

## **Part Four**

### **Into the Millennium: New Challenges, at Home and Abroad**



## Chapter Eight

### To 9/11, 2000–2001

*“Today, our fellow citizens, our way of life, our very freedom came under attack in a series of deliberate and deadly terrorist acts.”*

President George W. Bush<sup>1</sup>

### **Renewed Desire for Change**

It was a new millennium, and the Chief of Staff of the Army, Gen. Eric Shinseki, wanted to refocus the Army. The heavy divisions, which stood ready during the cold war and defeated the Army of Iraq in 1991, were too heavy to respond quickly to the panoply of challenges facing the United States. Operations in Somalia, Haiti, Bosnia, and Kosovo had conclusively validated this position. Shinseki concurred that the need for change was inevitable, stating, “If you don’t like change, you’re going to like irrelevance even less.” He wanted a lighter, quicker force designed around brigade-sized packages with the necessary capabilities versus the divisional forces then in existence. His goal was to have brigades that could deploy anywhere in the world within 96 hours and a full division that could move within another five days.

Shinseki established a transformational process that began with the Legacy Force of current units and charted how they would realign as an Objective Force of the Army of the future. It comprised units of action of approximately brigade size that could accomplish distinct mission-essential tasks and units of employment that were higher headquarters designed of nominal division, corps, or army elements structured to accomplish any mission. Units of action were either maneuver or support elements. This process also necessitated changes in doctrine and organization. Subordinate to this effort was a more focused Aviation Restructuring Initiative that addressed reductions to Army aviation forces, possibly including MEDEVAC units.

However, real world exigencies and developments required the Army to continue operations in several parts of the world while responding to attacks on the homeland and the initiation of offensive operations in several more theaters. Shinseki did not see the fruition of transformation on his watch, but his successor, Gen. Peter Schoomaker, continued the process.<sup>2</sup>

## **Organization**

### *The Army Medical Department (AMEDD)*

The winds of change also began to blow across the medical community. Lt. Col. Dave MacDonald became the medical evacuation officer in the Force Development branch on the Office of The Surgeon General staff in Falls Church, Virginia. After completing the Army Command and General Staff College course at Fort Leavenworth, Kansas, he had remained there for two years as an instructor. It became his turn to do a staff tour, but it was a short one. While at Leavenworth, he had been selected for battalion command, and rumor had it that he would get a unit in the summer of 2001.<sup>3</sup>

When he reported to his new position, he was immediately embroiled in an Aviation Restructuring Initiative induced effort to reduce the MEDEVAC fleet. Army aviation accounted for 25% of the overall Army budget, and the Army Staff pushed for efficiencies to reduce that cost, including one proposal that would have reduced the UH-60 MEDEVAC fleet—both active and Army National Guard (ARNG)—by 30%, by reducing all units from 15-ship to 12-ship (and possibly 10- and 8-ship) formations, with the intention of then using the released UH-60s to replace UH-1V aircraft still used by several ARNG MEDEVAC units. MacDonald argued for maintaining the 15-ship Medical Force 2000 companies while developing proposals to reduce the companies as directed. He searched—with little success—for empirical data that he could use to determine the requisite force structure for each package. He discovered that the MEDEVAC community had not been very proactive in maintaining a good database to show its successes and validate the structure of its units. What he found instead was a rather casual attitude that, “We know it works; it’s worked in the past; it’s working now; we need to keep it.” He could not find data showing how many lives had been saved or why the 15-ship company was the best structure to support the needs of the corps or division. A modified Table of Organization and Equipment for the MEDEVAC units requiring 15 aircraft but assigning 12 was developed, but it was not implemented because subsequent events overrode all initiatives to reduce the MEDEVAC fleet. However, the idea for a 12-ship MEDEVAC company was accepted and resurfaced in a few years.<sup>4</sup>

MacDonald stayed engaged in the issues and debates until June 2001, when he was ordered back to Fort Bragg, North Carolina, to command the 56th Medical Battalion (Evacuation), the unit under which he had commanded the 57th Med Co (AA) a few years prior. As he prepared for the move, he recalled those earlier dif-

difficult times with the 57th. He resolved that as soon as he arrived at Fort Bragg, he would make office visits to all of his medical *and* aviation counterparts so that he could immediately assume the role of “marriage counselor” between the medicine and aviation units at Fort Bragg.<sup>5</sup>

At Fort Sam Houston, Texas, Maj. John Lamoureux also was involved in these transformation and modernization issues. After his tour with the 421st Medical Battalion in Germany, he served a short tour as an observer/controller at the Hohenfels Training Center and then returned to Fort Sam Houston to serve as an instructor in the Medical Service Corps basic and advanced courses. At Fort Sam Houston he was selected to serve as the executive officer for the AMEDD Center and School Commander, Maj. Gen. Kevin Kiley.

Lamoureux’s experiences had clearly shown that on any deployment, MEDEVAC always struggled to establish itself with an aviation element to get the necessary operational and logistical support to operate properly. He and Kiley were impressed with the 101st Airborne Division (Air Assault) model and agreed that it could be the basis for a reorganization of MEDEVAC units as divisional elements rather than corps-assigned companies with their slice of supporting units. However, their analysis also showed that the 101st also always needed to have another MEDEVAC unit in general support for backhaul, so that the Forward Support MEDEVAC teams of the 50th could focus on direct tactical support to the brigades.

At one point, Kiley had his combat developers shape a proposal for MEDEVAC units as divisional assets with the options developed by MacDonald from 15 down to eight aircraft. When the overall proposal was ready, Kiley briefed it to the Surgeon General, Lt. Gen. James Peake. After some detailed and often heated discussions, Peake supported it. He then briefed it to the Training and Doctrine Command commander. Gen. John Abrams listened carefully and responded, “I agree with all of your points. I think you are making all the right arguments, and I really can’t counter anything. The problem is, I can’t approve it.”

Kiley and Peake were taken aback and asked him why. Abrams answered, “We have a troop cap, and if I put a MEDEVAC company in the division, that is so many troop numbers that I have to take out, specifically on the gunfighter side.” It was the classic “beans versus bullets” argument. Peake was not finished. “When,” he followed up, “would a division ever deploy without MEDEVAC?” Again, Abrams pondered and then said, “No, I cannot do it. We are going to have to make the Corps slice thing work.... I cannot afford to take those slots away from the warfighters.”<sup>6</sup>

Another individual keenly watching these initiatives was MacDonald’s old Eagle Dustoff compatriot and Lamoureux’s early mentor, Col. Scott Heintz, then serving at Fort Rucker, Alabama, as the director of the Medical Evacuation Propensity Directorate. He reported to the AMEDD Center and School at Fort Sam Houston, but also served as the MEDEVAC Consultant to the Surgeon General. This second designation was an unofficial position but afforded him the ability to communicate directly with the Surgeon General on MEDEVAC matters. This

was a classic medical phenomenon whereby physicians frequently consulted with specialist experts when dealing with a patient. In this capacity, Heintz advised the Surgeon General on MEDEVAC-related decisions. Scott's varied experience as a MEDEVAC officer and pilot made him the natural choice for this function.<sup>7</sup> He did not want to see the units reduced in size and assigned to the divisions, but understood that Shinseki's drive for transformation would ultimately affect every part of the Army, including MEDEVAC. He was resolved to fight for his units and personnel.<sup>8</sup>

### *New Aircraft*

While working with Kiley, Lamoureux was involved in another long simmering MEDEVAC issue: the procurement of a new helicopter. The MEDEVAC fleet still possessed a large number of UH-1V aircraft, especially in its ARNG units, which were far beyond their best days. Almost all of its UH-60s were "A" models dating back to the early 1980s and some of the oldest helicopters in the overall Army Black Hawk fleet. There were a few UH-60Ls with bigger engines and four UH-60Qs, essentially "A" models but with updated cargo cabins optimized for patients, forward looking infrared systems for better all weather navigation, and improved avionics. All of the new Ls and most of the Qs belonged to ARNG units, thanks to individual senators making specific legislative earmarks. An updated aircraft for the general Army MEDEVAC fleet was needed, but it had to be procured through the overall Army acquisition process and compete with the needs of the aviation community at large.

### **MEDEVAC Aircraft Variants**

<b>Model</b>	<b>Engine</b>	<b>Load</b>	<b>Special Equipment</b>	<b>Range (nautical miles)</b>
UH-60 A	T-700 1,560 HP	6 Litters	Carousel Internal Hoist	319
UH-60L	T-701C 1,880 HP	Same	Carousel Internal Hoist	315
UH-60Q	T-700	Same	Forward looking infrared On board Oxygen Medical Monitoring Litter Lift On board Suction Defibrillation Global Positioning System Glass Cockpit External Hoist	319
HH-60A	T-700	Same	Same	319
HH-60L	T-701C	Same	Same	315 <sup>9</sup>

Both Kiley and Peake wanted to replace the older MEDEVAC aircraft with new UH-60Qs, like the four that had been modified postproduction and given to the Tennessee ARNG. However, the UH-60Q aircraft still had the same older engines as the “A” models. Subsequent events would indicate that they just did not have enough power to operate at higher elevations.

Accordingly, the AMEDD modified its request for new aircraft to specify the “Q” model with the better engines of the “L” model. To keep the designations from getting too confusing, the force planners redesignated the new aircraft the HH-60L, using the joint designation for rescue aircraft used by the Air Force. Three had been procured through the acquisition process in the late 1990s and assigned to the 507th at Fort Hood, Texas. Lamoureux attended several conferences as Kiley and Peake met with the Army Staff G-3 and Lt. Gen. Richard Cody to argue for Army procurement of HH-60Ls for MEDEVAC. They forwarded a modernization plan that called for the procurement of 192 HH-60Ls in two force packages at a cost of \$883 million, but did not receive any commitment for funding.<sup>10</sup>

## **Doctrine**

### ***Service Doctrine – Field Manual (FM) 3.0, Operations, June 2001***

As the new century was beginning, Shinseki directed another rewrite of FM 100-5 *Operations*, the Army’s capstone warfighting document, in support of his transformation initiative. Recognizing recent Joint Staff doctrinal literature renumbering guidance, the new manual was republished as FM 3.0 and was fully compatible with joint doctrine. Shinseki knew well that the Army was a doctrine-based institution. Doctrine guided its actions, organization, equipment, and even manning across the range of military operations and spectrum of conflict as part of joint and combined operations in a broad range of events from major wars to peacekeeping to stability and support operations.

As its predecessor FMs had done, this new manual also reaffirmed that the Army forces were the decisive component of land warfare in joint and combined operations. Fighting and winning the nation’s wars were the foundation of Army service. The Army was prepared to take action across the full spectrum of conflict, from war to peace. Increasingly in the international security environment, this action included peacetime military engagement like humanitarian, counter-drug, or peacekeeping operations. Additionally, Army forces helped civil authorities—both at home and abroad—prepare for and respond to natural disasters. The document was filled with many vignettes drawn from events that had occurred since the publication of the 1993 edition of FM 100-5, and it graphically showed how the world had changed and the Army had adapted. Shinseki wanted to leverage new and evolving technology to surmount these threats.

Combat service support forces, including medical elements, had to remain prepared to support these operations. Increasingly, the Army was being called upon to mount support operations to assist foreign and domestic civil authorities. In these cases, the real enemy was disease, hunger, or the consequences of natural disasters. The Army, with its mobile and well-organized units of trained specialists

equipped with many capabilities, was an obvious asset to meet such potential needs. The Army intended to dominate in both land warfare and in operations other than war. The MEDEVAC units were some of the enabling forces that provided these “soft” capabilities.<sup>11</sup>

***Joint Doctrine – Joint Publication 4-02, Doctrine for Health Service Support in Joint Operations, July 2001***

Almost concurrently, the Joint Staff published an update to Joint Publication 4-02. It introduced a new term, force health protection (FHP), which rested on three pillars: (1) a healthy and fit force, (2) casualty prevention, and (3) casualty care management. The health service support system facilitated this by conforming to the joint commander’s overall plan, being responsive and flexible, being mobile and anticipating the need for rapid movement, providing uninterrupted care, and coordinating for the efficient employment of health service support resources to support the planned operation.

The document reaffirmed that timely patient movement played an important role in FHP and that movement by air was the preferred method. Initial movement to a theater Level III facility was a service component responsibility, but, in any theater, Army MEDEVAC helicopters were used for patient transfer to hospital ships. This publication was released in conjunction with subordinate documents that prescribed joint doctrine and tactics, techniques, and procedures for health services logistics support and patient movement.<sup>12</sup>

This rewrite also included specific functions for assigned joint force surgeons. Under the joint construct or in a coalition environment, combined/joint force commanders and subordinate component commanders (like the combined/joint force land component commander) were assigned a combined/joint forces surgeon as a specialty advisor to report directly to them. The combined/joint forces surgeon was responsible for combined/joint coordination of health service support initiatives and planning, joint coordination of intratheater patient movement that linked into the intertheater movement system, and the reception, staging, onward movement, and integration of assigned and attached medical units.<sup>13</sup>

The update also recognized that in military operations other than war, the health threat had to be evaluated for a patient base much larger than just the U.S. force alone. It stated:

When preparing for and conducting operations during MOOTW [military operations other than war], elements of the health threat to the indigenous population, allied and coalition forces, U.S. Government employees, DOD [Department of Defense] contractors, and as appropriate, IO [international organizations], and NGOs [non-governmental organizations], must be assessed. The impact of the health threat as a contributing factor to social, political, and economic stability in both peace and other operational environments must be considered.<sup>14</sup>

This was a significant change because it recognized that the patient base that any deployed MEDEVAC force had to support could be much larger than the traditional military force used to determine its allocation.

***Service Doctrine – FM 8-10-26, Employment of the Medical Company (Air Ambulance), May 2002***

In May 2002, the Army published Change 1 to FM 8-10-26. Perhaps reflecting lessons learned in several operations—but most prominently in Task Force Hawk—it included several updates designed more closely to integrate the MEDEVAC units into aviation task forces.

These updates specified that units not operating in a theater general support capacity and tied to a medical evacuation battalion should be included in the aviation brigade communications net. Additionally, forward support MEDEVAC teams should have long-range communications capability for battle tracking and situational awareness of ground and air units. They should maintain division A2C2 information and comply with standard use Army aircraft flight routes into and out of the maneuver brigade areas.<sup>15</sup>

The change also included an entire section on combat search and rescue as an additional mission. During the war in Vietnam, MEDEVAC crews made many rescues under fire, but this mission had been absent from subsequent doctrinal manuals. FM 8-10-26 recognized the role that the MEDEVAC helicopter and crew could play in this mission in a general way. It prescribed a mission training plan, standard operating procedures, and event checklists.

The change also pointed out that if a MEDEVAC helicopter was utilized as part of an aviation or larger joint task force to rescue personnel in enemy territory, it could lose its protection under the laws of war and Geneva Convention. Moreover, this use of a MEDEVAC aircraft for combat search and rescue required the removal of the distinctive Red Cross for the mission. However, it did not provide for the arming of the aircraft.<sup>16</sup>

***Service Doctrine - FM 4-02, Force Health Protection in a Global Environment, February 2003***

FM 8-10 was next to be updated and republished as FM 4-02 in consonance with the Joint Chiefs of Staff joint publications system. The manual was more expansive than the earlier version. The overarching references to AirLand battle and the restructuring of medical support to enable and sustain it were eliminated. The new focus was on FHP enabled by the military health system's capabilities to deliver health care across the continuum of military operations in any environment. These capabilities rested on three pillars, including (1) a healthy and fit force, (2) casualty prevention, and (3) casualty care management, and they supported the joint mission as part of guidance from the Joint Chiefs of Staff under Joint Vision 2020.<sup>17</sup>

A robust capability to evacuate the wounded was a key part of casualty care management. This applied to U.S. soldiers, allied troops, contract personnel under Army employ, or indigenous civilians. Planners needed to be aware of the limits of specific modes of transportation in terms of operational range, speed and lift limitations, and tactical use considerations. The en route teams had to leverage

technological advances in communications, computers, and medical equipment to facilitate and enhance medical treatment provided to patients while they were en route between facilities. MEDEVAC was performed as per FMs 8-10-6 and FM 8-10-26.<sup>18</sup>

The new FM also defined medical evacuation and medical regulating as a key functional area for the AMEDD. It formalized the concept of theater evacuation policy and redefined evacuation priorities. Although re-acknowledging that tactical evacuation was still a service component responsibility, it reaffirmed the Army commitment to shore-to-ship evacuation and defined the theater patient movement requirements center as that command and control node responsible for the medical regulation and movement of patients between Level III and IV hospitals.<sup>19</sup>

The manual explained in general terms how FHP was applied in classic offensive and defensive operations, stability operations, and support operations for domestic community assistance (like Military Assistance to Safety and Traffic), domestic preparedness, disaster response, or foreign humanitarian assistance. Such actions were almost invariably joint and/or combined and could be coordinated with other governmental and nongovernmental organizations.<sup>20</sup>

Overall, FM 4-02 was a significant update of medical doctrine. From the perspective of MEDEVAC, it clearly defined the new and more dangerous world environment and the multifold events that could require the dispatch of MEDEVAC units.

From the return of the MEDEVAC forces from Vietnam in 1973 to the tumultuous events of the beginning of the millennium, MEDEVAC doctrine was never static. It was addressed in Army doctrinal manuals at several levels and then in joint doctrine as it evolved. Guided by officers experienced in battle and understanding the intricacies of medicine and aviation, it steadily morphed as the world, nation, and Army changed. Rooted in the past while exploiting evolving technology and anticipating the future, it continues to guide MEDEVAC operations as a key component of the continuum of care.

## **Operations**

### *Still in the Sinai*

Mirroring the ongoing support operations in Balkans and Central America, the country was still honoring its obligation to support the Multinational Force and Observers in the Sinai that had been created to enforce the ceasefire between Israel and Egypt at the Camp David Peace Accords in 1979. The U.S. contingent still consisted of an infantry battalion and an aviation element, which included a MEDEVAC team. Many MEDEVAC pilots and medics from the active and Guard units did tours with the Nomads—the call sign they still used—of the 1st Support Battalion. Beginning in 2002, however, all of the infantry battalions were Guard units.

The Nomads were called for another type of duty in January 2004, when a civilian Boeing 737 crashed shortly after takeoff from the Sharm el-Sheikh Airport.

The alert crew was scrambled from South Camp to recover injured passengers. Unfortunately, all 148 persons on board were killed when the aircraft slammed into the Red Sea. The crew participated in the recovery of human remains. All were decorated for their actions.<sup>21</sup>

In late 2005, UH-60s replaced the UH-1s and were also painted in the distinctive white and orange paint scheme. The Nomads of the 1st Support Battalion continue to provide the same excellent level of support to the soldiers of the Multinational Force and Observers.<sup>22</sup>

## 11 September 2001

The events of that crisp late summer day are well known and documented. Like the United States and its Army, the MEDEVAC community was shocked by the horrific events. As events unfolded, President George W. Bush said, “No American will ever forget this day.” That was certainly true for the men and women of MEDEVAC.<sup>23</sup>

Following his tour as the commander of the 159th Med Co (AA) and then a short tour as the executive officer of the 421st Medical Battalion (Evacuation) in Germany, Maj. Mike Avila was assigned to the Army Staff in the Pentagon. He reported for work in early July, as the aeromedical evacuation support officer for the Director of Military Support Operations. The Army Staff in the Pentagon oversaw military support for civil authorities. Among his many duties, Avila oversaw the Military Assistance to Safety and Traffic program. He also was involved with issues introduced to him from other governmental agencies including the Department of Transportation and the Federal Emergency Management Agency.

Just a few weeks into his job, he was directed to attend Army Staff “new guy” training. The second day of that training occurred on 11 September. Avila was sitting in his classroom located on the “C” Ring, in the newly renovated Army section on the west side of the building with 20 other personnel engaged in some interactive computer training. He had been working away for about an hour when a young sergeant from his office came in and asked him to return to his work area. Avila had almost finished his work and did not want to be interrupted. He asked the young troop why he needed to return. The soldier told him that a plane had just hit one of the towers in the World Trade Center and some air evacuation might need to be worked. As a career aviator, Avila had a bit of trouble trying to understand how an airplane like that could hit a building on a clear day. He told the soldier that he would be right down and quickly tried to finish his work so that he could get credit for the course.

A few minutes later, the building shook noticeably, and the lights flickered. Sound tile fell from the ceiling. Avila had grown up in California and experienced many earthquakes, but the near instantaneous “BOOM” indicated some kind of explosion. Everyone was stunned. The instructor opened the door and smoke rolled in.

“Everybody get out,” she shouted. Avila grabbed his backpack and followed the crowd into the hall. There was not a sense of panic, but everybody moved earnestly. As the smoke increased, the rumors started that an aircraft had hit the building. That really unnerved everybody, and they evacuated the building. Then the sirens went off and people started to panic. Avila was not that familiar with the building but made his way back to his new office. He was briefed on what had just happened. He was stunned but called his wife and told her that he was all right, but would be home late.<sup>24</sup>

His office was chaos with phones constantly ringing and people coming and going. Outside, local police, fire departments, and emergency services from the local area responded within just minutes, mirroring the massive response in New York City. Military personnel from within the building and local bases also swarmed to the scene. Wounded persons were immediately treated and dispatched via ground ambulance to local civilian and military hospitals. The ambulances formed in long lines. While waiting for patients, many doctors who had accompanied the ambulances joined the growing medical effort outside the stricken building. Civilian, police, and military helicopters landed in every open area to offer their services. The overall emergency response to both catastrophes was a mix of local, state, and federal jurisdictions that were dealing with combined airplane crashes, fires, and whole or partial building collapses. Since the incipient event in both cases was determined to be terrorist attacks, the United States reacted. When the Secretary of Defense directed that the nation move to Defense Readiness Condition 3, the national airspace was closed and all nonemergency civilian aircraft were ordered to land.<sup>25</sup>

The Department of Justice was the lead agency in charge of the response. Military support for New York was provided under the Joint Forces Command. The Military District of Washington, reporting directly to the Headquarters, Department of the Army, provided the military response to the Pentagon in support of the local authorities.<sup>26</sup>

## **Operations**

### *MEDEVAC Response*

The nearest MEDEVAC unit to the Pentagon was located 12 miles south at Davison Field on Fort Belvoir, Virginia. Detachment 1 of the 148th Med Co (AA), Washington, DC ARNG, received a call from the Military District of Washington requesting launch of MEDEVAC helicopters to the Pentagon. Within an hour, three aircraft had been launched. However, local civilian emergency medical teams, civilian helicopters, and military ground ambulances were handling the casualties. The 148th crews returned to Davison Field, but kept aircraft and crews on alert for the next 72 hours.<sup>27</sup>

Col. Scott Heintz was at the National Guard Bureau Headquarters in Falls Church, Virginia, working with the Army Staff on aviation transformation issues. There was a break in the meeting and everyone was watching TVs positioned in

the hallways and the coverage of the breaking news of the planes flying into the Twin Towers. Two Captains ran downstairs and announced to the group that they had just watched—from their window—a commercial airliner fly into the Pentagon, less than 3 miles away. Everyone was stunned. The meeting was cancelled. Heintz immediately drove to the Office of The Surgeon General to offer help. When he subsequently discovered that all civilian aircraft were grounded, he realized that he would not be returning home to Tampa, Florida, for several days and volunteered to work in the operations center in The Surgeon General’s office until he could get a flight home.<sup>28</sup>

Col. Pauline Lockard was attending a Command and Staff meeting in the Surgeon General’s Office. One of the staff officers came in and reported to Peake (The Surgeon General) that an airplane had just flown into the World Trade Center in New York City. Based on that sparse report, Lockard assumed that it was some kind of pilot error. Then the staff officer interrupted the meeting again with the news of the second aircraft. The Surgeon General suspended the meeting just as they heard the explosion at the Pentagon.

Lockard’s husband was a U.S. Marine Corps officer and worked in the Pentagon. She immediately tried to call him on his cell phone but could not make contact. Then she had to subordinate her personal concerns as she and the rest of the Office of The Surgeon General staff were immediately overwhelmed with the momentous events swirling around them and the nation. She recalled that, “Around [2 PM] my husband contacted me and indicated he was ok, so my focus then shifted 100% to what needed to be done to support the situation. ...I wanted to be right on the ground to help but knowing the Surgeon General needed his staff to be prepared to shift in any direction, I had lots to do.”<sup>29</sup>

Other ARNG units also reacted. In New York, one of its aviation battalions located at Rochester was being converted to what would later become the 249th Med Co (AA). Lt. Col. Chris Holiday, who was the commander, quickly ran a unit recall and locked down the facility. The unit was just beginning its transition, but his troops reported in. Several who lived outside of New York went to some personal expense to report. They were keyed up and prepared for any orders. The unit was not tasked initially to respond, though, and Holiday dismissed them.<sup>30</sup>

Statewide, other armories also filled with Guardsmen reporting for duty. When New York Governor George Pataki declared a state of emergency and signed an order directing 8,000 Guardsmen to report for active duty, they rapidly formed into task forces and departed by convoy to New York City. They maintained security lines, guarded airports, set up medical collection points, constructed emergency shelters for evacuees, and did just about whatever they were asked to do. Other Guardsmen from Maryland and Virginia performed similar tasks around the Pentagon. Fewer were needed because of the large military population in the building, which was composed of many with honed emergency skills.<sup>31</sup>

The nearest MEDEVAC unit to New York City was the 1159th Med Co (AA), New Hampshire ARNG. Within one hour, they had five helicopters and crews at the main facility in Concord. However, they were not called either.<sup>32</sup>

For the next several days the 112th Med Co (AA), Maine ARNG, launched

several crews to perform numerous state missions such as pipeline patrols and forest fire surveillance until the Federal Aviation Administration reopened the national airspace to civilian and other nonfederal aircraft.

In Oregon, Matt Brady was driving to work. In his civilian capacity, he was a guard for the Oregon Department of Corrections and had just been transferred to a new correctional facility. He heard the reports on the radio as he drove to the new site. Like most people, he assumed that the first strike was an accident, but when the second aircraft hit, he immediately sensed that the combined event was an act of war. He rushed into the building when he arrived at work, found a television, and stood transfixed as the tragic scenes unfolded. He intuitively knew that he and his unit, the 1042d Med Co, would be directly affected by what he was watching. They had not been home from Bosnia very long and he had not finished unpacking. “Why bother?” it now occurred to him. He knew that he would soon be back in uniform.<sup>33</sup>

Multiple governmental and civilian agencies began mounting steadily growing responses to these devastating events. Avila as the Director of Military Support Operations diligently stayed abreast of the fast-moving developments and expected to get requests to order in MEDEVAC units. The necessary legal instruments under various laws and Army Regulations were in place. However, the Director of Military Support Operations did not receive any requests from the Department of Justice or the Federal Emergency Management Agency for MEDEVAC support.<sup>34</sup>

The troops in the field units were also stunned by the prophetic events. Maj. Bob Mitchell had taken command of the 507th Med Co (AA), at Fort Hood in July 2000, after serving three years as a personnel officer in the U.S. Army Personnel Command and then attending the Army Command and General Staff College at Fort Leavenworth. He was on alert duty that morning and had just done an aircraft engine run when he was called on the radio and told that he might want to come in and see a “weird” television news report about some kind of accident in New York. He was standing in operations watching the news reports when the second airplane hit.

Soldiers were immediately keyed up as they anticipated some “serious butt kicking” to happen soon. The news also solved a bit of a morale problem that Mitchell had with his unit. When he first arrived, he directed a series of readiness drills to ensure that his unit was ready on short notice to deploy. Normally, the 507th was not designated to deploy early in any contingency. Mitchell knew that, but felt that it spawned a bit of a lackadaisical attitude. He had spent a lot of time at Fort Bragg and was used to the “sense of urgency” that was the calling card for the units of the XVIII Airborne Corps. His drills were met with a lot of carping. All of that ended as the news from New York and then the Pentagon spread throughout the unit.<sup>35</sup>

Maj. John Lamoureux was in his office at Fort Sam Houston with the television on in the background when the first reports appeared. Listening to the initial comments that a small plane had hit one of the Twin Towers, he immediately noticed that the weather was clear. Then he saw a close-up shot of the impact hole in the building and realized that the tower had been hit by something larger than a small plane. As a career pilot, none of this made sense. He was watching when

the second plane hit and knew immediately that this was a premeditated attack on the United States.

Kiley was at a conference in Florida. His senior staff was having a routine meeting led by the Chief of Staff, Col. Frank Blakely. Lamoureux entered the meeting and briefly announced what had transpired. Then he had the news coverage piped in on the video teleconferencing screen. The staff discussion switched to the ongoing events. A short time later, Fort Sam Houston, like all military installations, received a FLASH message from the Pentagon announcing the crash of the aircraft there and directing all bases to immediately go to Force Protection Condition Delta, which meant that the entire base had to be secured. The staff meeting then became a planning session to determine how to do this at Fort Sam Houston. They also had to keep Kiley briefed on developments via cell phone as he and his aide drove the 11 hours back to the base in a rental car because of the cancellation of all air traffic.

Fort Sam Houston, in existence since 1845, had grown up side-by-side with San Antonio and their road structures were completely integrated. Fort Sam Houston was a completely open post and had never been totally secured. Over the next several hours, approximately 26 vehicle and pedestrian access points were either locked down or secured with military police, members of the command band, and soldiers attending various courses at the medical schools there.<sup>36</sup>

At Fort Polk, Louisiana, Capt. John Fishburn, a MEDEVAC pilot with the 717th Med Co (AA), New Mexico ARNG, was on a training flight and preparing with a detachment from his unit for deployment to Kosovo as part of KFOR 3B. The situation in Kosovo had been steadily improving, and he and his fellow Guardsmen anticipated a relatively smooth deployment and tour. His flight was abruptly terminated, though, when the tower controller called him and ordered him to return to base. When he queried the controller, he was informed of the developments in New York and Virginia, and the closure of all U.S. airspace. He and the members of his unit were subsequently confined to Fort Polk. When the airspace restriction was lifted, they finished their predeployment training, and then shipped out for their tour with KFOR. As they left, they could not help but wonder if this was just the beginning of a much longer and larger effort.<sup>37</sup>

Maj. Mike Pouncey was serving with the 498th Med Co (AA) on deployment in Bosnia with Task Force Eagle under SFOR 10. He remembered these events clearly:

I remember that day like it was yesterday. I was walking back to the Task Force Med Eagle area of the compound and remember seeing about 15 people in a horseshoe formation around someone's door. I could tell by the look on everyone's face that something wasn't right, so I walked up right after the first plane hit the first tower and I remember seeing the smoke coming from that tower and the report of a plane crashing into the building.... We knew...we knew the easy, relatively stable deployment environment we were enjoying 10 minutes prior, was over. Prior to 9-11, we flew up to New York ...in order to put our aircraft on the ship for deployment [to Bosnia]. The port was right there in New Jersey - just a mile or so south of the Statue of Liberty. I couldn't help but think to myself as I watched all those people jump to their death... If we could have been there, we might have been able to save a few from the roof. It only took a matter of minutes before the call went out to take off our soft caps and go to full battle-rattle (meaning, put on all your gear). At that time, we didn't know if we were about to be attacked either.<sup>38</sup>



MAST. A 68th Med Co performing a beach rescue on Oahu in 2003.  
Source: U.S. Army.

## **A Path to War**

That evening, President George W. Bush addressed the nation regarding those horrible events, by stating:

Today, our fellow citizens, our way of life, our very freedom came under attack in a series of deliberate and deadly terrorist acts. ...Thousands of lives were suddenly ended by evil, despicable acts of terror...The pictures of airplanes flying into buildings, fires burning, huge structures collapsing, have filled us with disbelief, terrible sadness, and a quiet, unyielding anger. These acts of mass murder were intended to frighten our nation into chaos and retreat. But they have failed; our country is strong...A great people has been moved to defend a great nation. Terrorist attacks can shake the foundations of our biggest buildings, but they cannot touch the foundation of America...America and our friends and allies join with all those who want peace and security in the world, and we stand together to win the war against terrorism.<sup>39</sup>

Nine days later, President Bush addressed a joint session of Congress. He said:

On September the 11th, enemies of freedom committed an act of war against our country...All of this was brought upon us in a single day – and night fell on a different world, a world where freedom itself is under attack.

Americans have many questions tonight. Americans are asking: Who attacked our country? The evidence we have gathered all points to a collection of loosely affiliated terrorist organizations known as al Qaeda...Our war on terror begins with al Qaeda, but it does not end there. It will not end until every terrorist group of global reach has been found, stopped, and defeated... These terrorists kill not merely to end lives, but to disrupt and end a way of life. With every atrocity, they hope that America grows fearful, retreating from the world and forsaking our friends. They stand against us, because we stand in their way.

Americans are asking: How will we fight and win this war? We will direct every resource at our command – every means of diplomacy, every tool of intelligence, every instrument of law enforcement, every financial influence, and every necessary weapon of war – to the disruption and to the defeat of the global terror network...This war will not be like the war against Iraq a decade ago, with a decisive liberation of territory and a swift conclusion. It will not look like the air war above Kosovo two years ago, where no ground troops were used and not a single American was lost in combat. Our response involves far more than instant retaliation and isolated strikes. Americans should not expect one battle, but a lengthy campaign, unlike any other we have ever seen. It may include dramatic strikes, visible on TV, and covert operations, secret even in success. We will starve terrorists of funding, turn them one against another, drive them from place to place, until there is no refuge or no rest. And we will pursue nations that provide aid or safe haven to terrorism. Every nation, in every region, now has a decision to make. Either you are with us, or you are with the terrorists. From this day forward, any nation that continues to harbor or support terrorism will be regarded by the United States as a hostile regime.<sup>40</sup>

The President's declarations quickly came to be labeled the "Bush Doctrine." They were incorporated into the next iteration of the National Military Strategy and fundamentally changed the way the United States would ensure its national security. Preemptive action became a strategic cornerstone of security and required a fully expeditionary force capable of rapidly imposing America's will on hostile foreign soil and then maintaining a robust presence to ensure lasting change.

The men and women of MEDEVAC joined their fellow soldiers as the nation initiated sustained combat operations in what would soon be called the war on terror. It would be a clash between two cultures: Western democratic ideals and Eastern Islamic fundamentalism. The first valued freedom, equal rights, and religious tolerance. The second was based in prejudiced hostility—especially for the United States and Israel—and the suppression of women, demonization of any religion other than Islam, and a strict adherence to radicalism that embraced terrorism and viewed death in holy war as glorious martyrdom.<sup>41</sup>

