

THE AIR FORCE MEDICAL SERVICE IN  
OPERATION ALLIED FORCE/SHINING HOPE

By James Nanney

Two operations in the spring of 1999 marked the first large-scale deployment of Air Force Medical Service (AFMS) contingency units that had been reengineered in the 1990s, based on lessons of the Persian Gulf War. From March to late June 1999, USAFE was active in Operation ALLIED FORCE in Kosovo, and later the humanitarian operation (Operation SHINING HOPE) for ethnic Albanian refugees fleeing Kosovo to Albania and Macedonia. The Balkan deployment showed that the Medical Service had chosen wisely in recent years by continuing to emphasize lightness and flexibility in its ongoing reengineering of deployable medical assets.<sup>1</sup>

Air Force medical support for Balkan operations was distributed in eleven countries and twenty-three locations. The main locus of line operations in the Air War over Serbia (AWOS) was Aviano Air Base, Italy, which served the 31st Air Expeditionary Wing of 3,800 permanent active duty personnel and 4,100 deployed active duty personnel. About 2,220 NATO military personnel at Aviano lived in a “tent city” that produced significant public health challenges. Other flying and support units were based at various locations around Europe. Flying activity was weighted toward the nighttime hours. Operation Allied Force lasted 79 days and its 170 Allied aircraft flew 7,962 combat sorties and 8,527 combat

---

<sup>1</sup> Paper, Lt. Col. Douglas J. Robb, “From Desert Storm to Allied Force: A Decade of Change for the Air Force Medical Service,” National Defense University, National War College, Washington, D.C., 2000.

support sorties. Apart from considerable in-place medical care provided at Aviano and other established Air Force bases in Europe, the air war over Serbia was medically supported almost entirely with deployed squadron medical element (SME) units and aeromedical evacuation units. Squadron medical elements were teams within the line squadron providing flight medicine and primary care to deployed forces. An SME consisted of a flight surgeon and two aeromedical technicians with (or without) an equipment package known as the “air transportable clinic.” An SME was sometimes augmented with the varied skills of one or two independent duty medical technicians.

A few larger units were also active. On 24 May, a 10-bed Air Transportable Hospital (ATH), the 406<sup>th</sup> from Ramstein AB, Germany, was deployed to Taszar, Hungary to help Army and Navy medics already in place in Hungary.<sup>2</sup> In June a second Air Transportable Hospital, from the 48<sup>th</sup> Medical Group at Lakenheath, England, deployed to Balikesir, Turkey.

Although the Air Force Medical Service in April 1999 had not finalized its reengineering of deployable units for the new Expeditionary Air Force, the Balkans operations also marked the first time a unit called “EMEDS” (expeditionary medical support) was packaged and deployed. This was the “86th Air Expeditionary Medical Squadron (EMDOS) Deployed” that flew to Tirane, Albania on 7 April 1999. Its 24 medics served as an integral part of the USAFE 86<sup>th</sup> Contingency Response Group of 130 personnel deploying from Ramstein Air Base, Germany. The mission was to provide lift-efficient surgical support, outpatient medical care, and medical evacuation in support of

---

<sup>2</sup> Press Release, TSgt. Ann Bennet, USAFE News Service, “Ramstein Medical Unit Deploys to Hungary,” 4 June 1999.

Humanitarian Operation SHINING HOPE.<sup>3</sup> The unit at Tirane reported to surgeon of Joint Task Force SHINING HOPE, who reported in turn directly to the Task Force commander rather than to the J-3 or J-4 staff. Although the Air Force Surgeon General did not approve the reengineering plan for the new “Expeditionary Medical Support (EMEDS)/Air Force Theater Hospital (AFTH)” units until September 1999, the 86<sup>th</sup> EMDOS was composed of various existing unit type codes whose packaging was modeled on the prototype basic EMEDS unit.<sup>4</sup>

Reliance on small units such as SMEs and the 86<sup>th</sup> EMDOS was made possible by a significant limitation on the assigned medical mission. In ALLIED FORCE, United States military medical care for refugees was restricted to emergency care, as stipulated by Title 10 of the United States Code. Once stable, refugees were transferred to a host nation of allied force medical facility. The U.S. European Command concluded that the Title 10 restriction was wise, since Air Force ATHs and EMEDS were “ill-suited and insufficient for providing routine medical care for large refugee populations.... Providing US military care would have required all deployable AF (and US Army) assets in theater at time when the US was engaged in an air war.”<sup>5</sup>

---

<sup>3</sup> After Action Report, 86th Air Expeditionary Medical Squadron (EMDOS) Deployed, to HQ USAFE/SGX, “Medical After Action Report....07 April –07 Jul 99,” 7 Dec 1999.

<sup>4</sup> Rpt, Air Force Medical Service, “Operation Allied Force,” January 2000. Brfg, Maj. Gen. Earl Mabry, AFMOA/CC, to Society of Medical Consultants to the Armed Forces, Spring Meeting, 9 April 1999. Brfg, Brig. Gen. Klaus O. Schafer, ACC/SG, to AF/SG, “EMEDS/AFTH Decision Brief,” 9 Sept 1999, slide 6. Rpt, USAFE/Command Surgeon’s Office, “Medical After Action Report Operation Allied Force,” 14 January 2000, pp. 2,4.

<sup>5</sup> Rpt, Air Force Medical Service, “Operation Allied Force,” January 2000.

With a few exceptions, the mixture and numbers of Air Force medics deployed met the needs of each deployment site. Preventive Aerospace Medicine (PAM) Teams deployed with the initial site survey teams and allowed the Medical Service to tailor subsequent health support to each site. A risk-based strategy of locating and relying on host nation medical support also was successful. Most of the initial support challenges were encountered in forward, bare-base operating locations. In a repetition of the Gulf War experience, the most consistently reported problem from all medical units was the lack of information systems support (secure and non-secure). Reporting of disease and non-battle injuries (DNBI) from forward units to USAFE/SG was hampered by inadequate communications links.<sup>6</sup> The units deployed to Albania and Macedonia also encountered special problems related to the dangerous and austere environment. The air base at Tirane, Albania, was the site with the greatest public health problems, requiring stringent sanitary and food discipline measures. Air Force medics provided the only medical supervision at the Tirane site for several weeks. In general, forward Air Force medical problems were notable when medical units depended on logistics resupply from rear areas rather than on adequate predeployment logistical preparations or judicious use of local resources.

The most significant medical factor potentially affecting flying safety was unusual fatigue and disruption of the normal sleep (circadian) rhythms. The aircraft stationed in Europe flew long hours, with missions often over five hours. B-2 bombing missions from Whiteman AFB, Missouri, lasted over 35 hours. This resulted in strong flight surgeon unit actions, including crew-rest and crew-size adjustments, and, in rare cases, the judicious use

---

<sup>6</sup> Memo, HQ USAFE/SGP, "Joint Universal Lessons Learned - Disease Non-Battle Injury (DNBI) Reporting Lessons Learned," 6 Dec 1999.

of pharmacologics. The challenges of aerospace medicine in such a stressful environment called forth a suitable response from both aviators and their medical support people.

Proof of the success of the Balkan operations came from the highest levels of the Air Force Line. On 1 July 1999 the Air Force Medical Service celebrated its 50th year of operations, in conjunction with the Senior Leadership Training Symposium at the Holiday Inn Boardwalk, San Antonio, Texas. Speaking via teleconference from Europe, the USAFE Vice Commander, Lt. Gen. William Beggert, praised the performance of the Air Force Medical Service in Operation ALLIED FORCE. He said that Air Force medical mobility units were the only medical units that responded rapidly to CINC orders, that all deployed Air Force personnel arrived in excellent health, and that not one Air Force sortie was canceled for medical reasons. The DNBI rate was less than expected, and the medical units worked closely with command channels and other functional support services.

General Beggert noted that his only medical concern during the operation was that the Medical Service on one occasion “leaned too far forward” in its eagerness to support the other Services. In mid-June 1999 the Air Force Medical Service prepared to send an ATH to Camp Able Sentry, Macedonia, to temporarily support Army troops in TASK FORCE FALCON, whose medical support had not yet arrived because of a shortage in USAREUR medical resources.<sup>7</sup> General Beggert and the USAFE commander, General John P. Jumper, had to intercede to prevent what they considered an inappropriate diversion of Air Force

---

<sup>7</sup> After Action Report, 52nd Medical Group FAST, Skopje, Macedonia, “After Action Report,” 6 December 1999. The Army’s 212<sup>th</sup> MASH moved into Skopje in place of the planned ATH.

medical assets from Hungary, where they still faced potential taskings.<sup>8</sup> While claiming that the Air Force was the most “joint” of the Services, General Beggert insisted that Air Force support functions should never become the outsourcing contractor (“Brown and Root”) for the other Services in-theater.<sup>9</sup> In his post-war report, the USAFE surgeon, Col. (later Brig. Gen.) George (“Peach”) Taylor, concluded that Air Force medical contingency units, “...are only begrudgingly allocated to support the medical needs of the other services.”<sup>10</sup>

In the final analysis, the Balkan operations showed the Department of Defense the relevance of Air Force Medical Service reengineering since the Gulf War. The Secretary of Defense’s report to Congress in January 2000 singled out Air Force medical units for praise:

Many of the Service medical units currently in use are sized for a major theater war and are cumbersome when used for smaller-scale contingency deployments. Army and Navy hospital assets, for example, are large and heavy, and thus require use of substantial lift assets when they must be deployed. Their lack of modularity simply does not permit rapid operational support in smaller scale-contingences. The Air Force’s Expeditionary Medical Support (EMEDS) and Air Force Theater Hospital (AFTH) are modularized, able to rapidly deploy to provide forward stabilization, and provide tailored force packages to meet the requirements of theater commanders across the full spectrum of military and humanitarian operations.<sup>11</sup>

---

<sup>8</sup> Article, SSgt, J.C. Woodring, USAFE News Service, “More Troops Arrive at Incirlik,” 9 June 1999.

<sup>9</sup> USAFE Surgeon Medical After Action Report, 14 Jan 2000. Videotape, “Senior Leadership Training Symposium, San Antonio, Texas, June-July 1999,” tape 12 of 15 tapes.

<sup>10</sup> Rpt, Air Force Medical Service, “Operation Allied Force,” January 2000.

<sup>11</sup> Report to Congress, Secretary of Defense, “Kosovo/Operation Allied Force After-Action Report,” 31 January 2000, p. 119.

In these words, the Department of Defense recognized that the Air Force Medical Service principle of rapid deployability — already embedded in small assets such as squadron medical elements, independent duty medical technicians, flying ambulance surgical teams, mobile field surgical teams, and critical care aeromedical transport teams — remained the keystone for medical reengineering in the new Expeditionary Air Force.