

The Doctors of War

by Bob Drury, photos by Max Becherer published in Men'sHealth magazine
See what doctors and medics go through to save lives on the battlefields of Iraq.

The call comes in at 1330 hours one recent hot, dusty afternoon in the heart of the Sunni Triangle. Ambush. A Humvee, call sign Hardrock Six, 3rd Infantry Division, hit flush by a rocket-propelled grenade. Two soldiers are down, one "urgent," one "priority." Urgent means loss of life, limb, or eyesight; priority means loss of blood. Precisely five minutes later, our UH-60 Black Hawk med-evac lifts off from Balad Air Base, 12 miles away. It soars over the blue-tiled roof of the mosque personally designed by Saddam Hussein, banks left, and within seconds clears the concertina wire surrounding Logistical Support Area Anaconda.

"No matter how many times you do it, you still pucker once you get over the wire," says one of the helicopter's pilots, Chief Warrant Officer Lance Duensing. Duensing is handsome, square-jawed, towheaded—not quite a buzz cut. He looks as if he'd prefer to be flushing quail near his home in the East Texas hill country. The pilot in command, Chief Warrant Officer Jackson Wood, his sunburned face as taut as a clenched fist, throttles the aircraft, the rotors drown out conversation, and we hurtle at 145 miles per hour toward the evacuation, or dustoff, site.

Near the Tigris River, the dull, silvery brown talc of the Iraqi desert turns greener, wetter, burgeoning into lush fields of corn and melon linked by ir-

tree capable of concealing a man with a Kalashnikov assault rifle or a shoulder-mounted rocket launcher. All eyes are outward except those of Specialist Elizabeth Shrode, the flight medic, who's busy arranging the blood sup-

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ply and bandages. She rechecks the oxygen tanks. Beside her, crew chief Brandon King fingers his M-16 and scans the terrain below, his toe tapping nervously on the armor-plated floor.

From the rear seat, I steal another glance at the medic. Her brown hair is pulled back in a tight bun, and beneath her flight helmet, her dark eyeliner flattens an oval face with sharp, high cheekbones. Rifling through her first-aid kit, she appears the picture of serenity. I turn back toward the window. I pretend to be searching for snipers. It's an act. I am scared.

This is a story about a pipeline. It begins with a bullet, a chunk of shrapnel, a percussive blast attempting to suck the life out of an American soldier somewhere in Mesopotamia, and culminates on a forested hilltop in Landstuhl, Germany. It is a story about the men and women who make this remarkable medical pipeline flow—the pilots, medics, surgeons, mechanics, nurses, and litter bearers who reclaim the lives of young American soldiers who, if not for their care, would die on a battlefield far from home.

War may be the best teacher of war, as Clausewitz observed, but from Gettysburg to Khe Sanh to Samarra, it has also been an unparalleled teacher of medicine. The rescuers in this story are aided by great leaps in modern tech-

nology, the conflict in Iraq having been the proving ground for a number of medical innovations: robotic prostheses for amputees, pills that read soldiers' vital signs, computer chips that pinpoint wounds, vacuum-sealed sterile pressure bandages, operating-room laser technology, and even a new form of antibacterial gauze with a veneer of Vaseline. All are very likely to be put to use in civilian emergency rooms across America someday.

But the primary components of this pipeline are the wisdom and heart, the dignity and valor, the expertise and dedication, of its practitioners. In many ways, this is a horrific story, as all narratives of violence visited upon youth need be. War, for all its lies, is about the truth, and no matter your view regarding the necessity or prudence of the invasion of Iraq, the fact remains that in a distant desert land, our country's soldiers are being torn to pieces at conveyer-belt rates. They would not make it home alive without this pipeline, which starts in the "golden hour," that first 60 minutes after a soldier is wounded in action, when life and death literally hang in the balance.

It starts with the medics in Balad—1337 hours: Wood maneuvers the Black Hawk at treetop level, darting, zigzagging, pursuing a course over as many open fields as possible, the better to spot and evade snipers. A downed American helicopter, even one with a red cross adorning its bulbous nose, is a major coup for the Iraqi insurgency. Below, children race from white-washed farms to peer up at the noisy bird, perhaps expecting to receive one of the soccer balls the med-evac crews often drop as gifts. Two boys fishing from a shallow punt in the slow-moving Tigris give a desultory wave. To the northeast, perhaps a mile distant, two small, single-engine Kiowa Warrior helicopters armed with laser Hellfire missiles flit like dragonflies about a whitish gray plume of smoke. This is the point of impact. The flight crew
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rigation ditches. Rows of date palms sprout in symmetrical patterns on both sides of the emerald waterway, each

does not know if the landing zone is still hot. No matter. They will try to set our aircraft down for no longer than 10 minutes. "Load and go" is the objective.

"We're in and out, no buts," the medic, Sergeant Gerry Bickett, had warned me earlier as we clambered into his helicopter. Bickett, tall, broad, hard as a sandbag, is nicknamed the Angry Medic. He drove home his point by jabbing a thick finger into my chest. "You fly with us and wander off, and we got the wounded loaded but we don't got you? Sayonara, we leave without you. You get some car speeding up and throwing a grenade into the bird. Or somebody in the bushes with an RPG. Don't need that. Understood?" I nodded.

Bickett told me that the 54th had flown more than 3,000 med-evac missions during this, its second tour in Iraq. (The 54th's 11-month tour ended late last November, a few weeks after my visit.) He could count on his fingers, he said, the number of times they'd put down longer than 10 minutes. One of those occasions, said fellow medic, Tomas Chavez, had occurred at the scene of a Humvee ambush-turned-firefight outside the northern city of Kirkuk. Chavez reluctantly recounted the story as Bickett swore under his breath at the memory.

Chavez's crew had arrived to find the driver of the Humvee dead, "... his head barely attached by little bits of muscle." Another soldier was wounded, critical but treatable, after having been run over by a second American vehicle in the confusion of the gunfight. A bullet had severed the femoral artery of a third soldier, Chavez's priority.

"He looked about 14," the medic said. "I'm kneeling in this spreading pool of his blood, reaching up into his gut looking for the artery, trying to see if I could feel any bleeding against my fingers in there, and this kid, ghost-white pale, he keeps grabbing my hand and repeating, 'Don't let me die. Don't let me die.'"

"I'm pushing his hand away, reaching in, trying to put some pressure on the severed artery. But I knew when you lose that much blood—" Chavez's voice trailed off. Bickett walked away, head down, muttering.

"That was one day we were on the ground for more than 10 minutes," Chavez said finally. "The boy died. It sucks. I had nightmares for months. Remembering this kid holding my hand. 'Don't let me die.' Jesus." Chavez shook his head violently, like a wet dog. "That's the exception, though."

I'm reminded of his words as, at 1339, exactly four minutes after lift-off, we close in on the cloud of smoke from

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the blasted Humvee. The Kiowa helicopters loom larger. Below, I catch sight of Abrams tanks and Bradley fighting vehicles tearing down one-lane dirt paths, throwing up gouts of dust as they race toward the point of impact. Two more soldiers down.

U.S. Air Force Balad theater hospital, one typical night: Helicopter rotors slice the desert air, the sound reverberating like the clang of a sword. The aircraft hover in-tiered formation, waiting, in turn, to land. A constant procession of two-wheeled, metal rickshaw-like litters streams into the emergency room. The ambulatory are herded into a corner area, while doctors, nurses, and medical technicians toting chest tubes, wound kits, bandages, anesthesia, antibiotics, and emergency airway tubes swarm the litter-bound, five or six to a patient. They break into teams, depending on wounds. Orthopedic surgeons with vascular specialists, neurosurgeons with ophthalmologists, heart surgeons with facial-reconstruction experts. The most desperate patients are stabilized, prioritized—for the trauma ward, for ICU, for surgery. In heartbreaking situations, some are marked "expectant," as in, expected to die.

From Tikrit, a specialist E-4 is wheeled in, a member of the New Hampshire National Guard, his head swollen grotesquely from a gunshot

wound. Next, from Balad city, a GI who has taken an RPG to the chest and looks as though he has passed through a wood chipper. Two Marines follow, from Anbar province, victims of an IED blast. Blood drips from too many wounds to count. "How's my buddy?" croaks the one still conscious. After him, another army grunt, looking no older than 15, his left arm gone, his torso and legs punctured by shrapnel. Followed by a burly soldier, another specialist E-4, his right leg hanging by sinews, his left arm swathed in bandages that reek of rotted flesh. It reminds me of a charnel house, men torn to pieces.

An Australian army chief of nurses stands at the tent entrance, tracking the patient and resource flow. Behind him, unscathed soldiers emerge from the night, shuffling their feet, worried, sad, pissed off, their rifles on safety. They have come to check on squad mates, to volunteer to give blood. Med techs race out of the E.R. with dirty instruments, rush back in with sanitized ones. Litter bearers bend to scoop up soiled desert camouflage uniforms, bandages cut from torn bodies. More stop to sop up puddles of blood. The smell of putrid, dying muscle and tissue is almost visible. It mixes with the rubbery odor of fluids used to clean wounds, to fill intravenous tubes. No one shouts or hollers. Still, authoritative voices, sharp enough to cut falling silk, pierce the din.

"Need x-rays right here, now!"



"Just frags, soft-tissue damage. Wheel him aside."

"Out of the way, move, move, move; body coming through."

"Internal blood pooling. Sonar
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scan, please."

Air Force Colonel Elisha Powell IV, M.D., the hospital's commanding officer, locks eyes with me. "Drury! Men's Health! Over here. Little help." Given the frenzy, I find his catch-in-the-throat baritone incongruously calm. "Talk to this soldier."

It is the burly GI close to losing his leg. His face is peppered with shrapnel, his front teeth missing, his lips swollen. I read his name off his chart, stroke his unbandaged right hand. "Charles, Charles, it'll be okay. You're going to be all right. Charles? You hear me, Charles?"

"Hell! I doin' here?" he rasps. He is from the California National Guard. Blown out of the turret of his Humvee by an IED while conducting a raid in south Baghdad.

"Charles, listen to me. These docs are the best, man. The best. Fix you up like new."

Dr. Powell, an orthopedic surgeon, bends over the soldier's shattered leg and says, without looking up, "Gonna get you on the cover of *Men's Health*, Charles."

I say, "That's right, Charles, get you on the cover."

With this, the slits of Charles's hot red eyes open almost imperceptibly. He turns his head.

"No way, man. Ain't got the abs." Then the IV of Valium, tender oblivion.

"O.R. 3 is open," someone says.

"I need it!"

Like this, for hours.

The Balad theater hospital, the busiest frontline medical facility since the Vietnam War, resembles nothing so much as a Bactrian bazaar. Two rows of parallel, 64- by 20-foot interconnected tents extending 300 yards have been laid over a concrete slab in the shape of a giant letter H. The double-corridorred canvas structure, connected by a middle passageway, houses a large emergency room, a pharmacy lab (with a mobile isolation chamber capable of mixing drugs, such as antibiotics or insulin drips, in a sterile environment), multiple recovery wards (for Americans, allied combatants, Iraqi civilians, and enemy wounded), warrens of offices, storage rooms, and nonmedical tents used as a conference room, small chow hall, and admitting office. Its six operating rooms are its only hardened

facilities, built to withstand a mortar attack.

One night, a wounded GI, his arm in a sling, stubs out his smoke and asks me if I know the name of the doctor in pale blue scrubs standing outside the door to the tented emergency room. "I swear that's the guy who brought me in," he says. It is, in fact, Tomas Chavez, who, when not flying DUSTOFFs, volunteers as a physician's assistant in the hospital's emergency and operating rooms. After

"It's all about speed. That's the biggest difference in saving lives in this war. We call it the Del Rio model. . . ."

Chavez and the wounded soldier exchange greetings, I sit down with the medic, who is emblematic of the symbiotic nature of the U.S. military's medical pipeline.

With his dark, brooding features and big coal eyes, Chavez, 30, is ribbed by his fellow medics as the Erik Estrada of the 54th. He's the oldest son of Mexican immigrants who settled in Tempe, Arizona. The first in his family to attend college, he was a senior majoring in premed when the 9/11 attacks occurred. He interrupted his schooling to enlist in the army and, like his fellow medics, before being deployed to Iraq was put through courses in trauma medicine, emergency medical skills, and Special Forces medical training. He intends to enroll in the University of Arizona's medical school when his four-year enlistment is up.

He says what he has learned assisting the doctors at the hospital has been invaluable out in the field. In the operating room, he may intubate the airway of one patient, remove small pieces of shrapnel from the flesh and bone of another. "Everything I do in there just gives me that much more confidence on a dustoff," he says. "It's the same for every medic I work with."

The operating rooms are the hospital's only sterilized shells, and as Chavez and I now walk the dusty hallways, he takes informal inventory of the new medical technology that war

naturally breeds. We pass areas laden with a pharmacopoeia of drugs, rooms stacked floor to ceiling with boxes of blood, QuickClot clotting agent, "clingy" gauze, and vacuum-sealed pressure bandages. "But new doesn't always mean better," he says, demonstrating how an older, plastic-hinged tourniquet outperforms its modern metal counterpart. "And the old standbys never go away," he adds, patting his flak vest and producing several tampons from his pockets. "Can't beat them for jamming into bullet holes."

Chavez and his fellow medics fear that now that the enemy knows the American battle rattle is keeping soldiers alive by protecting their vital organs, they will raise the ante. "We're already seeing a lot more burn victims. They've learned about the armor plating, so they're packing their IEDs with detergent, oil, and gasoline," he says.

"My first tour, I figured you never know what you're gonna find at the point of impact: soldiers trapped in burning vehicles, firefights, bodies blasted by IEDs," Chavez continues. "But now, after two tours, it pretty much comes down to finding one thing: anybody who's still alive. Then making sure they're still alive by the time you get 'em back to base."

Chavez pauses. "Don't paint us the heroes," he finally says. "We only go out and get 'em. It's the Air Force docs in the base hospital who keep 'em alive."

It's well past midnight. Outside, beneath a starless canopy, Dr. Powell, exhausted, satisfied, sighs. "Didn't lose one tonight," he says. This is routine. Ninety-six percent of the wounded who arrive alive at Balad theater hospital to be treated by the Air Force's 332nd Expeditionary Medical Group survive. Dr. Powell is taking a moment to introduce me and photographer Max Becherer to the Swamp, a grimy, pillbox-like structure adjacent to the hospital, where he and his surgeons catch catnaps between shifts. They have named it in homage to the living quarters of the characters Hawkeye Pierce and Trapper John on *M*A*S*H*.

"It's all about speed. That's the biggest difference in saving lives in this war," he says. "We call it the Del Rio model, after a small town in West Texas

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about 150 miles from our stateside base in San Antonio. When you get hurt in Del Rio, there are lots of little community hospitals between Del Rio and San Antonio. But you shouldn't stop there if you have a severe trauma. You want to go right to San Antonio. The medics know it; the pilots know it. Don't make the intermediary stop. It's a waste of time, and time is precious."

Twenty-five minutes is the average time elapsed between a point-of-impact dustoff and a wounded patient's arrival in a Balad operating room. This includes stops for emergency room triage, portable CAT scans, digitized computer x-rays, and sonarimaging scans that detect internal bleeding.

Although it lacks Hawkeye's still, the Swamp does have a tar-beach roof to which the medicos now retire to sit in rickety beach chairs and smoke thick, pungent cigars. The roof overlooks the perimeter wire, the pitch-black "real Iraq" not 20 feet away. Dr. Powell offers me a cigar, reads my thoughts. "Keep the glowing end cupped in your hand," he says.

My eyes drift toward the wire, with its canal berm offering natural cover. "It only takes one," says Becherer.

"Think of the mortars as lightning," shrugs Major Corey Harrison, M.D., a redheaded E.R. specialist from New York. His body armor is smeared with dried blood. "If it's your turn, it's your turn. Nothing you can do."

Balad hospital is staffed by a remarkable collection of Air Force surgeons and trauma-care doctors, aided by a few Army or Navy practitioners, as well as multinational auxiliaries (Aussie nurses, Iraqi interpreters). The medical group includes four orthopedic surgeons, two neurosurgeons, six trauma surgeons, a facial-reconstruction specialist, a heart surgeon, a urologist, a vascular surgeon, two hand surgeons, and an ophthalmologist. Their pedigrees form an impressive roster: Ivy League universities, Georgetown, Notre Dame, and (like Dr. Powell himself) the Air Force Academy.

"Even with an unlimited budget, I couldn't buy in private practice the team I have here now," says Dr. Powell. He screws up the features on his hawk-like face, and a sudden breeze rustles his salt-and-pepper hair. "Not at the Mayo Clinic, not at the Hospital for

Special Surgery in New York. No-where."

"Back in the States, we'd be at each other's throats," adds Colonel Jack Ingari, M.D., a Harvard graduate, the hospital's second in command, and one of the nation's foremost microscopic-vascular-surgery hand specialists. He laughs. "Who's making more money? Who's the top dog? Who's the lead surgeon, and who's the assistant?"

"Jeez," he continues, "there'd be scalpels in people's backs."

"Think of the mortars as lightning. If it's your turn, it's your turn. Nothing you can do."

"As corny as it sounds, over here it's a higher calling," says Dr. Powell. "No one in an emergency room back in the States sees in six months what we see here in one night. Most of the things I've seen here—the huge blast wounds, the head injuries, the amputations, the open fractures—I'll never see again in my professional career."

Now the conversation ceases, and several surgeons prick their ears toward the night sky. Somewhere in the distance, the muffled beat of a helicopter's rotors ruffle the air. The doctors stand as one, douse their cigars. "They say medicine is a marathon," Dr. Powell says. "Well, out here it's a sprint."

Around 5 o'clock the following evening, I witness Dr. Powell and Dr. Ingari performing a delicate procedure on a soldier whose leg has been shattered by an IED. It is called an internal fixation. After drilling a hole down to the marrow in one end of the boy's femur, the doctors insert a steel rod through the length of the broken bone and hold it together by tightening screws through pre-cut holes in the rod. The device keeps the long bone from moving or shortening as it mends, and a drain is left in the wound to collect excess blood and lower infection risk.

"This is something that's never been done in field hospitals before," says Dr. Powell. "Normally, a patient would have to wait until Landstuhl, or even the States, because no one would think to do it in the field. But we've

got people here innovative enough to perform all sorts of new procedures, and I guarantee you the one thing that will come out of this war, besides the technological advances, will be the experience that we're pumping through this system. These surgeons and nurses and enlisted techs are going to be the ones who carry America's health-care system through future mass-casualty events."

He sweeps his hand in the direction of the emergency room. "The young doctors you see out there? They'll be the leaders in their medical communities when they get out. They'll be the folks teaching everybody at our medical centers and our medical schools and our trauma hospitals for the next 20 years. No one else will have this experience."

To punctuate his remarks, the base's warning siren sounds, and a recorded voice intones, "Incoming. Incoming. Incoming." In the E.R., medical staffers nonchalantly lay aside scalpels, intubation tubes, anesthesia drips, to don helmets and armored vests before returning to work. Somewhere on the far side of the base, four staggered mortar explosions resound. The only surprise, one trauma doctor tells me later, is that the blasts were spread out over several seconds. "Usually, they're bangbangbang."

The next morning, an explanation. The enemy has perfected a new ploy: placing mortar tubes into buckets of water, which are then frozen and planted near the wire in the middle of the night. When the morning sun melts the water, the mortars drop, hit the bottom of the metal buckets, and fire. Because the pails vary in size, the water melts at different rates, producing the staggered firing effect.

A few hours later, two Iraqi boys are delivered to the Balad theater hospital by a med-evac from the 54th. Gerry Bickett, cursing, carries one in. Ten-year-old playmates from a village near the Syrian border, they'd stumbled across a small, unexploded IED, picked it up to examine it, and thrown it away. That's when it exploded, raking them both with shrapnel and breaking the leg of one child. The boys' fathers have accompanied them on the Black Hawk, and as the two slight, nervous men pace

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the emergency room in their soiled dishdashas, Dr. Powell and Dr. Ingari operate immediately.

Afterward, over coffee, I ask the 44-year-old Dr. Powell, still wearing his surgical scrubs, how often he is reminded of his own children back in San Antonio. "Sometimes you feel a tremendous amount of pressure, but to be an effective surgeon, you have to compartmentalize those feelings," he says.

"I have to focus on saving these patients' lives, be they Iraqi or American kids, rather than dwell on the fact that I have a 12-year-old boy and a 10-year-old girl back home.

"Our patients don't have time for us to feel sorry for them," he goes on. "They come to us to fix them, to repair their fractures, to close their wounds, to make them better. If I start thinking that this could be my son or my daughter . . . let's just say they don't want us to feel sorry for them. They want us to patch them up and get them back to their units."

Combat takeoff, 0300. The cavernous C-17 Globemaster cargo jet taxis, picks up speed, and shoots into the coal black sky like a rocket. Through the dim, red blackout lights, I watch as the head nurse, maintaining her balance while wearing 40 pounds of Kevlar, monitors the machines attached to the six litter-bound patients strapped onto metal cots. Most are unconscious. Eleven additional soldiers, walking wounded who are armored, helmeted, and belted into fold-down chairs lining both sides of the windowless fuselage, brace themselves against gravity. The C-17's pilots will take stomach-twisting evasive action to 24,000 feet, level off at 30,000 feet, and turn on the lights once they have escaped Iraqi airspace.

If a combat landing on an Iraqi airstrip is comparable to being a passenger in a kamikaze dive-bomber, the combat takeoff, says U.S. Air Force Lieutenant Colonel Scott Van De Hoef, M.D., "is like being strapped to the back of a giant arrow shot straight into the air."

A few hours earlier, Dr. Van De Hoef and I had stood alongside the Balad flightline in the shadow of the CASF's tented facility, where the physician works. CASF stands for Continuity Aeromedical Staging Facility,

and as Dr. Van De Hoef explained, "I guess you'd describe us in baseball terms as kind of like a middle reliever, the bridge between the starters at Balad and the closers in Landstuhl."

Dr. Van De Hoef, 36, a Florida family practitioner, has a soft smile and an easy wit, although at the moment we spoke, humor seemed antithetical to the point. He and his medical team had just finished lifting a horribly burned soldier through the yawning clamshell of a C-17, where his life-support system

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would be monitored by a critical-care air-transport team (CCATT) during the five-hour flight to Ramstein Air Base in Germany. Each CCATT consists of a trauma surgeon, flight nurse, and respiratory technician.

The burned GI had been delivered from the theater hospital to the air transport by a CASF ambulance bus and carried into the jet with what looked like a desktop computer resting on his chest. "Packaging the patient," it's called, and it consists of a ventilator, a cardiac monitor, a blood-oxygen monitor, vacuum suction tubes to keep wounds clean, and a blood-pressure monitor. If the Black Hawk medevac helicopters are flying emergency rooms, the CCATT flights are movable ICUs. When necessary, an Air-Evac flight can accommodate 36 litters, stacked three high on stanchions.

I asked Dr. Van De Hoef about the frequency of the Air-Evac flights out of Balad, considering that injured soldiers are typically whisked out of the hospital within 24 hours. He ran a finger down the sheaf of paper attached to the clipboard he was holding. "I've had wounded soldiers from everywhere in Iraq come through here for . . . let's see . . . Sorry, this register goes back only eight weeks. But in that time, we've loaded over 100 flights, more

than 1,300 patients. You can extrapolate a year's worth." (It works out to about 8,000 living patients a year. Battle dead are shipped home directly on separate flights.)

He shook his head slowly. "You only hope you can do right by the families who can't be here when you're taking care of their kids. Last week, we had a kid come through, his face looked familiar, and I thought I recognized the name. I asked him, 'Didn't I just send you out of here?' He goes, 'No, that was my brother.'"

Tonight's Air-Evac crew, an amalgam of Mississippi National Guard airmen and German-based Air Force medical staff, have their hands full during the uneventful flight to Ramstein Air Base. The nurses hustle from litter to litter, monitoring and remonitoring the myriad machines recording the vital signs of the wounded.

At Ramstein, the wounded exit the plane in a teeming rain—carried, limping, walking—and are transported from the American air base via blue ambulance buses to the circular drive outside the Landstuhl Medical Center's emergency room. Employing a "joint tracking system," medical personnel in Germany are already aware of the specific treatment each injured soldier requires, be it burn care or the management of brain injuries, bullet wounds, or amputated limbs.

An Air Force chaplain outside the hospital positions himself to be the first to speak to any conscious soldiers coming off the bus. "We've been praying for you since you were injured," he says. Off to one side, I spy several American nurses near a smoking kiosk, their eyes rimmed in red. I learn that they are mourning the passing of a patient, a young soldier who was kept alive on a ventilator long enough for his parents to fly in from the United States and watch him receive his Purple Heart.

"We have empathy, but we can't have sympathy," one tells me. "We'd fall apart." Her swollen eyes belie her words.

"Compassion fatigue—it happens to all of us," says U.S. Air Force Major Tim Woods, M.D., the lanky 38-year-old general surgeon whom I accompany on his rounds through the in-

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tensive care unit at Landstuhl Medical Center. "Sometimes you start thinking about how overwhelming it all is."

The Landstuhl facility, the largest American military hospital outside the United States, sits atop a small mountain overlooking the town of the same name. Staffed jointly by about 2,000 Army and Air-Force medical personnel, the 162-bed medical center is bounded by dark, wet hills blanketed by maple, black locust, and birch. Although a quarter of its multinational patients arrive with hard-core battle injuries from Iraq and Afghanistan—"down range," as the war zones are called—the hospital is, aesthetically, far enough from Balad to be on another planet.

That is, until you encounter its patients. In one room Dr. Woods introduces me to the burn victim, a kid in his early 20s whose only request is to be "made whole enough" to rejoin his unit. Dr. Woods asks me not to follow him into a second room. Inside is a boy, unconscious on the bed, the victim of an RPG attack. "He's not going to make it," Dr. Woods says.

The doctor describes Landstuhl as a "stabilizing and reconnecting" facility. "In Balad, they stop the bleeding, save the patient's life," he says. "Here, we get them on the road to rehab and recovery that, hopefully, continues back in the States." (All patients who are wounded in action and sent to Landstuhl head home from here; 22 percent eventually make it back to their units.) Any patient not confined to a ventilator at Landstuhl begins physical rehab immediately upon arrival. It's not as easy as it sounds. There are amputees' bones to be beveled and skin grafts to be performed. Immune systems are weak, and viral pneumonias and bacterial infections rage.

But at the end of the day, Dr. Woods says, it's the speed with which the wounded arrive in his ward that holds him most in thrall. "That's the most important and amazing medical advance of this war."

I cannot share his enthusiasm, I admit to him. I have seen more than enough of the torn and shattered young victims who constitute this pipeline. He nods. "I know. I see these kids coming in, half my age, just blown to hell. Rips up my insides."

DUSTOFF site, 1340. The Black Hawk medevac puts down in a blinding cloud of dirt and grit. It has taken us exactly five minutes to get here, an arid soccer field abutting a small cluster of flat brown houses. Medic Elizabeth Shrode and crew chief Brandon King heave two litters from the helicopter's side door. Shrode dashes toward an inert body, splayed perhaps 20 yards from the idling helicopter. King, tethered by a radio cord, stops several feet from the Black Hawk, drops to one knee, swivels his M-16 in an arcing motion.

"In Balad, they stop the bleeding, save the patient's life. Here, we get them on the road to rehab and recovery that, hopefully, continues back in the States."

Ground troops from a nearby Bradley fighting vehicle rush to meet Shrode, now bent over the fallen soldier. He has short, blond curls. He does not look much older than my 8-year-old son. His face, a death mask, has gone gray. Shrode feels his wrist, searching for a pulse. She drops his arm and places her fingers against his neck. Blood pools in the sand. He is lifted onto a litter. Most of his insides spill onto the ground. Only now do I realize

that his feet are facing backward. He has been blown in half, his body held together only by his belt and uniform pants.

Shrode turns, yells something to the ground troops. She is looking for the second soldier. There were supposed to be two: one urgent; one priority. The platoon leader on the ground appears confused. He races back to the Bradley, picks up a field telephone. Using hand signals, he indicates that the dead boy on the litter is alone. Shrode and three GIs lift the body onto the Black Hawk. King covers them. We lift off again at 1345. Just five minutes on the ground. We arrive at the Balad theater hospital five minutes later. There is no urgency to the flight.

Back at the 54th's headquarters, a maintenance team immediately begins the task of power-washing blood from the aircraft. The crew huddles in a semicircle. No one says a word. I walk away. Sergeant Joe Renteria, the company's medical-standardization instructor and, at 31, the wise man of the outfit, approaches me.

"You okay?" he asks.

"Oughta see to your crew," I say.

"I'm seeing to you."

"Kid didn't look much older than my son."

"You can't take it personally."

I look up at him.

"We got the best track record in the army," he goes on. "We bring 'em back alive . . . almost all the time." ■



The Vietnam Veterans Association Mike Novosel Chapter of Harrisburg, PA, adds \$1,500 each year to our Mike Novosel DUSTOFF Scholarship. Go to <http://dustoff.org> for application instructions. Applications must be submitted by 1 May each year.

Nominate Your Hero for the DUSTOFF Hall of Fame

DUSTOFFers, don't let our legacy go untold. The Hall of Fame honors those who exhibited our ethics and standards in their actions and their contributions to DUSTOFF. Do your homework. Find out about that man or woman who made a difference in your career by his or her inspiration. Research your hero and nominate them. Deadline is May 1. Details are on the dustoff.org homepage. Click on the Hall of Fame tab at the left of the opening page for information. It's OUR Hall of Fame; let's make it complete.

New Entries on the Flight Manifest

SPC Brian E. Benesh	L
SGT Johnathan D. Clavier	M
James L. Coleman	M
COL Mike Hulsey	L
SGT Patrick G. Jackson	L
CPT Mark A. Lawrence	L
SPC Robert R. Long	L
Kim D. Mansfield	L
Mark W. McCall	M
CW2 Richard McCorry	L
SGT Joseph Pellegriti	M
SPC Steven M. Rabinovich	M
SGM James W. Reeves	L
Gary L. Scofield	M
SGT Robert L. Shearer	L
William J. Simone	L
CPT Roderick Stout	L
SFC Scott Stover	L
SSG Roger Tomczak	L
SGT Thomas Yates	M
SGT Kimberly D. Viles	L



Treasurer's Report 5/1/2006–10/14/2006

Interest Income	\$166.53
Membership Dues	\$1,777.50
Memorial Donations	\$1,000.00
Historical Project—Book	\$500.00
Sales Income	\$3,617.12
Scholarship Fund Income	<u>\$5,010.00</u>
Total Income	\$12,071.15

Charity	\$1,000.00
Newsletter Publishing	\$2,410.58
Operating Expenses	\$419.53
Sales Expense	\$1,913.78
Scholarship Fund Expenses	<u>\$5,300.00</u>
Total Expenses	\$11,043.89

How to Contribute Articles to *The DUSTOFFer*

The DUSTOFFer would like to publish your article. If you have a recollection of a particular DUSTOFF or MAST mission, please share it with our members. If your unit has been involved in an outstanding rescue mission or worthwhile program, please submit your essay about it to *The DUSTOFFer*. Don't worry about not being the best writer. We will edit your material professionally. Send photographs with your article or attach them electronically to your e-mail.

Send typed, double-spaced hard copy to the address below, or e-mail your article to secretary@dustoff.org or jtrus5@aol.com.

Please send your submissions to:

The DUSTOFFer
P. O. Box 8091
San Antonio, TX 78208

DUSTOFF—Australian Rules

Lloyd Knight served with the Royal Australian Air Force, No. 9 Squadron, at Vung Tau, in Vietnam in 1969. They flew in support of Australian and New Zealand Army units from their forward base at Nui Dat, which means "small hill." This base was located in Phuoc Tuy Province, about 75 kilometers to the southeast of the Capitol, Saigon. The squadron's main mission was troop-carrying sorties of various types, including the insertion and extraction of reconnaissance and fighting patrols, Special Air Service operations, general troop movement, and medical evacuation (MedEvac). The squadron also had a gunship flight.

It had been a very long day. Dusk descended as we made our final approach to the helicopter landing area at Nui Dat. We completed our approach to a hover and air taxied over to the fuelling area to gas up, preparatory to returning to our main base at Vung Tau, about a twenty-minute flight to the south. A delay on our final mission for the day had made us late, so all the other squadron aircraft had returned to base.

For tactical expediency, helicopters were usually refueled with engines running. This was potentially dangerous because of fire risk. The pilot's seatbelts were undone and seat armour retracted to allow a rapid escape in the event of a mishap. The crewman conducted the fuelling operation, with the door gunner manning the fire extinguisher.

I was riding left seat. This is normally the copilot's position in the Huey. Because I was the Squadron Training Officer, I often occupied this seat while the young pilot I was checking flew from the command—right seat. In this case the training officer takes on the copilot duties.

As the crewman was completing the fuelling operation, a call came from the Command and Control Centre, to which I replied, "Albatross zero two, go ahead."

The controller responded, "A platoon has come under heavy fire, twenty minutes from your position. One soldier critically injured. Require immediate DUSTOFF. Both Medical Corps units (U.S. Army) are presently deployed and cannot respond. Are you

able to accept this task?"

"DUSTOFF" is the acronym for the motto of the U.S. Army Medical Corps: "Dedicated, Unhesitating Service to Our Fighting Forces." The term was used to describe a helicopter operation that provided the "Med-evac" of wounded troops.

I answered, "Albatross zero two, affirmative, go ahead with location and details."

They were fairly sure the enemy had succumbed to the return fire or had quit the vicinity. He had called in the gunnies in case they went hot again.

The other pilot called to the crewman, "DUSTOFF!" and told the door gunner to grab the spare stokes litter. This is a seven-foot long stainless steel stretcher fitted with straps, used to lift casualties or cargo. One of these units was located near the fuelling point for just such an exigency. The crewmen had also received rudimentary first aid training to enable them to cope with this type of mission.

I copied down the details, which were in code: the location grid reference, call sign and radio channel, and the nature of injuries. The wounded digger had four gunshot wounds to the thorax. Because of the seriousness of his injuries, we also were instructed to take the casualty directly to the military hospital in Saigon.

I advised the crewman and door gunner to wear their bulletproof plates under their flak jackets because we could come under attack. These curved shields, made of Kevlar, were part of the bulletproof vest issued to all crew. The crewman and gunner often placed them under their seats, to protect their important parts from rounds fired from directly below the aircraft.

The other pilot and I exchanged seats, and he took over the copilot du-

ties.

With all checks completed, we took off into the now black night and headed west at an altitude of around two thousand feet, about six hundred meters, to our task site. The copilot established communications with the platoon. The officer in charge advised us that the potentially hot area was several hundred meters to their south. They were fairly sure the enemy had succumbed to the return fire, or had quit the vicinity. He had called in the gunnies in case they went hot again.

Because they were located in the tall timber, he warned that we would need to perform a hundred-foot winch lift. The casualty wasn't really stable. He had lost a lot of blood, and there was nothing more they could do for him except get him to hospital. He was already strapped into a fold-up litter and ready to be lifted. I advised that we would terminate our approach to a hover in the treetops using the landing light.

The Huey is equipped with two powerful, controllable lights. The landing light, under the belly, can be rotated from vertically down to straight ahead. The searchlight is located under the nose and can be swiveled in all directions. Each pilot can control the lights, and the crewman/winch operator on the right side of the aircraft can switch the landing light on and off. We would use no other lights, to make the aircraft as inconspicuous as possible.

The patrol had floated a balloon light, which was attached to a string, up through the trees to mark their position. This is a helium-filled, red balloon with a small battery-powered light inside. They also flashed a Morse Code letter with a shielded torch, which we read back to confirm their identification. This was an added security measure, used in case the enemy also sent up a balloon to attract the helicopter crew to the wrong location, and thereby became a target.

We made our approach to the balloon, heading west to place the left gunner facing the previously hot area. I turned on the landing light at the last

(DUSTOFF, continued on page 22.)

(DUSTOFF, continued from page 21.)

minute and told the crewman, "You have the con."

During winching (hoist) operations, the pilot hands over the directing of the aircraft's position to the crewman/winch operator. He then coaches the pilot into the final position, something similar to the old WW II bomb-aimer. He keeps the pilot informed about the progress of the deployment of the winching cable, the hook-up, and the instruction to "Take the weight." The pilot applies power to ensure that the helicopter is capable of lifting the extra load. Then the crewman reels up the patient, keeping the crew informed of the progress of the operation. He also keeps a check on the tail rotor's clearance from obstacles. It's a highly responsible job.

The crewman gave me the last few corrections to our position, to place the aircraft directly over the casualty. I descended until the skids were at treetop level, having ensured that the tail rotor was in a clear area. The crewman started the cable on its way to the wounded man below.

When the hook was about half-way down, all hell broke loose to our left. Heavy fire came up through the trees, and our door gunner started pounding away with his M60 machine gun. The Aussie troops below also returned heavy fire and another fight was on.

The man on the ground yelled on the radio, "Get that chopper out of there!" I had already switched off the light and was applying power, climbing vertically so the hook wouldn't snag in the trees. The copilot set maximum transient power, and we climbed at about four thousand feet per minute. The winch operator was madly reeling in the cable, and the gunner continued to let them have it to our left.

As we went through a one thousand-foot increase in altitude, I nosed over and high-tailed it out of there into the safety of the big black sky. As we climbed rapidly to the west, two gunnies rolled into an attack on a reciprocal course to our left. We turned right, to the east, and set up an orbit at a couple of thousand feet and three kilometers from the firefight.

After about twenty minutes, we advised the Platoon Leader that we would

need to refuel if we were going to take the casualty to Saigon. He replied that they would need at least a half an hour to subdue this new threat, so we scurried back to Nui Dat. We flew at maximum cruise speed, landed and filled the tanks. We hadn't been called back in yet, so we returned at our best endurance speed to conserve fuel.

Arriving back on station after an absence of forty minutes, we could see that the fight was still going on. It was really hectic down there, with heavy

When the hook was about half-way down, all hell broke loose to our left. Heavy fire came up through the trees, and our door gunner started pounding away with his M60. . . .

machine gun fire, grenades, and rockets. The gunships were giving their best, making pass after pass against the heavy resistance. We commenced orbiting again and waited to be called in to make another attempt.

During this period of relative respite, the crew started to talk on the intercom. There was an aura of virtual light-heartedness that was probably a self-protective reaction, due to the various levels of anticipation as to what we could expect next. We discussed the pros and cons of risking being shot down.

I have never felt "scared" during combat operations. That seems to come later when you are safe, and have time to ponder the "what-ifs." However, I do recall vividly that throughout that half-hour wait, I certainly felt apprehensive about returning to such a potentially dangerous situation.

Decisions, decisions! It would not be smart to place the aircraft and crew, and the troops underneath, in a position where we would all be wiped out by being shot down. On the other hand, our duty was to rescue the person down there, who was obviously in a life-threatening state. On that occasion, I didn't have to make the decision.

After about another twenty minutes, the shooting had ceased, and the gun-

nies said they were returning to base. The bloke on the radio called us saying, "Thanks for your help, DUSTOFF, the battle's over; come back in the morning."

The young door gunner, who had just experienced his first firefight, said, "Thank goodness, he must be all right now."

There was a moment's silence before the older, experienced crewman said, "Yeah, I suppose so. We don't recover body bags at night."

The young man sobbed into his microphone, "I didn't know that's what he meant, but I didn't want to go back down there again."

Over the years, I have often wondered what a difference another couple of minutes would have made. If we'd managed to get him on the hook before they started shooting, maybe we could have towered out and saved him.

Then I think about the other possible outcomes. He may have been snagged in the trees and brought us all down. He may have been shot again! And, of course, with such severe injuries, his chances of surviving that kind of ordeal would have been extremely slim. ■





Top of the Schoolhouse

by ISG Michael Stoddard



This is my first "Top of the Schoolhouse" article, as I recently took over from ISG Carl Martin on 26 July 2006 during our Change of Responsibility Ceremony. I personally want to thank him for his time and dedication while serving as the ISG. He can be proud of the job he did and the impact he had on the students and staff here at USASAM.

We also said a goodbye to COL Monica Gorbandt, as she deployed in support of Operation Iraqi Freedom for 90 days. She will be in our thoughts and prayers, and we look forward to her safe return.

I want to thank the USASAM staff personally for the warm welcome my wife Aimee and I received. We feel very honored to be part of the USASAM family. As for me, I bring 17 years of active service, with over seven years flight experience, to the table. My most recent assignment prior to coming here was as the MEDEVAC Observer/Controller and Aviation Division Sergeant Major at the Joint Readiness Training Center/Fort Polk.

It has been a very busy FY 2006 for USASAM, and our FY 06 numbers show the training tempo is high. USASAM trained a total of over 3,300 students last year between the Flight Medic (300-F6), Flight Surgeon (6A-61N9D), Medical Evacuation Doctrine (2C-F7), Aeromedical Psychology Training (6H-F27), Joint En Route Care Course, Hypobaric Chambers, Aviation Resource Survey (ARMS), and Flight Physiology training for fixed and rotary wing aviators.

The Medical Evacuation Doctrine Course (2C-F7) continues to play a vital role in the education of combat health support planners. The course covers not only Doctrine, but stays current and relevant in the fight by addressing Tactics, Techniques, and Procedures (TTP), as well as Lessons Learned, and includes lesson plans on the role of air ambulance companies in the General Support Aviation Battalions (GSAB). The course has graduated over 78 students in the last six

months, conducting two resident courses and one MTT in support of the Iowa National Guard. The course is scheduled to do an MTT in Guam in late October.

The Flight Medic Course did a great job ensuring that these 19 new Flight Medics are ready to withstand the stressors they will face while flying in support of the War fighter.

I would like to take this opportunity to introduce everyone once again to the Joint En Route Care Course (JECC). This course has changed a little since first introduced back in 2004. The JECC mission is to provide concise, realistic, relevant, and current en route trauma transport training to Joint and Coalition Flight Medics, Registered Nurses, Physician Assistants, and Physicians. The objectives of the JECC are to provide concise and relevant didactic content, realistic, battle-focused lab content, and real-time lessons learned and Internet feedback from students and subject matter experts in the field for DOD aeromedical teams. For more information on the JECC, please go to the USASAM website at <http://usasam.amedd.army.mil>.

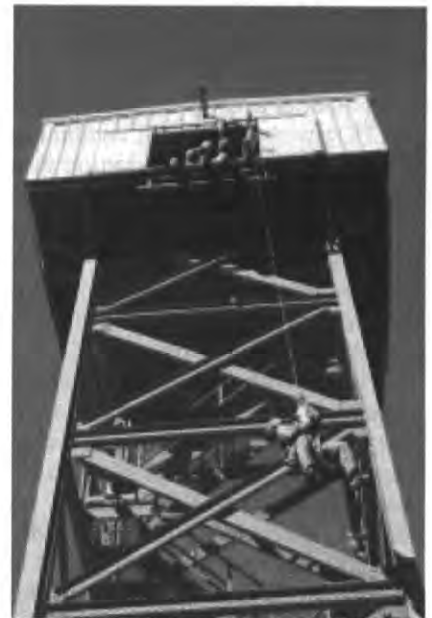
The Flight Medic Course just graduated 19 students from class 06-04. Most of these students will get the call to deploy to Iraq or Afghanistan within six months. The Flight Medic Course did a great job ensuring that these 19 new Flight Medics are ready to withstand the stressors they will face while flying in support of the War fighter.

I would like to acknowledge SSG Rock Rakosi from the Arizona National Guard for a job well done. He was the

Honor Graduate for Class 06-04.

In closing, I look forward to supporting all the DUSTOFF community and commit to providing world-class training from the best instructors the AMEDD has to offer. If you have any questions, concerns, comments, or suggestions about how USASAM can better assist you in the field, please feel free to contact me at COMM: (334) 255-7417 DSN 558-7417, or visit our website at <http://usasam.amedd.army.mil>. Thank you for your DEDICATION and COMMITMENT! DUSTOFF!

—DUSTOFFer—



The Flight Medic Course



From the Consultant

by COL David MacDonald

This marks the first anniversary of both my tenure as Director MEPD and MEDEVAC companies under Aviation Branch command and control. With the help of many Army Medical Department (AMEDD) professionals, much has been accomplished this past year. These accomplishments have laid a strong foundation that will ensure a standardized and efficient MEDEVAC system.

MEPD's primary objective for this first year was revising Army and Joint medical evacuation doctrine to reflect current and future operations under the transformed structure. This was an important first step, as codifying modern medical evacuation doctrine was required to ensure intratheater medical evacuation standardization across the Army and Joint force.

Both the Assistant Commander for Force Integration (ACFI) and Director of Combat & Doctrine Development (DCDD) were integral in combining FM 8-10-6 (Medical Evacuation in a theater of Operations) and FM 8-10-26 (Employment of the Medical Company, Air Ambulance) into one manual, Field Manual Interim (FMI) 4-02.2 (Medical Evacuation), which reflects current and future doctrine.

This interim FM requires review within two years of publication to ensure relevance. This review will capture doctrinal changes and allow an accelerated revision of this manual, an attribute necessary in today's rapidly changing environment. FMI 4-02.2 is in final draft and is posted on the MEPD web site <<https://www.us.army.mil/suite/page/86394>>. It is scheduled for final publication during second quarter fiscal year (FY) 2007.

Joint medical evacuation doctrine Joint Publication (JP) 4-02 (Health Service Support in Joint Operations) supersedes JP 4-02.2 (Joint Tactics, Techniques and Procedures for Patient Movement in Joint Operations). DCDD, ACFI and Aviation Branch Doctrine of Training and Doctrine (DOTD) supported MEPD's input, identifying the Army as the preferred

service to perform intratheater air and ground medical evacuation in support of a combined joint task force (CJTF). Also, Transportation Command has submitted a Joint Capabilities Document for Secretary of Defense approval, which supports MEPD's doctrinal input. Both documents are scheduled for approval and publication during second quarter FY07.

Aviation branch understands that the MEDEVAC fleet has skipped a generation of modernization and fully intends to maintain the current modernization program.

Revising the medical evacuation officer (67J) career path was also an MEPD priority. DA Pam 600-4 (AMEDD Officer Development and Career Management) is being revised and will reflect the new career path for the 67J. The revised DA Pam outlines, in detail, the 67J career progression from Second Lieutenant thorough Colonel and delineates a diverse career path that includes Joint, AMEDD and Aviation staff and command opportunities. The 67J will have broad professional education requirements in both Aviation and AMEDD curriculums, as well as civilian postgraduate opportunities within the Long-Term Health Education and Training program. This enhanced career path outlines that the 67J must be proficient in both the Aviation and AMEDD branches and truly defines the 67J as the "pentathlete," General Schoomaker describes in his vision.

MEPD also focused efforts on MEDEVAC structure and modernization. MEDEVAC units have one of the highest OPTEMPO's in the Army in support of GWOT and the oldest fleet in Army aviation.

To mitigate the high OPTEMPO

and meet mission requirements, Aviation branch recognized the need for an additional nine MEDEVAC companies, raising the current authorization from 28 to 37 MEDEVAC companies. General Cody has approved adding five MEDEVAC companies to the force structure: four Army National Guard (ARNG) companies and one company in the United States Army Reserve (USAR). The addition of the remaining four companies will be a topic of discussion during the next Aviation Implementation Conference (23-27 October 07).

The HH-60M is the next generation MEDEVAC aircraft. Full fielding of the HH-60M will take a minimum of 20 years (year 2029) at current projected procurement rates. Program Objective Memorandum 07-11 has a total of 54 HH-60Ms programmed, with the first delivery in APR 08 and first unit equipped in FY 09. Aviation branch understands that the MEDEVAC fleet has skipped a generation of modernization and fully intends to maintain the current modernization program.

Finally, this past year MEPD proposed capturing DUSTOFF history from 1973 to the present, picking up where the last DUSTOFF history book left off. With a lot of help from many retired DUSTOFFers and current AMEDD leadership, this proposal is now a reality. The Office of Medical History has contracted Darrel Whitcomb to write the continuing history. He is currently collecting data and conducting interviews. The book is scheduled for completion by August 2008.

Next year, MEPD will focus on refining and solidifying the 67J and flight medic career paths. Additionally, we will work on codifying Joint and Army medical evacuation doctrine, to possibly solidify the AMEDD as the executive agent for intratheater medical evacuation. Furthermore, we will recommend a force design update to im-

(Consultant, continued on page 25.)

Pavilion Dedicated in Honor of MG Spurgeon Neel

He is known as the "Father of Army Aviation Medicine." The late Major General Spurgeon Neel was the driving force behind the Army's adoption of using helicopters to evacuate the battlefield wounded to definitive care.

In a formal ceremony on September 29th, the Spurgeon Neel Aeromedical Evacuation Pavilion of the Army Medical Department Museum at Fort Sam Houston was dedicated in his honor. Participating in the ceremony were the Chairman of the Museum Foundation Board and former Army Surgeon General, retired Lieutenant General Quinn H. Becker; Commander of Fort Sam Houston and the Army Medical Department Center and School, Major General Russell J. Czerw; and Mrs. Alice Neel, widow of Major General Neel.

In addition to his innovative work on behalf of military patients, General

Neel pioneered the use of aeromedical evacuation helicopters for the transportation of civilian traffic accident and other casualty victims.

Reflecting on General Neel's contributions, the President and CEO of San Antonio AirLife, Dr. Robert W. Hilliard, FACHE, said, "Major General Neel's vision and commitment to the concept of the United States military's providing rapid and responsive air medical transport capability to wounded and injured service members have saved untold lives. His success in influencing the military policymakers

to integrate the air medical transport concept into military doctrine, coupled with the fact that in 2006 there are approximately 800 civilian air medical programs in the United States alone and several hundred more around the world, is a tremendous tribute to Major General Neel's air medical transport legacy. Few individuals have had such a positive impact on both military and civilian healthcare delivery."

—DUSTOFFER—

(Consultant, continued from page 24.)

prove the MEDEVAC company structure by adding one flight medic per Forward Support MEDEVAC Team (FSMT), changing the rank of the team sergeant, Staff Sergeant, to Sergeant First Class, and changing the designation from FSMT to Medical Platoon. Finally, coordinate for enhanced communications capability to ensure connectivity to everyone the MEDEVAC mission supports.

This next 12 months are a critical time in the transformation of the MEDEVAC mission. With the possibility of a Joint Medical command and the Army becoming the executive agent for intratheater medical evacuation, I believe MEDEVAC will continue to transform beyond the current structure.

In conclusion, the AMEDD aviator continues to remain true to the aeromedical evacuation mission by quietly, professionally, and superbly executing the MEDEVAC mission. I am extremely proud to be a part of this unique and august group. Thank you for who you are and what you do every day.

—DUSTOFFER—



LTG Quinn Becker



The ribbon-cutting.



Mrs. Alice Neel and LTC (R) Ralph McBride



2007 DUSTOFF ASSOCIATION REUNION

Schedule of Events

February 16–18, 2007



Friday, 16 February 2007

1200–1900 — Registration

1100–1200 — Registration for Chuck Mateer Golf Classic (Fort Sam Houston Golf Course)

1200–1800 — Chuck Mateer Golf Classic (Fort Sam Houston Golf Course)

1400–1800 — Hospitality Suite open

1900–2200 — Unit-Level Reunions (See note below and on page 9.)

2200–0200 — Hospitality Suite open

Saturday, 17 February 2007

0900–1000 — Professional Meeting

1000–1100 — Business Meeting

1100–1300 — Spouses' Luncheon—Citrus Restaurant

1430–1600 — Hall of Fame Induction, Rescue of the Year, and Crewmembers of the Year Awards—AMEDD Museum, Fort Sam Houston

1500–1800 — Hospitality Suites open

1800–1900 — Cash bar at Banquet

1900–2200 — Banquet: Welcome

Invocation

Dinner

Entertainment/Dancing

2200–0200 — Hospitality Suite open

Sunday, 18 February 2007

0900–1000 — DUSTOFF Memorial Service—Holiday Inn Riverwalk

If you are interested in any of these unit-level reunions, contact the Unit Captains

498th Med. Co. — Ron Chapman, 603 Meadow Grove, San Antonio, TX 78239, (210) 653-3114.

159th Med. Co.— CPT Thomas Powell, thomas.k.powell@us.army.mil, (210) 221-9337 (W)

283rd Med. Co. — David Bennett, P.O. Box 24, Ferris, TX 75125, (214) 354-9062 (C), swaerial@msn.com

507th Med. & 82nd Med. — CPT Mark Knight, (210) 221-5285 (W), (210) 323-6931 (C), mark.knight@amedd.army.mil



28th Annual DUSTOFF Association Reunion February 16–18, 2007 Registration Form



Member's name _____ Spouse's name _____

Home address _____

Military address _____ e-mail address _____

Please list your combat-related deployments by theater/year/unit _____

Dues:			Totals
New Member Dues	\$15 + \$10 initial fee (E5 & below—\$7.50)	\$ _____	\$ _____
Annual Dues	\$15 (E9 & below—\$7.50)	\$ _____	\$ _____
Past Dues (Catch up)	\$15 per year owed as back dues	\$ _____	\$ _____
Life Member Dues	\$100 (one-time payment) (Enlisted—\$50)	\$ _____	\$ _____
Reunion Registration:			
Member/Spouse	\$25/person _____ persons	\$ _____	\$ _____
Non-member/Spouse	\$30/person _____ persons	\$ _____	\$ _____
Single-day Registration for Guest of Registrant	\$15/person _____ persons	\$ _____	\$ _____
Late Fee (if after 15 Jan 07)	\$15/person _____ persons	\$ _____	\$ _____

Hotel Reservations:

Call the Holiday Inn–Riverwalk at 800-445-8475 or local (210) 224-2500 to reserve your room. Mention you are with the DUSTOFF Association to get the special rate of \$93/night.

You can register online at <www.holidayinn.com/sat-riverwalk>. The Group Code is "OFF." These rates apply for 16 through 18 February 2007. If you would like to stay longer at that rate, call Dan Gower, 210-379-3985, and he'll try to arrange it with the hotel.

Chuck Mateer Golf Classic:

Ft. Sam Houston Club Member	\$20/person	_____ persons	\$ _____
Non-member Military	\$32/person	_____ persons	\$ _____
Non-member Civilian	\$37/person	_____ persons	\$ _____

Friday Night:

Mexican Buffet (FSH Golf Club)	\$15/person	_____ persons	\$ _____
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Spouses' Luncheon:

Citrus Restaurant	\$20/person	_____ persons	\$ _____
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Saturday Night Banquet:

Beef	\$30/person	_____ persons	\$ _____
Cbicken	\$30/person	_____ persons	\$ _____

Please send registration form and check to: DUSTOFF Association
P. O. Box 8091
Wainwright Station
San Antonio, TX 78208

DUSTOFF Association
P. O. Box 8091
San Antonio, TX 78208-0091

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San Antonio, TX

Address service requested

DUSTOFF Association
Membership Application/Change of Address

- ☐ **I want to join the Association as a Member**
Officers and Civilians **\$10.00 Initial fee**
\$15.00 Annual fee
\$25.00 Total
- ☐ **I want to join the Association as a Member**
Enlisted **\$ 7.50 Annual fee**
E-5 & below **No Initial fee**
E-6 & above **\$10.00 Initial fee**
- ☐ **I want to join the Association as a Life Member**
Officers and Civilians **\$100.00 One-time fee**
E-9 and below **\$ 50.00 One-time fee**
- ☐ **Check here if change of address, or e-mail change to secretary@dustoff.org**

Rank _____ Last name _____ First name _____ M.I. _____
Mailing address _____
E-mail _____ Spouse's name _____
Home phone _____ Work phone _____

Send check or money order, payable
to DUSTOFF Association, to:

DUSTOFF Association
P. O. Box 8091
Wainwright Station
San Antonio, TX 78208