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Military Medicine and the Profession of Arms: Brigadier General Frederick Blesse and being an Army doctor

For Army physicians professionalism is a major challenge: are they physicians first and officers second or vice versa? This is a case study of what made Frederick A. Blesse an effective Army doctor. He spent less than 5 years of a 33-year Army career treating patients, but held positions of high responsibility and directed medical care for hundreds of thousands of soldiers. Blesse put the Army first: he certainly knew enough medicine to make medical decisions, but he understood the Army and that gave him the experience for effective staff work and how to push a project to completion. It also gave him credibility in the Army, where the main focus is not medicine.

Early Career, 1917-1930

Born in Elgin, IL, in 1888, Frederick Blesse graduated from Hahnemann Medical College in 1913.¹ He completed an 18-month rotating internship where he rotated through all clinical parts of the hospital at Chicago Union Hospital in 1915. He completed an 8-month surgical internship there the following year and entered private practice around St Louis, MO. In 1916 he applied to join the Army Medical Corps, and took the qualifying exams 2-9 January 1917. As Blesse waited to hear about his Army commission the US declared war on Germany. He registered for the draft, taking no chances that he would be left out of the fight altogether.

He was ordered to Washington DC and entered active duty on 18 July. His first assignment was a single month at an abbreviated course at the Army Medical School, the predecessor of the Army

¹ He spelled his surname Blesse while others in the family kept the accent for Blessé.

Medical Department Center and School.² So rapid was the Army's growth that Blesse, inexperienced as he was, was then assigned as an instructor at the Medical Officers Training Camp, Fort Benjamin Harrison, Indiana.³ After three months as an instructor he was reassigned to command Ambulance Company No. 24, then at remote Fort Clark, TX, and shortly to be on the road via Fort Bliss to even more isolated Douglas, AZ, on the Mexican border. In September 1918 he was reassigned to Fort Sam Houston, where the 18th Division was organizing. As a First Lieutenant he was assigned to command Field Hospital No. 271, a subordinate unit of the division. The 18th Division never deployed, and when the Army started demobilizing after the November 11, 1918 armistice, Blesse was transferred from the division to the hospital at Fort Sam Houston. He served as a ward surgeon and then as adjutant. These were standard assignments for a junior medical officer: ambulance companies included a litter-bearer section, an aid station section, and an ambulance section, while field hospitals had very limited clinical personnel and equipment (for instance, lacking X-ray machines) and were intended to provide short-term care until patients were evacuated sooner.⁴

He was then assigned as post surgeon for Fort Sherman, Panama Canal Zone, a small coastal artillery fort. His main professional concerns were venereal diseases and malaria, and he helped plan the extensive ditching and filling work to drain the swamps.⁵ After three years in Panama, he was assigned as post surgeon to Fort Omaha, NE, a small post just outside the city of Omaha that housed various headquarters. The only major incident there was an interruption of the

² See Stephen Craig, "Evolution of Military Public Health Education, 1893-1966," *Army Medical Department Journal* (April-June 2006):7-17 for more about the Army Medical School.

³ On the MOTC, see the *Annual Report of The Surgeon General, U.S. Army, 1919*, pages 1128-1134. (Hereafter ARSG with year.)

⁴ For more on ambulance company and field hospital training, see William Bispham, *Medical Department of the United States Army in the World War, VII, Training* (Washington, DC: GPO, 1927), chapter 4. For doctrine, see *Manual for the Medical Department, U.S. Army, 1916* (Washington, DC: War Department, 1918), 207-216.

⁵ ARSG 1921, 199 and ARSG 1922, 208-9.

municipal water supply for two weeks in 1923, and it appears to have presented no medical challenges.⁶

Due to the disruptions of the war and the post-war shortage of medical officers, after seven years in the Army he was finally able to complete the normal officer training schools, first the Army Medical School (graduating from the 1924-25 iteration) and the Medical Field Service School, at Carlisle Barracks, PA, being an honor graduate in June 1925. He was assigned to Camp Little in Nogales, AZ, but en route his orders were changed, reassigning him as an instructor at the Medical Field Service School. He had a concurrent assignment in the 1st Medical Regiment (the school demonstration troops) as Adjutant and as Plans and Training Officer. His duties were demonstrating to officer and NCO students from all components how to run the medical detachment of an infantry regiment, including what platoon medics should do, directing litter-bearers, and running an aid station.⁷ Blesse apparently showed a strong aptitude as a field medical officer, training officers and troops, and shaping the troops into effective units; he certainly had many such assignments early in his career and seems not to have sought assignments in hospitals.

⁶ *ARSG 1924*, 276.

⁷ NARA RG112 Entry N(Posts)(Carlisle 315) boxes 41, 45, 47.



Officers and color party of the 1st Medical Regiment, 16 July 1925. CPT Blesse is seated, far right. The regimental commander, seated second to left, would be Surgeon General 1935-39, and three of the other officers would be senior officers in WWII with whom Blesse would work.

Credit: Army Medical Department Center of History and Heritage

A Rising Star, 1930-1940

In 1930 Blesse was the only Medical Department officer selected to attend the Command and General Staff School (CGSS) at Fort Leavenworth, KS. Medical officers were not allowed to focus solely on medical matters, and he wrote papers on World War One combat operations in Palestine, and also compared US and German medical evacuation systems. As a CGSS graduate he was eligible for the General Staff Corps, and his next assignment (1932-35) was as a staff officer, the chief of the Training Division of the Office of The Surgeon General. There he oversaw policies and plans for Regular and Reserve medical units and the medical ROTC programs; the writing of training regulations; and oversaw the training program (including the correspondence courses mainly for Reserve and National Guard personnel) at the Medical Field Service School. There were no major events for him to cope with, other than cuts in Army strength and training budgets due to the Great Depression and having to use work at Civilian

Conservation Corps camps in lieu of individual and unit training. Blesse was apparently disappointed by this and thought that troops were inadequately trained.⁸

Blesse was one of two Medical Department officers sent to the Army War College in 1935-36, a clear indication he had been identified as a future senior leader. His next assignment was quite different: he was sent to the Philippines as Executive Officer of the Philippine Army's medical regiment which was severely below strength, mostly a paper organization. However, after a year US policy on Philippine defense changed: as part of the ten-year plan for Philippine independence the Philippine military would be expanded and made more capable. The small American Military Mission in the Philippines, directed by retired General Douglas MacArthur, had more officers assigned, and from the autumn of 1937 LTC Blesse split his time between the medical regiment and working part-time on MacArthur's staff to help organize a Philippine Army Medical Service (PAMS).⁹ Now Blesse's War College experience became far more relevant as he had to develop a medical service from (almost) scratch, making the case for resources and shaping the environment rather than working within it. From 38 officers in the whole PAMS in 1935, expansion was dramatic: 333 reserve officers were called up for training in 1936, and 113 were on duty at the end of the year.¹⁰ Blesse found his work "very interesting. It gives you a good chance to use your own ideas and initiative" and it made him grapple with

⁸ *ARSG 1933*, 161; *ARSG 1934*, 148; *ARSG 1935*, 142.

⁹ Full-time assignment to the Mission was 1 March 1938, when Blesse's two years in the Philippines was extended a year. Blesse was not the first physician on MacArthur's staff. MAJ Howard Hutter was a friend of MacArthur's and provided medical care to the Mission, and to MacArthur's mother who accompanied him to Manila. Daniel Holt and James Leyerzapf, *Eisenhower: The Prewar Diaries and Selected Papers, 1905-1941* (Baltimore, MD: Johns Hopkins University Press, 1998), 293. Blesse outranked Hutter, and, as many American Military Mission records were lost when the Japanese occupied Manila in 1942, it is not clear how responsibilities were reorganized when Blesse was assigned to the Mission.

¹⁰ *Annual Report of the Chief of Staff of the Philippine Army 1936* (Manila: Bureau of Printing, 1937), 8-9. See also Roman Salacup, "History of the Medical Service Armed Forces of the Philippines," *Military Surgeon* 104/3 (March 1949), 183-187.

strategic issues such as force structure, personnel, finances, and supplies.¹¹ Blesse's time at Carlisle and in the Training Division served him well, as he used them as models. He designed medical units to support the new Philippine infantry divisions, established medical care for the training camps, won support to train adequate numbers of medical personnel (which came at the expense of training combat-arms personnel), and obtained what supplies and equipment he could in the Philippines to reduce costs. Blesse received the Philippine Distinguished Service Star (equivalent to the U.S. Distinguished Service Medal) for his work, and returned to the US in August 1939. He left with letters of appreciation from MacArthur and, more significant for his future career, LTC Dwight Eisenhower, who also served on MacArthur's staff.

In May 1940 he was assigned as Division Surgeon of the 3d Infantry Division, then reorganizing, coming to full strength, and training for amphibious warfare at Fort Lewis. As there were only four divisions in the Army at the time, it was a key appointment. He reorganized the divisional medical regiment (for the 'square' division of four infantry regiments) into a medical battalion for a three-regiment 'triangular' division, and doubtless encountered COL Eisenhower who commanded one of the infantry regiments.

What Blesse was not doing in the 1930s was developing his practice and training as a physician. He had been selected for Army schools and leadership positions, but he had no further medical training beyond self-study as a member of the American Medical Association. During the 1920s and 30s there was increasing specialization among civilian doctors; while most American physicians were still general practitioners, the increasing depth of medical knowledge led

¹¹ Letter, Blesse to MG Charles Reynolds, 4 Nov 1938. I am obliged to COL (Ret) James Blesse who provided copies of his father's WWII diary and other papers, which are now on file in the Army Medical Department Center of History and Heritage, Fort Sam Houston TX. See also Frederick Blesse, "The Filipino Fighting Man: An appraisal of the men charged with defending the Philippine Commonwealth," *Philippines* 1/8 (November 1941), 6-7.

specialists to organize themselves into Boards. Board certification recognized those who had special experience and expertise, but also established standards to be recognized as a specialist in, for example, dermatology, or pediatrics, or pathology. The Army had few such clinical specialists, due largely to its requirements. Most Army doctors were needed to provide care at posts and units scattered around the world and thus had to be general practitioners; few could be spared for the major hospitals where they could see enough patients with particular conditions to specialize in any type of medicine – you could not be a dermatologist if you did not see enough dermatology patients. A few military physicians could forge distinguished clinical careers, but most were clinical generalists. This was not to slight patient care, it was a deliberate decision on managing finite human resources; Surgeon General Merritte Ireland expected to use reservists to provide most patient care, while Regular Army doctors would be administrators and command medical units.¹² A senior doctor commented after WWI “The post-graduate school of the army specialist was at Leavenworth ... he specialized in sanitation, the care and discipline of the soldier, and more particularly, in transportation, administration and the field tactics of the Medical Department.”¹³ As Major General Sam Seeley, whose service career included being Chief of Surgery at Walter Reed General Hospital, recalled “we of the Medical Corps of the Army were not specializing.”¹⁴ Instead the Army had doctors who thought of military medicine as their specialty: they knew about how to keep troops healthy (through sanitation, public health, and offering diversions to alcohol and prostitution), enough about trauma to care for the wounded, and how to organize medical support from the unit level up to planning major

¹² Merritte Ireland. “The duties and responsibilities of the Medical Department in the formulation of mobilization plans,” *Military Surgeon* 55/1 (July 1924), 1-9.

¹³ James L. Bevans, “The Function of Medical and Surgical Consulting Staffs determined by the experience of the late war,” *Military Surgeon* 46/5 (May 1920), 465-506, 484.

¹⁴ Quoted in Albert Cowdrey, *The Medics’ War* (Washington, DC: US Army Center of Military History, 1987), 14.

operations.¹⁵ It could be said they focused on ‘wholesale’ medicine rather than ‘retail’ care for individual patients.

Senior Leadership Positions, 1941-50

In January 1941 Blesse was called to Washington to serve as the Medical Department staff officer in the War Department General Staff (analogous to the Department of the Army Staff) G-4 office, where he advised on medical supplies and hospitalization. In May and June he was assigned as chief of the Planning and Research Division of the Morale Division of the WDGS, then in July moved to be Chief Surgeon at General Headquarters, US Army (GHQ). GHQ was responsible for training all continental U.S.-stationed ground forces, drafting operations plans for future operational theaters, and commanding theaters and task forces as assigned by the Chief of Staff. Blesse’s responsibilities were thus broader than the current Forces Command surgeon, or any of the Combatant Command surgeons.

As US forces took defensive positions on British Caribbean and Atlantic islands, those US garrisons fell under GHQ in Caribbean Defense Commands; Blesse was responsible for their health, and argued (unsuccessfully) to have a doctor on the Caribbean Defense Command staff.¹⁶ Blesse also developed the medical support plans for the US troops occupying Iceland, and for various operations that never took place.

In March 1942 GHQ was retitled Army Ground Forces (AGF) and lost responsibility for the overseas garrisons and operations. That let Blesse focus on the health of troops in training – by far the largest part of the Army at the time, around 2 million men – and on designing new

¹⁵ For more about a profession of military medicine see Bobby Wintermute, *Public Health and the U.S. Military: A History of the Army Medical Department, 1818-1917* (Routledge, 2011) especially 72-74.

¹⁶ Ebbe Hoff, *Medical Department, U.S. Army, Preventive Medicine in World War II, VIII, Civil Affairs/Military Government Public Health Activities*, (Washington, DC: Office of The Surgeon General, 1976), 112.

medical units. The Army was forming not just new units but new types of combat units, notably armored and airborne divisions, and they needed effective medical support. New units were one challenge, but units organized to refight WWI also needed to be reorganized as new equipment became available and operations were more mobile. Blesse was responsible for designing medical support, determining what training, equipment, doctrine, and organization were required, then overseeing the training so the units would be ready when deployed. Unlike many headquarters in the US, AGF was run as a military unit, with personnel marching in formation to the headquarters building every morning and colors being carried and passed in review on Saturdays.¹⁷ During WWII the Army was organized into co-equal Army Ground Forces, Army Air Forces, and Army Service Forces, with The Surgeon General subordinate to Army Service Forces. As Ground Surgeon, on paper Blesse had equal status with The Surgeon General and certainly had to coordinate with both The Surgeon General and The Air Surgeon. His personal emphasis on effective staff work was useful and he worked harmoniously with the Medical Department.¹⁸

In December 1942 he was sent to North Africa to be the chief surgeon of 5th Army when it was activated on 4 January 1943, a key assignment as 5th Army was the first army organized overseas for action in WWII. Blesse was the personal selection of the new army commander, LTG Mark Clark, whom he knew from Fort Lewis and GHQ. 5th Army's missions were manifold: preparing to defend the rear areas if fascist Spain declared war; training US forces;

¹⁷ *A Short History of the Army Ground Forces* (Army Ground Forces, c1946), <http://www.history.army.mil/books/agf/AGF002/index.htm> accessed 4 Feb 2014.

¹⁸ Charles Wiltse, *Medical Department, U.S. Army, Organization and Administration in World War II* (Washington, DC: Office of The Surgeon General, 1963), 52, 49; Albert Glass and Robert Bernucci, eds., *Medical Department, U.S. Army, Neuropsychiatry in World War II, I, Zone of Interior*, (Washington, DC: Office of The Surgeon General, 1966), 312.

helping organize Free French forces; and supporting II Corps as it advanced into Tunisia.¹⁹ Blesse supervised medical training and the troops' health and sanitation. Due to shortages of experienced officers, his responsibilities went even further, including drawing up operational medical plans for what became II Corps' advance into Tunisia for COL Robert Arnest MC, the Corps Surgeon, to implement, while Blesse scrounged up officers and men for his own staff.²⁰ An additional duty was being part of an Army-wide board that examined unit organization, equipment, and supplies and made recommendations back to AGF. He also visited the hospitals operating in his area, even though they answered to the joint British-American theater command, Allied Forces Headquarters, AFHQ. On 31 January he heard that he would be moved up to AFHQ because Eisenhower (both allied and US theater commander) wanted him there. Given Eisenhower's propensity for staff officers he personally knew and trusted, Blesse's years in the Philippines were probably as important as his being already in North Africa.

¹⁹ Fifth Army History, part I: From Activation to the Fall of Naples (HQ Fifth Army, 27 October 1944), chapters 1 and 2. <http://cgsc.contentdm.oclc.org/cdm/ref/collection/p4013coll8/id/1451> accessed 25 February 2015.

²⁰ Blesse Diary, 23, 30 December 1942; 1, 3, 8, 31 January 1943, 24, 26 February 1943.



Photo Blesse took while he was Chief Surgeon of 5th Army, showing his interest in prompt evacuation of casualties and how soldiers were improvising to accomplish the mission.

Credit: Blesse family

In March 1943 Blesse became Chief Surgeon, North African Theater of Operations, U.S. Army (NATOUSA), the US component of AFHQ, and Deputy Surgeon (with a British boss) of AFHQ itself.²¹ In many cases, available records do not show what Blesse thought or his personal effect on choosing options, but we know what was happening in the area and under his responsibility, and that he was involved in activities large and small. At NATOUSA, he excelled in supporting operations and adapting many advances from civilian medicine for field use in the Army, but

²¹ For a description of the NATOUSA medical organization, see W. Paul Havens, Jr., *Medical Department, U.S. Army, Internal Medicine in World War II, I, Activities of Medical Consultants*, (Washington, DC: Office of The Surgeon General, 1961), 152-4, and History of the American Medical Section, AFHQ, 10 November 1945, RG112 entry 31, box 241.

faced a tremendous range of responsibilities. During Blesse's years as surgeon, NATOUSA had to support three invasions - Sicily, Italy, and Anzio - and continuing operations on the Italian mainland while supporting the troops back in North Africa.²² Those operations all called for detailed planning and continuing care of casualties by NATOUSA hospitals. For Sicily, where a corps headquarters had to do an army's amount of planning work, the NATOUSA surgeon's office (which was really Blesse and four other officers, with Blesse the only physician) actually did most of the medical planning for the US forces. Blesse's staff assigned medical units to the invasion forces, even coordinating their movement to embarkation ports; coordinated US Navy, British, and invasion task force evacuation plans; arranged with the Army Air Forces for air evacuation; and coordinated the reception and hospitalization of the casualties in North Africa.²³ For the Salerno invasion, Fifth Army's staff was more robust, and Blesse's staff helped select units and plan supplies, for which Mark Clark personally thanked Blesse.²⁴

Blesse changed operational plans to include air evacuation of wounded from bridgeheads rather than relying on water evacuation, speeding evacuation from days to hours. He stayed abreast of operations, visiting hospitals and forward areas, including visiting all three US amphibious invasions and coming under fire.²⁵ However, as the theater matured and more US troops were in secure rear areas, a wide range of preventive medicine topics required more of his attention.

Malaria and dysentery were still endemic, and there was a major bacillary dysentery epidemic in North Africa (with rates peaking at 445 cases per thousand average strength in June 1943), and

²² See Charles Wiltse, *The Medical Department: Medical Service in the Mediterranean and Minor Theaters* (Washington, DC: Office of the Chief of Military History), 1964, chapters 3-7 and 9 for an overview of medical support during the period Blesse was in the Mediterranean.

²³ See Hospitalization and Evacuation During the Sicilian Campaign, RG112 entry 31 box 246, NARA and Historical Report, Medical Section Fifth Army 27 July – 31 December 1943, RG 407 Box 2378, NARA.

²⁴ Historical Report, Medical Section, Fifth Army 27 July-31 December 1943, NARA RG407 box 2378; Mark Clark, *Calculated Risk*, (New York: Harper & Brothers, 1950), 211-2.

²⁵ Blesse Diary, 20 July, 1 August, 24 September-1 October 1943, 2 and 5 February 1944.

Blesse was involved in both traditional and novel control methods. Traditional ones included sanitation; novel ones included new anti-malaria drugs and DDT to control both mosquitos and lice that would spread diseases.²⁶ Venereal disease was also a major problem, especially as prostitution was legal, and rife, and GIs' pay was ample. Blesse repeatedly advised theater leadership to put brothels off limits, but he did not win the argument.²⁷ Blesse also had to establish the first US policy in WWII for medical care of prisoners of war. He largely relied on captured medical personnel and supplies but also made US personnel, facilities, and supplies available when needed.²⁸



Frederick Blesse as a brigadier general.

Credit: United States Army Military History Institute

²⁶ Havens, *Medical Consultants, I*, 170-179, 224-5; Ebbe Hoff, ed., *Medical Department, U.S. Army, Preventive Medicine in World War II, IV, Communicable Diseases Transmitted Chiefly Through Respiratory and Alimentary Tracts*, (Washington, DC: Office of The Surgeon General, 1958), 362-70.

²⁷ Ebbe Hoff, ed., *Medical Department, U.S. Army, Preventive Medicine in World War II, V, Communicable Diseases Transmitted Through Contact or By Unknown Means* (Washington, DC: Office of The Surgeon General, 1960), 5, 204-12.

²⁸ Wiltse, *Mediterranean*, 201-3; Havens, *Medical Consultants, I*, 193-208; Blesse Diary, 8 and 12 May 1943.

Blesse used his long experience in Army medicine to bring many advances in care to the troops. When sulfa drugs proved to be bacteriostatic rather than bacteriocidal he advised doctors to appropriately modify their reliance on these drugs.²⁹ Conversely, when plasma proved less effective than whole blood in treating shock he oversaw building a whole blood supply system.³⁰ Blesse used multiple lines of communication; when BG Norman Kirk, the nominee for Surgeon General, visited North Africa, Blesse briefed him carefully and sent back specific requests – and on his first day in office Kirk wrote to Blesse saying material would be shipped air freight.³¹

Blesse dealt with combat fatigue when it became an unexpected problem – the Army was convinced that pre-induction screening had weeded out all those who might break down in combat and thus “organized psychiatric effort was nonexistent” in the theater – and he quickly adopted forward treatment of exhausted men rather, which remains the standard today.³² Blesse saw a young captain, Frederick Hanson, performing forward psychiatry with excellent results.³³ Judging by results rather than rank, he supported various aspects of Hanson’s work, picked him to be the theater consultant in psychiatry and supported Hanson making a training film.³⁴ When

²⁹ Edward Churchill, *Surgeon to Soldiers: Diary and Records of the Surgical Consultant Allied Force Headquarters, World War II* (Philadelphia: Lippincott, 1972), 63-67; see also B. Noland Carter, *Medical Department, U.S. Army, Activities of Surgical Consultants, I*, (Washington, DC: Office of The Surgeon General, 1962), 42-3.

³⁰ Churchill, *Surgeon to Soldiers*, 48-55; Douglas Kendrick, *Medical Department, U.S. Army, Blood Program in WWII* (Washington, DC: Office of The Surgeon General, 1964), esp. 54-57, 391-95; Carter, *Activities of Surgical Consultants I*, 141-3, 338, 525. Blesse’s relationship with the consultants was not all sweetness and light. At one point he ordered Churchill not to write personal letters to friends in Washington, something Churchill breezily dismissed as the “ostrich technique” (*Surgeon to Soldiers*, 81-2). When Churchill felt his arguments for whole blood were being ignored he went to the *New York Times* reporter in North Africa and got his views published. This may have encouraged Blesse to engage the press himself: he gave at least one interview to the *Times* and was interviewed for two radio programs. “Medical Shift in Algiers,” *New York Times* 4 December 1943, 7; Blesse Diary, 19 June 1943, 28 February 1944.

³¹ Letter, Kirk to Blesse, 1 June 1943, NARA RG 112 entry 31AJ box 4.

³² Albert Glass and Robert Bernucci, *Medical Department, U.S. Army, Neuropsychiatry in World War II, II, Overseas Theaters*, (Washington, DC: Office of The Surgeon General, 1973), 1, 11, 26.

³³ Hanson had trained as a neuropsychiatrist in Canada, joined the Royal Canadian Army Medical Corps, and was in England when US forces deployed there. He transferred to the US Army, and thus brought British experience in psychiatry that was more advanced than US practice.

³⁴ Glass and Bernucci, *Neuropsychiatry, I*, 66n.

the Army accepted the value of forward psychiatry and established the position of division psychiatrist, there was a mass training class of 60. Hanson was especially important to that assembly since he was the most combat-experienced psychiatrist in the Army. Blesse helped the fledgling program have a strong start by sending Hanson back to lecture, but wrote to Surgeon General Kirk “I hope you will not find it necessary to keep [Hanson] there very long for I need him, and if you have no objection I would like to have him return here just as soon as possible.”³⁵

He started work to review the nutritional content of combat rations; menu options in the “C” ration were so few that men stopped eating the food and ran low of energy and nutrients.³⁶ Blesse shifted medical personnel to establish specialty hospitals, improving the quality of care by concentrating patients with, for example, hepatitis, at one hospital with specialist staff who gained further experience by seeing larger numbers of patients. He improvised reconditioning centers to maximize return-to-duty rates rather than over-evacuate trained and experienced men back to the U.S. and need ever more men in a combat theater.³⁷ In these various examples Blesse worked well with a range of eminent medical specialists, doctors with far more clinical expertise than he did himself. He had a surgical consultant, LTC Edward Churchill, who had been commissioned a lieutenant colonel straight from the faculty of Harvard Medical School, and a medical consultant, LTC Perrin Long, who had similarly come straight from Johns Hopkins. Both were more eminent clinicians than Blesse, but Blesse used their expertise to improve medical care across the theater. For instance, Long was an expert in antibiotics and advised

³⁵ Glass and Bernucci, *Neuropsychiatry*, I, 408-9; Wiltse, *Mediterranean*, 254n. See also Kirk’s letter to Blesse thanking him for sending Hanson, 23 December 1943, RG 112 entry 31AJ, box 4.

³⁶ Carter, *Activities of Surgical Consultants*, I, 208-14.

³⁷ Wiltse, *Mediterranean*, 194-6, 216-7; Churchill, *Surgeon to Soldiers*, 214-17.

against excessive reliance on sulfas instead of surgery; he also advised in mid-1943 that most of the penicillin available for medical purposes be used to treat VD patients.³⁸ Blesse agreed this was the right priority for the Army – it would return many soldiers to duty, and quickly – and he implemented it. Later, when more penicillin became available, Blesse wanted an officer in each hospital trained to use it, to get maximum benefit.³⁹ Blesse harnessed these experts, reports from others, and his own sense, and issued a series of circular letters to Medical Department units in NATOUSA that established standards of practice.⁴⁰ Circular letters applied purely to the Medical Department, and did not require staff coordination. These were updated periodically, or adapted to special circumstances such as forward surgery in amphibious operations. Other changes, such as adapting various units to provide effective forward surgery and hospitalization, required staffing, and Blesse had solid credibility with non-medical officers to win any arguments; he could take the clinical expertise from others and transform it into a workable Army solution.

There were administrative matters that Blesse had to deal with. He managed to work well with the Army Air Forces medical staff, something the AAF noted was unusual.⁴¹ He also had to work out better ways to utilize personnel. There were political pressures to efficiently use professional personnel (especially doctors and dentists) and Blesse had NATOUSA survey doctors about their education and experience so specialists could be used to best effect (he had doctors in theater, not just those newly arriving, surveyed) and went to the press to get some good publicity about moving doctors from “desk jobs such as adjutant, registrar, and mess officer” and replacing them

³⁸ Churchill, *Surgeon to Soldiers*, 63-67; Havens, *Activities of Medical Consultants*, I, 185-6. Presumably other penicillin was available for surgical patients, including the wounded.

³⁹ Letter, Blesse to Kirk, 6 February 1944, RG 112 entry 31AJ box 4.

⁴⁰ A number are in Mather Cleveland, ed., *Medical Department, U.S. Army, Orthopedic Surgery in the Mediterranean Theater of Operations*, (Washington, DC: Office of The Surgeon General, 1957), 299-316.

⁴¹ Wiltse, *Organization and Administration*, 272.

with Medical Administrative Corps officers.⁴² Blesse also disbanded some small hospitals and reallocated the personnel to expand larger hospitals, getting more bed space from the same number of personnel.⁴³ Finally, Blesse did what he could to move older doctors out of combat units and into rear-area ones; wounded or injured medical officers were also offered rear-area assignments rather than a return to combat, and he tried to set a two-year maximum on front-line assignment of doctors.⁴⁴

Blesse was well aware that North Africa and the Mediterranean were important combat theaters in the progress of the war but also testing grounds for the major battles to come in France and Germany. He wrote back to colleagues at AGF on force structure topics, but also encouraged consultants to visit from England to observe the latest developments.⁴⁵ The European Theater's surgical consultant visited, collected a range of the NATOUSA circular letters as well as his own observations, and took those back to England to adjust US policy and pass the information on to the British as well.⁴⁶ Blesse also approved creating a NATOUSA *Medical Bulletin* that published articles of clinical use in the theater. Blesse wrote an editorial in each issue, at one point reminding doctors that the Army needed as many soldiers returned to duty as possible, not just saving lives: "there appears to be a tendency ... to concentrate on the more serious cases and to

⁴² Charles Wiltse, ed., *Medical Department, U.S. Army, Personnel in World War II*, (Washington, DC: Office of The Surgeon General, 1963), 281-3; "Medical Shift in Algiers," *New York Times*, 4 December 1943. The MAC was a predecessor of the Medical Service Corps.

⁴³ Wiltse, *Personnel*, 301.

⁴⁴ Wiltse, *Personnel*, 334.

⁴⁵ Blesse Diary, 16-18 April, 31 May 1943, 15 February 1944.

⁴⁶ B. Noland Carter, ed., *Medical Department, U.S. Army, Activities of Surgical Consultants, II*, (Washington, DC: Office of The Surgeon General, 1964), 121-127, 181. See also Kenneth Allen, *Medical Department, United States Army, Radiology in World War II*, (Washington, DC: Office of The Surgeon General, 1966), 419 et seq.

lose interest in those who are recovering. As a result, many convalescents are overlooked, and are not promptly returned to duty.”⁴⁷



Blesse visiting a surgical ward at an unidentified evacuation hospital in Italy, late 1943 or early 1944.

Credit: United States Army Military History Institute

Blesse’s credibility with his commander was important in handling one particularly sensitive moment. When LTG George Patton slapped two soldiers the report went through medical channels to Blesse, who then had to take it to Eisenhower. Eisenhower sent Blesse as the courier for his hand-written reprimand of Patton, to investigate fully, but to also keep matters quiet.⁴⁸

⁴⁷ “Keep ‘Em Fighting,” *Medical Bulletin of the North African Theater of Operations* 1/3 (March 1944), 1.

⁴⁸ On the slapping episode see Stephen Ambrose, *The Supreme Commander: The War Years of General Dwight D. Eisenhower* (New York: Doubleday, 1970), 228-30 and Dwight D. Eisenhower, *Crusade in Europe* (New York,

Nobody recorded just what was said in either interview, but it is obvious that Eisenhower trusted Blesse as an officer and gentleman and not just as a physician, and Patton extended Blesse the same courtesy although they had not served together before operations in North Africa.

Blesse was not perfect. When given warning of a typhus epidemic in Naples in November 1943, he ignored offers of assistance from both the United States of America Typhus Commission (a joint military-civilian organization) and the British Typhus Commission for six weeks. While there only three cases in US military personnel, who were vaccinated against typhus, countermeasures against typhus in the civilian population were delayed, and the epidemic affected military logistic routes running through Naples.⁴⁹

In May 1944 Blesse returned to Army Ground Forces, not necessarily a step up or down, but his replacement as theater surgeon in North Africa was a major general, indirectly reflecting the level of work Blesse had been doing. Back in Washington, Blesse continued to seek professional advice, trying to get a dentist and veterinarian added to his staff for their particular expertise.⁵⁰

Blesse continued to monitor health conditions at training camps, and inspect medical units training for deployment. He also had to sift the various suggestions from combat theaters for changes to standard unit organization and equipment, and discern what had lasting value and what was ephemeral; to help, he tried to get combat-experienced officers rotated onto his staff.⁵¹

His experience with Army staffs led him to seek advice from commands about what worked, not

Doubleday, 1948), 179-181. Blesse was oblique in his diary, simply mentioning going to see Patton: Blesse Diary, 18 and 20 August 1943.

⁴⁹ On the epidemic, see Wiltse, *Mediterranean*, 363-5 and Ebbe Hoff, *Medical Department, U.S. Army, Preventive Medicine in World War II, IV, Communicable Diseases Arthropodborne Diseases Other than Malaria*, (Washington, DC: Office of The Surgeon General, 1964), 214-231. Blesse may have had some suspicion of the preventive medicine section; his diary for 20 June 1943 includes the comment "Simmons [chief of preventive medicine at the Office of The Surgeon General] seems to be trying to run this end."

⁵⁰ Wiltse, *Organization and Administration*, 129.

⁵¹ Wiltse, *Organization and Administration*, 129-31.

just get the information through back channels; getting it through official channels meant that theater commanders agreed with the reports and suggestions.⁵² One major concern was getting men of better physique into combat units; the physical profile system was adopted while Blesse was Ground Surgeon in 1944. He also stressed involving individual soldiers in protecting their own health: troops going to Europe received trench-foot training, and those going to the Pacific received tropical disease training.

After the war the Army reorganized combat divisions, adding a medical company to each infantry regiment while keeping a (slimmed-down) medical battalion; airborne divisions went from having a single medical company to having a full medical battalion and medical companies in each combat regiment.⁵³ Blesse retired for age in 1948 but the next day he was recalled to serve and stayed until 1950. His input was still required on questions of new equipment, maximizing use of professional personnel, and efficient organization of units.⁵⁴ For instance, he organized a conference on evacuation hospitals, with US, British, and Canadian medical officers and civilian consultants considering the organization, equipment, and personnel of such units.⁵⁵

In hindsight, his highest-profile action was getting approval for TO&E 8-571, the Mobile Army Surgical Hospital.⁵⁶ From early 1943 Blesse had worked on ways to push resuscitative surgery forward on the battlefield, and had one proposal fail in August 1944. But in mid-June 1945 Blesse renewed his efforts, overcoming opposition from Army Service Forces and some of the

⁵² Letter, Blesse to MG Albert Kenner (SHAEF Surgeon), 19 July 1944, NARA RG337, Special Staff, box 26.

⁵³ See charts in John Wilson, *Maneuver and Firepower: The Evolution of Divisions and Separate Brigades* (Washington, DC: US Army Center of Military History, 1998).

⁵⁴ War Department Equipment Board, 1945, <http://server16040.contentdm.oclc.org/u/?p4013coll11.782> accessed 19 March 2014; George Jeffcott, *Medical Department, U.S. Army, United States Army Dental Service in World War II* (Washington DC: Office of The Surgeon General, 1955), 294-7; Jacob Devers, *Postwar Report, Army Ground-Field Forces* (Office, Chief, Army Field Forces: Fort Monroe, 1949).

⁵⁵ Devers, *Postwar Report*, 60.

⁵⁶ For more detail, see Sanders Marble, "Forward Surgery and Combat Hospitals: The Origins of the MASH," *Journal of the History of Medicine and Allied Sciences* 69/1 (2014), 68-100.

surgeons in the Army Medical Department, and through experience and effective staff work he won the battle.

Retirement

In 1950 Blesse again retired from the Army and in December became director of the Henrico County health department, overseeing public health just outside Richmond, VA.⁵⁷ Befitting a staff officer, he started by improving the record-keeping so he could judge priorities. He won county funding for an outpatient clinic with free physical examinations and vaccinations for children who could not afford them, prenatal, well-baby, and dental care; then managed to cajole local doctors into volunteering at the clinic. He had health education assemblies for families as part of school registration. He won a 50% increase in the health department budget, although since county population more than doubled that was still a per-capita decline in health department resources. He also wrote the county ordinance about septic tanks and other sewage disposal (including establishing a licensing process for septic tank installers), and helped establish a sanitary landfill in the county. He got Henrico County into trials of the Salk polio vaccine, with over 1,000 children vaccinated; he also got dogs vaccinated with reduced-price rabies vaccinations, but he could not persuade the county commissioners to make rabies vaccination mandatory. All these bear hallmarks of the public health measures Army physicians were trained in, and also show Blesse had powers of persuasion: his Army rank would have cut little ice in a still-rural Virginia county.

Fred Blesse had a heart attack at home, and lingered a week before dying on 4 June, 1954, at age 65. President Eisenhower sent a condolence telegram, referring to his “long time friend,” and

⁵⁷ This section is based on the 1950-1954 County of Henrico annual reports. I am obliged to Ms. Jane Geoghegan of the Henrico County Library for copies.

church services were organized both in Richmond and at Fort Myer, before interment at Arlington National Cemetery.⁵⁸

Conclusion

BG Blesse had a successful career as an Army doctor, with the two terms in that order. He knew medicine, but after 1924 hardly practiced and was a medical leader, leading as both a commander and a staff officer. He effectively integrated emerging medical practices and personnel into the Army, reorganizing and equipping units to accommodate personnel and equipment shortages, and to bring the best medical practices to soldiers. His effectiveness was due not to his clinical acumen but to his understanding medical support and the realization that preventive and curative medical requirements must be tailored to meet exigencies both in garrison and on campaign. Career paths have changed, but arguably no Army doctor can 'be all they can be' by focusing solely on fixed facility medicine: to be *Army* professionals they must also give due regard to the unique demands of the profession of arms.

⁵⁸ Telegram, President Eisenhower to Mrs. Frederick Blesse, Blesse family papers, Army Medical Department Center of History and Heritage.