit to New Orleans. Surveying the death and destruction, he immediately determined that his mission priorities were as follows:

1. Search and rescue;
2. Life sustainment;
3. Medical support established in every parish (county); and
4. Communications.[79]

MEDEVAC Units

Literally while the General was speaking, the 498th Med Co (AA) deployed a team from its home base at Fort Benning, Georgia. Its six UH-60s, eight crews, and 28 support personnel arrived at the main airport at Baton Rouge, Louisiana, 35 miles northeast of New Orleans. All aircraft were equipped with hoists and all aircrew members were trained to use night vision goggles. However, the unit had recently returned from its second deployment to OIF, and none of its crews was qualified for or current for over-water operations.

Immediately upon arriving, they met with representatives of the 1st Battalion, 244th Aviation Regiment, of the Louisiana ARNG who were running aviation operations there under Task Force Eagle. Once briefed, the 498th crews launched and proceeded to New Orleans to commence search and rescue operations. The crews adjusted aircraft and crew schedules to maintain 24-hour operations. During the first week of recovery operations the crews performed 108 hoist rescues and 178 rescue missions, recovering 822 personnel. Additionally, they performed 65 resupply missions and moved 58 nonmedical personnel.[80]

Some of the missions flown were very challenging. On one mission, survivors were trapped in a building that was almost completely submerged. The only access was through a skylight. The medic used a jungle penetrator to break out the skylight to gain entrance and then evacuate the family. On another mission, a crew was operating at night with night vision goggles when a small light was spotted leaking out of a building almost completely submerged except for the roof. The flight medic was lowered by hoist onto a partly submerged balcony. He extracted the survivors and helped them to be hoisted aboard.[81]

The second week was not nearly as intense as the first seven days. Most missions flown were support sorties for the now massive ground elements and units in the area. The 498th returned to home station on 16 September as primary search and rescue operations terminated. The unit had flown 365 hours in the operation and recovered 917 personnel.

Much of what the unit did was ad hoc and required tactical and administrative flexibility. The 498th had neither an "official" assignment to nor connection with the 1st Battalion, 244th Aviation Regiment, but developed an excellent working relationship with it and other units at the Baton Rouge Airport to accomplish the mission. All unit commanders and supervisors were stretched to the maximum because they had to perform their supervisory duties in addition to flying missions.[82]

Joining the various elements at Baton Rouge was another aviation team from the 2d Battalion, 4th Aviation Regiment (GSAB), from Fort Hood. It included an

HH-60L from the C Company (formerly the 507th Med Co [AA]), which provided general support with the rest of the battalion. Capt. Cory Boudreau was the small MEDEVAC detachment leader. He recalled the team's first mission:

> On 2 September, CW2 Roderick Peterson and I departed Baton Rouge Airport en route to the Superdome. As we transited east along Lake Pontchartrain, the damage looked minimal until we crossed over I-10. We were both amazed at the water level and destruction. Houses were underwater as far as we could see. After the initial shock, we continued to the Superdome… There were numerous fires and more helicopters than we could count… There was no common air to air frequency to deconflict aircraft. Everyone was just under the rule of see and avoid… On our way to the Superdome, we saw hundreds of civilians with "HELP" signs written on their roofs and people who had cut through their roofs in order to escape… Nobody on board had ever seen anything like this and weren't sure what to do. There were so many we didn't know who to choose. We finally just … found [a needy person] and began hoisting. We sent [S.Sgt.] Gregory Givings, flight medic, down to get a woman who was sitting on the corner of her roof. She had cut out just enough room for herself to stand up and be seen. She was very distraught and very excited to see Greg… We just crept along until we saw another person and started hoisting until we had a full aircraft. Once full, we were like "where do we take them?" There was no real plan. We just watched other aircraft and had heard through some of the traffic … about a place called the "Clover Leaf." It was the intersection of the highway that looked like a cloverleaf and was the dropoff point closest to the area we were operating. I thought we had seen the worst until we saw the cloverleaf. It looked like a refugee camp. I can't recall how many people were there but there were hundreds. The amount of people carrying their only belongings and the amount of trash made it look like a third world country…We did 25 live hoists and rescued 19 personnel. The hoisting was very demanding due to the congestion of aircraft, flying debris and trash, power lines, and the lack of any landing areas if something in fact did go wrong…[83]

Boudreau and his small detachment operated until 9 September. They did 57 live hoists in the first 72 hours and saved 70 people before returning to home station to rejoin their unit as it prepared for deployment to Iraq.[84]

Detachment 1 of the 146th Med Co, Tennessee ARNG, sent a small team of 11 personnel and two UH-60Q aircraft. Arriving on 2 September, they also staged out of Baton Rouge and joined the effort over New Orleans and the local area.[85]

At Fort Polk in western Louisiana, the effects of the storm had been minimal. MEDEVAC crews from the U.S. Army Air Ambulance Detachment were called upon for some local patient transfers. Prudently, though, the unit prepared for heavier duty. On 1 September, the unit was directed to deploy to the Hammond Airport, east of Baton Rouge. Upon arrival, the commander, Maj. Ed Zarzabal, set up a hasty command center, and crews immediately launched and headed for New Orleans, not knowing what to expect. Pilot CW3 Lori Russell remembered, "I felt nervous anticipation …not quite as many butterflies as a mission where gunfire may come into play (although there was a rumored possibility here), but the unknown always makes you a little more tense. As we flew into the [Super] Dome, you could see aircraft swarming everywhere you looked, like mosquitoes buzzing around. The next thing that hit you was the stench … a mix of rot and garbage in stagnant sewer water."

Russell and her crew flew several missions that day to pinpoint the problems and challenges and the location of the delivery and casualty collection points for

those rescued and recovered. Using conventional city maps, they literally flew down the avenues and streets to specific addresses to make recoveries. Every power line, pole, antenna, and tree was a threat. The ground and water were littered with loose material that was easily disturbed by the downwash of the helicopter blades. Many recoveries were by hoist. On several occasions, Russell and her crew had to improvise landing procedures in a field or on a roof to collect those needing recovery. It was a long and challenging day.[86]

CW2 Jerry Eads led another crew. Experiencing similar challenges, he and his crew recovered more than 500 individuals from the flooded areas. They were perched on top of buildings, highway overpasses, and—in a few cases—in trees and on top of vehicles.[87]

MEDEVAC assets also gathered at the Naval Air Station, New Orleans, located 10 miles south of the city near the suburb of Belle Chasse. On 8 September, the "Eagle Nest" command center was moved there too, and all residual aviation recovery operations consolidated at the base. One of the key officers in the operation, Lt. Col. Garrett Jenson of the Louisiana ARNG, said, "This unprecedented historic joint service effort played a vital role in assisting the rescue of 60,000 displaced citizens from New Orleans." The *USS Iwo Jima* docked on the Mississippi River in downtown New Orleans and also served as an additional rescuee dropoff point.[88]

The 1022d Med Co (AA), Wyoming ARNG, was busy at its home station at Cheyenne preparing for deployment to Egypt to support Operation BRIGHT STAR when the call came to assist for Katrina. It took a day to straighten out the necessary orders for the change of mission. They self-deployed four of their UH-60s to the Naval Air Station at Belle Chasse. As soon as the helicopters refueled, the crews launched to join the ever expanding rescue effort. Wyoming Air National Guard C-130s flew in its support gear.

With limited command and control over the city (just the area immediately around the Superdome), the crews intuitively joined the effort. It was "just mass confusion," one pilot noted as he watched the gaggle of helicopters over the city. As the crews found somebody needing recovery, they did so, primarily by hoist, and delivered them to the recovery facility at the main airport on the west side of the city. The unit remained until 20 September.[89]

Alerted under the EMAC agreement, the 149th Med Co (AA) of the Texas ARNG deployed three UH-60A aircraft, crews, and support personnel as part of a larger state aviation task force to Baton Rouge on 30 August. Initially assigned to the Louisiana ARNG, the unit fell in under Task Force Eagle and flew rescue missions one hour after arriving. Within the first 24 hours, crews rescued 732 stranded persons. The unit aircraft were not equipped with hoists, and all recoveries in the flooded areas were made off rooftops, bridges, and highway overpasses.

Within the first week, the unit crews recovered more than 2,500 people. They also provided general aviation support and transported food and supplies, and—even on a few missions—dropped sandbags to staunch flooding. They also flew a few actual MEDEVAC missions, transporting five critically wounded civilians and two patients suffering cardiac arrest. The detachment returned to its home

base near San Antonio on 20 September.[90]

On 31 August, the 24th Med Co (AA), Nebraska ARNG, deployed two UH-60s, three crews, and a small maintenance team to the Naval Air Station at Belle Chasse. The unit fell in on the large helicopter force gathering there and quickly joined into the effort. Equipped with hoists, the unit was very busy the first week, steadily receiving taskings from the Eagle's Nest. After two weeks, crews swapped out their crews. The operations tempo steadily declined, however, and on 30 September, the unit returned home.[91]

On 2 September, the 832d Med Co (AA), Wisconsin ARNG, mobilized as part of a larger state task force. It deployed 38 soldiers and three UH-1V aircraft to Camp Beauregard, near Alexandria, Louisiana. Operating from there and the Naval Air Station at Belle Chasse, the unit detachment remained for four weeks, swapping out personnel at the two-week point. The crews flew 331 hours, rescued or evacuated 133 persons (59 by hoist), transported 210 other personnel and 13 animals, and delivered more than 17,000 pounds of food and water.[92]

The crews dealt with some unusual challenges during the recoveries. One mission flown by an 832d crew highlighted this experience. CW3 William Richey and CW2 Doug Determan were the pilots. Flying over the city, their crew chief, Sgt. Eric Leukert, spotted a man in a boat. The man appeared to be exhausted and signaled that he wanted to be picked up but he was tied to a pole under some high-tension power lines. Leukert signaled to the man to move away from the wires. Determan spotted a flooded vehicle not far away. He hovered over it and had Leukert lower the medic, S.Sgt. Patrick Deuberry, onto the roof of the vehicle. Determan then used the rotor wash of the helicopter to push the boat over to the vehicle. When the man was safely with Deuberry, Determan resumed his hover over them and Leukert hoisted both into the aircraft. They then delivered the very appreciative man to the recovery center set up at the New Orleans Airport and resumed their mission.[93]

Other MEDEVAC elements supported rescue and recovery operations in Mississippi. Just recently released from active duty and a long tour at Fort Bragg, the 249th Med Co (AA), New York ARNG, deployed six of its UH-1s, crews, and support personnel to Camp Shelby, near Gulfport, Mississippi, in early September. The 249th worked with Task Force 185th Aviation from the Mississippi ARNG to perform search and recovery missions. They flew logistical support missions throughout Mississippi, delivering food, ice, water, and infant supplies to various local distribution points. They also flew medical teams to towns isolated by damaged roads and bridges. As the immediate needs abated, four aircraft and crews returned home on 15 September, while the other two crews and support personnel remained to the end of the month.[94]

On 1 September, the 148th Med Co, Georgia ARNG responded to the EMAC request. The unit already had two UH-1Vs, crews, and support personnel at Hagler Army Airfield located at Camp Shelby, Mississippi, supporting summer training for ARNG and USAR units. The 148th was under the operational control of Lt. Col. Paul Frazier, the airfield commander. Frazier established a de facto command center to coordinate the aerial rescue efforts taking place in Mississippi

being mounted by aircraft staging out of Hagler, the airport at Jackson, and eventually, the airport at Gulfport when it was reopened.[95]

CW4 Jim Brennan was one of the 148th pilots. He was an old hand at hurricane response, having flown support for Florida in September 2004, when Hurricane Charley came ashore near Fort Myers. He and the other crewmembers repositioned to Jackson, Mississippi, to ride out Katrina, and then returned when the storm had passed. The unit dispatched four more UH-1Vs and crews. Three aircraft and crews stayed at Camp Shelby and the other three went to the Naval Air Station at Belle Chasse. Each of the teams supported task forces in their areas. Initially, the crews at Belle Chasse performed hoist rescues and recovered about 120 people. The Shelby crews primarily conducted search missions or delivered supplies, equipment, and personnel. Overall, the unit crews accomplished approximately 1,500 personnel evacuations before returning home on 20 September.[96]

Detachment 1 of the 148th Med Co (AA), Washington, DC ARNG, deployed six UH-1 helicopters and 19 soldiers to the Baton Rouge Airport and joined Task Force Eagle. Under the command of 1st Lt. Florian Heithier, the crews flew rescue and recovery missions and rescued seven persons in the first three days. The crews also made many reports of floating bodies. Those recoveries were passed off to teams in boats. After three days, they moved their operation to the Naval Air Station at Belle Chasse, seven miles south of the downtown New Orleans area, and were joined by Lt. Col. Maureen Bellamy and several other troops as replacements for soldiers who had initially deployed. When settled there, the crews flew actual MEDEVAC missions, ferrying patients between medical facilities as they reopened. The unit also kept two aircraft on MEDEVAC alert as required for classic medical response. The unit redeployed at the end of September to its home base at Fort Belvoir, Virginia.[97]

Hurricane Rita

Mother Nature struck again on 24 September when Hurricane Rita swept ashore just south of Houston. The storm was not as strong as Katrina, and the damage was not as severe. Yet, preventive actions had to be taken. JTF-Rita was established with the Fifth U.S. Army, commanded by Lt. Gen. Robert Clark, as the lead command. Texas activated 10,000 Guardsmen for state duty and also requested aid under the EMAC agreement. Some elements assigned to JTF-Katrina were transferred to JTF-Rita and repositioned as necessary. The 149th Med Co (AA), Texas ARNG, was activated again on state orders and deployed to Ellington Air Force Base near Houston. Four helicopters, crews, and support personnel from the 498th Med Co (AA) from Fort Benning joined the 149th at Ellington. The 149th provided general support for the directed evacuation of the area by transporting food and water to predesignated rest stops along the main highways. The unit also flew numerous missions evacuating infirm elderly patients from retirement homes to hospitals further inland.[98]

In support, JTF-Katrina was directed to conduct search and rescue operations as far west as the Texas-Louisiana border. Helicopter units still in Louisiana,

including the 812th and 832d Med Cos (AA), responded with helicopter and crews repositioned at Lafayette. Several helicopters were assigned the gruesome task of hunting for and in some cases, recovering caskets that had been blown from the above ground cemeteries so common to the area.[99]

To relieve departing units, in late September, the 112th Med Co (AA), Maine ARNG, deployed a detachment of three UH-60s and 15 personnel for 30 days of duty. The 112th also based at the Naval Air Station at Belle Chasse and provided general support for residual operations.[100]

Results

The national response to Katrina and lesser Rita was unprecedented. The military portion of that was the largest Department of Defense domestic response since the Civil War. Within hours of the realization that Katrina would hit Louisiana, 2,500 Guardsmen were on state-ordered active duty. Within 24 hours of Katrina's landfall, 8,500 Guardsmen and 1,000 active duty troops were in the disaster area. At its peak on 11–12 September, 50,116 Guardsmen and 22,670 active duty personnel from all services served with countless personnel from other governmental agencies and even other nations to help the residents of the stricken areas to begin to recover.

For the first several days, search and rescue was the priority mission. A nominal command and control system was established by the Task Force Eagle personnel at the Superdome and subsequently moved to the Naval Air Station at Belle Chasse. That only applied to helicopters immediately in that area. Most crews acted intuitively and did what needed to be done for those in such distress below. Overall, the collective rescue forces that responded to the disaster rescued 33,544 personnel.[101]

More than 400 helicopters sent to the disaster area performed much of the rescues. The numbers for the collection of units that operated as Task Force Eagle were more descriptive. The helicopters and crews of the task force flew 3,307 hours, rescued or evacuated 60,091 personnel, and carried 3,016 tons of cargo of all classes. The hometown 812th Med Co logged 204 hours in the first seven days performing 144 hoist recoveries and the overall recovery of 482 evacuees. Those numbers also included 2,514 patients who were medically evacuated out of medical facilities threatened or damaged by Katrina. Most were carried by the MEDEVAC units.[102]

However, the congressionally mandated bipartisan review of the response to Katrina criticized the overall effort noting that, "Search and rescue operations were a tremendous success, but coordination and integration between the military services, the National Guard, the Coast Guard, and other local, state, and federal rescue organizations was lacking."[103]

Those totals included the efforts of the MEDEVAC units that operated more as aviation than medical elements. Three active duty and eight ARNG Guard units responded to the disaster with detachments of varying size. All integrated with aviation units because of the absolute lack of any usable surviving infrastructure.

The crews all noted the deficiencies reported above as they flew through the chaos and mayhem that reigned over the stricken area. However, their professionalism enabled them to run a mishap-free operation. No data exist that shows the number of rescues or evacuations that the MEDEVAC units and personnel exclusively logged. The MEDEVAC units' contribution, however, was true to their mission and purpose as defined by doctrine, convention, and heritage.[104]

Organization

Medical Evacuation Proponency

Just a few weeks before Hurricane Katrina, MacDonald replaced Lockard as the director of the MEPD at Fort Rucker. As he watched the horrific events occurring along the Gulf Coast and tracked the actions of the MEDEVAC forces among the larger military and national response, he conducted a review all of the issues facing the community. Operationally, the long MAST commitment was suspended, but his units were engaged in Central America, Kosovo, Iraq, and Afghanistan. Developments in the longer war on terror just five years into the new millennium suggested the good potential for other actions in other arenas.

The Army faced an extended high operations tempo, and MacDonald saw the stress it put on the MEDEVAC force. Organizationally, the ATI was a *fait acompli*. The units shed their heritage identities and reformed within the aviation battalions. MacDonald had to stay engaged with his counterparts in Army aviation as they worked through all of the issues in the Transformation Charter. However, he was under no illusions regarding the struggle's difficulty. He easily recognized what had happened in ATI. The aviation commanders had imposed on the MEDEVAC community the format used by the 50th Med Co in the 101st. Although that may have made great sense from a tactical unit perspective, it encumbered the MEDEVAC community's ability to respond to joint or combined needs or be used as an operational or strategic asset. MacDonald remembered, too—somewhat regrettably—that it was he and Heintz who had initially authored chapter 9 of the 101st Division *Gold Book,* which specified that format and its operational procedures. MacDonald later recalled:

> If you understand how … aviation saw us, how we would best be structured, it smacks of the *Gold Book,* and it is déjà vu forming because how they structure aviation now is exactly how it was structured in the 101st. When you look at the leadership that has done Army aviation transformation, and you look at the right shoulder patches, you can understand why some of those decisions were made.[105]

MEDEVAC doctrine would need to be rewritten under the joint doctrine structure and format to reflect its newer deeper integration into aviation. MacDonald explained it all in a 30-slide "Quad Charts" Briefing.

Using that as his analysis tool, he then determined what the MEPD focus would be during his watch. His focus included the following:

1. Guide the development of evacuation doctrine;
2. Oversee the transformation of MEDEVAC;
3. Advise during the development of new equipment, aircraft, and vehicles; and
4. Work on personnel solutions for MEDEVAC troops.[106]

All of this would have to be done while the Army itself was going through great change, but the Army has always experienced change. In fact, it seems sometimes that the only thing that is constant is change itself.

* * * *

It was the new millennium. Events of the previous decade had suggested that the Army needed to transform from a ponderous armor-heavy division structured force to a lighter, more mobile force built around autonomous brigades. A new chief of staff embraced that need, and following on the actions of his predecessors, attempted to focus the process and increase the pace of change. Those efforts collided with world events as a lurking enemy dragged the United States into a global war on terror. That struggle has led to the dispatch of U.S. Army forces to several more theaters in ongoing operations. These two parallel and challenging developments plus dramatic events at home have put great strain on Army.

The MEDEVAC community has not been immune to that strain. True, the long commitment to the MAST mission was effectively suspended, but the MEDEVAC force endured the stress of its wholesale reorganization under the ATI, and Hurricane Katrina showed that domestic crises can occur at any time. More ominously, though, the long-term duration of the war on terror is worrisome. No end is yet clearly evident.

The MEDEVAC community will adjust and adapt as transformation occurs and the campaigns continue. It has before, and it will do so again. The reason is fundamentally simple. The men and women of MEDEVAC are masters of both aviation and medical service. They will support their soldiers in harm's way as they always have. That is their legacy and enduring mission.