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Ph. D- History	2003
TITRE DE LA THÈSE / TITLE OF THESIS:	
"Officers and Ladies": Canadian Nursing Sisters, Women's Work, and the Second World War	

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TOMAN, Cynthia

AUTEUR DE LA THÈSE - AUTHOR OF THESIS

Ph. D. (History)

GRADE - DEGREE

Department of History

FACULTÉ, ÉCOLE, DÉPARTEMENT - FACULTY, SCHOOL, DEPARTMENT

TITRE DE LA THÈSE - TITLE OF THE THESIS

"Officers and Ladies": Canadian Nursing Sisters, Women's Work, and the Second World War

R. Heap

DIRECTEUR DE LA THÈSE - THESIS SUPERVISOR

M. Stuart

CO-DIRECTEUR DE LA THÈSE - THESIS CO-SUPERVISOR

EXAMINATEURS DE LA THÈSE - THESIS EXAMINERS

C. Gaffield

E. Kranakis

L. McLean

K. McPherson

J.-M. De Koninck, Ph.D.

LE DOYEN DE LA FACULTÉ DES ÉTUDES SUPÉRIEURES ET POSTDOCTORALES

SIGNATURE

DEAN OF THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

"OFFICERS AND LADIES":

CANADIAN NURSING SISTERS, WOMEN'S WORK, AND THE SECOND WORLD WAR

by

Cynthia Toman

Thesis submitted to
the Faculty of Graduate and Postdoctoral Studies
in partial fulfillment of the requirements for the
Ph.D. degree in History

Université d'Ottawa/University of Ottawa

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ABSTRACT

"OFFICERS AND LADIES":

CANADIAN NURSING SISTERS, WOMEN'S WORK, AND THE SECOND WORLD WAR

Cynthia Toman,
University of Ottawa, 2003

Supervisor: Professor Ruby Heap
Co-director: Professor Meryn Stuart

Canadian nurses volunteered for military service in overwhelming numbers during the Second World War (1939-1945), comprising a second generation of military nurses known by rank and title as Nursing Sisters. Prevailing discourses portray them as 'extraordinary women,' patriots, heroines, feminists, and technological change agents. A small, diffuse body of literature documents their enlistments and postings but we know relatively little regarding how multiple identities and variables intersected to shape their experiences.

This research examines Canadian military nurses' work from a feminist perspective through the lens of medical technology and discourse analysis, analyzing how variables such as gender, class, race, ethnicity, nation, marital status, and age intersected to shape their experiences during the Second World War. Based on oral histories, military records, professional literature, and archival sources, I ask: Who enlisted as Nursing Sisters? How did the military transform them into military nurses? What influenced decisions concerning where and how they served? In what technological and military contexts did they practice? How did these contexts shape the nursing care of soldiers? What influenced the transfer of technology to nurses? How did these experiences shape wartime and postwar civilian nursing practice? How did shared experiences as military nurses and as soldiers influence postwar identity as Nursing Sisters?

War enabled the transformation of at least 4381 civilian nurses into Canadian Nursing Sisters who served 'for the duration.' They were posted to England, Northwest Europe, the Mediterranean, Hong Kong, and military hospitals across Canada, in Newfoundland, the United States, and South Africa. They worked in military general and specialty hospitals, hospital ships and trains, prisoner of war and internment camps, casualty clearing stations, field dressing stations, and field surgical units. Medical technology legitimated their presence within a complex

military-medical-technological system while gender shaped their presence there as professional nurses, professional soldiers, and quintessential women. I argue that medical technology, gender, and war situated the Nursing Sisters as an expandable and expendable feminine workforce for the military, legitimated their presence at the frontlines of both war and medical technology, and facilitated the formation of a symbolic community and a social memory as military nurses.

ACKNOWLEDGEMENTS

My interest in the Second World War Canadian Nursing Sisters has sustained me for more than three-and-a-half years of fascinating research. I found that existing gaps in knowledge related to these nurses impoverished me personally and professionally, as a woman, a nurse, and a historian. I despaired at the paucity of primary sources with awareness that the Nursing Sisters are presently in their mid-80s to mid-90s. We are rapidly losing opportunities to study war as nurses' work, and to study these nurses who were the first women in the Canadian military. First, I want to thank the twenty-five Nursing Sisters who participated in oral history interviews for this research—for they are the main primary sources. Lt. Colonel (retired) Harriet J. T. Sloan patiently introduced me to the military, fielded a multitude of inquiries over the years, piloted the first oral history interview, provided introductions to military nurses across Canada, and graciously read parts of the thesis. She is a remarkable friend who served during the Second World War and was Matron-in-Chief of the Canadian Forces Medical Services (1964-1968). Through her leadership of the Nursing Sisters Association of Canada, I was introduced to other members and resources of the association.

A number of organizations and archives provided important and timely assistance. I would like to thank my colleagues from the Canadian Association for the History of Nursing, the British Columbia History of Nursing Professional Practice Group, the Alberta Association of Registered Nurses Museum and Archives, and the Margaret M. Allemang Centre for the History of Nursing who helped me to identify sources and key people for interviews. In particular, I acknowledge the valued assistance of Judith Young and Margaret Allemang in transcribing a previous set of interviews that included fourteen Second World War Nursing Sisters. Edith Landells generously shared her expertise and contacts from her three-volume publication, *The Military Nurses of Canada: Recollections of Canadian Military Nurses*. Anne Crossin, archivist at the Winnipeg General Hospital and Health Sciences Nurses' Alumnae Archives and Lorraine Mychajlunow, archivist at the Alberta Association of Registered Nurses Museum and Archives

made available sources from their professional organizations. Professor emeritus of the University of Alberta Dr. Shirley Stinson encouraged and assisted my research in Alberta. Dr. Charles Roland, Hannah Chair for the History of Medicine at McMaster University, shared a transcript of his interview with Nursing Sister Kay Christie. Retired provincial public servant, James Frederick Brailey of Orangeville, Ontario, shared notes and sources from the Royal Canadian Military Institute. In addition, there were innumerable research assistants at the National Archives of Canada and the Department of National Defence Directorate of History and Heritage, who helped me with the mysteries of military records, photographs and documentary art, audio-visual collections, and musical scores related to Nursing Sisters.

I have been extremely fortunate to work with two of the best supervisors for this research. Professor Ruby Heap guided me through the intricacies of history and women's studies. Professor Meryn Stuart not only shared her nursing history and women's studies expertise, but also mentored me along the paths of scholarship and academia, generously accepting me as a colleague. Families inevitably share in the process through their many accommodations to doctoral studies. I extend my gratitude and deep appreciation to Earl and Wes for technical support, to Susan and Ang for encouragement and movie nights, and to Maariya for precious giggles and love. They have tracked my progress toward the finish line eagerly, even using my own arguments against me when the task seemed heavy.

This research has been supported by a doctoral scholarship from the Social Sciences and Humanities Research Council (2001-2003) and a declined Department of National Defence Security and Defence Forum Ph.D. Scholarship (2001). This thesis represents a small portion of my research with the Canadian Nursing Sisters, to whom I dedicate it. The pleasure and privilege has truly been mine. If they find their experiences reflected within its pages, then the labour has been rewarded.

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LIST OF ABBREVIATIONS

AARN	Alberta Association of Registered Nurses
CAMC	Canadian Army Medical Corps
CCS	Casualty Clearing Station
CEF	Canadian Expeditionary Force
CGH	Canadian General Hospital
CHC	Canadian Hospital Council
CMA	Canadian Medical Association
CNA	Canadian Nurses Association
FDS	Field Dressing Station
FSU	Field Surgical Unit, also called a Field Surgical Centre
FTU	Field Transfusion Unit
ICN	International Council of Nurses
NS	Nursing Sister
NSAC	Nursing Sisters Association of Canada
QAIMNS	Queen Alexandra's Imperial Military Nursing Service
RCAF	Royal Canadian Air Force
RCAMC	Royal Canadian Army Medical Corp
RCN	Royal Canadian Navy
RNABC	Registered Nurses Association of British Columbia
RNAO	Registered Nurses Association of Ontario
SAMNS	South African Military Nursing Service
TANS	Territorial Auxiliary Nursing Service
USANC	United States Army Nurse Corps
VAD	Voluntary Aid Detachment
WD	Women's Division

INTRODUCTION

The care of sick and wounded soldiers has been a long-standing problem for the armed forces. Historian Roger Cooter pointed out that there was a shift in the perception of military medical care at the end of the nineteenth century, as "servicemen were beginning to demand health care as a right, and to regard it as a kind of 'social wage' earned in the service of their country."[1] Major issues have included who should provide that medical care, how medical units should be organized and administered, and how to negotiate a balance between civilian and military needs for medical personnel.

Canadian nurses volunteered for military service in overwhelming numbers from the first call for mobilization of the Canadian Active Service Forces medical units on 1 September 1939, throughout the following years to 1945, when one-third of the serving Nursing Sisters extended their commitment by volunteering for the Pacific theatre. Although official military historian, Colonel C. P. Stacey, had pronounced Canada to be a very 'unmilitary community', the number of nurses who volunteered was so large that a moratorium was placed on their enlistment only ten days after that first call.[2] The nurses' response was in sharp contrast to the conscription of male Canadians that began in late 1940, and to the drive for conscription of American nurses that began in 1944.[3] Canadian nurses readily filled every allotted nursing position, in all three branches of the armed forces during the war. Thousands of them placed their names on a waiting list that grew ever longer during the Second World War, and they responded just as readily to calls for service with the Allied forces.

These nurses comprised a second generation of military nurses known by rank and title as Nursing Sisters. They capitalized on a reputation as professional nurses, professional soldiers, and quintessential women which they inherited from their foremothers, the Nursing Sisters of the First World War (1914-1919).[4] Their experiences during the Second World War

reflected that inheritance, and partially reconstructed mid-twentieth-century civilian and military nursing practice. More than fifty years after the war, Nursing Sister Irene Lavallee stated succinctly that, "We were only military nurses because there was a war."[5] Her remark reveals the contingency of their roles, and war as an enabling set of conditions. Events of the Second World War brought this generation of Nursing Sisters together while medical technology legitimated their presence within a gendered military-medical-technological system. I argue that medical technology, gender, and war situated the Nursing Sisters as an expandable and expendable feminine workforce for the military, while legitimating their presence ever closer to the frontlines of both war and medical technology, and facilitating the formation of a symbolic community and a social memory as military nurses.

The Nursing Sisters, contrary to popular belief, were not members of a religious order. They were nurses who had graduated from hospital schools of nursing, typically after three years of apprenticeship training, as was customary in North America through most of the twentieth century.[6] When two Canadian military contingents left to serve with the British forces in South Africa (October 1899 and January 1900), four nurses volunteered to go with each contingent. They served as auxiliary members of the British Army Reserve, where they acquired the title of Nursing Sister in accordance with British tradition. A Canadian militia order accredited them as Lieutenants for the purpose of pay and allowances but it did not grant them the title or authority accompanying that rank. On their return from South Africa in 1901, the Canadian Militia Reserve organized a Nursing Service. These original eight nurses, plus two others, became the first officially-recognized, Canadian military nurses with Georgina Pope as the first Matron.[7]

When the medical services re-organized in 1904, the newly-formed Army Medical Department consisted of two divisions—a permanent forces Army Medical Corps (PAMC) to staff small hospital units in military districts across Canada and a non-permanent Army Medical Corps (NPAMC) to serve as field units. Canadian Nursing Sisters were the first nurses in any modern armed forces, as well as the first women, to achieve rank as officers in 1904. They enlisted with the relative rank and pay of Second Lieutenants and became First Lieutenants after six months.[8]

The order that granted rank also stipulated, however, "that the official designation of these latter would in no case be other than nursing sister, nor would they have any military command or authority."[9] Thus, in a relatively brief period, nurses working in the military had established themselves as both professional nurses and professional soldiers. Scarcely a decade later, the First World War reinforced these two images while also shaping them as ideal women who epitomized "patriotism, femininity, piety, and duty to others" within a prevailing ideology of maternalistic roles in caring for soldiers.[10]

At the beginning of 1914, there were still only five nurses in the permanent force, and although the organizational plan called for twenty-five Nursing Sisters in the reserve force, that number was never authorized for enrollment. Re-named the Canadian Army Medical Corps (CAMC) upon the declaration of war, the military medical service enlarged considerably through the enlistment of civilian physicians and nurses who were drawn primarily from large teaching hospitals, and organized accordingly as associated hospital units. Medical personnel enlisted as soldiers of the Canadian Expeditionary Force (CEF), and were demobilized at the end of the war. Although the number of nurses varies according to the source and who was included or excluded from the statistics, it is generally considered that a total of 3141 Nursing Sisters served during the First World War.[11] Of that number, 2504 Nursing Sisters served overseas, 447 served in Canada, and 190 served as members of the British forces. These South African and First World War nurses comprised the first generation of Canadian Nursing Sisters.[12]

King George V bestowed the title of 'Royal' Canadian Army Medical Corps (RCAMC) on the permanent medical services in 1919, and by 1921, it had reverted to its pre-war establishment of forty-three medical officers. The number of nurses in the permanent force varied from five to fourteen during the interwar years.[13] A few hundred nurses joined the reserves partially to position themselves for a vacancy in the permanent force and partially in anticipation of another war. Thus, when Order No. 135 was issued in September 1939, there was a small core of Nursing Sisters ready to become part of the Canadian Active Service Force. Stacey noted that almost half of all persons who enlisted initially were either currently- or previously-serving

members of the permanent and non-permanent forces. The highest response rate (89%), however, came from the medical services branch. He also pointed out that five First World War Nursing Sisters were among the very first persons to enlist for the Second World War.[14]

Clearly, this second generation of Nursing Sisters had expectations based on their nursing heritage and shaped by their own socio-political, economic, professional, and technological contexts. Some of them would meet and exceed their expectations; some would have experiences that challenged them to the very core of personal survival and meaning; some would emerge from the war with regrets; still others would maintain a silence on their war experiences for the rest of their lives. They comprised a well-defined, gendered cohort. While they shared multiple identities (as women, as nurses, and as military personnel), there is no universal 'Nursing Sister' category—just as historian Kathryn McPherson found there is no essential category 'nurse.'[15] Prevailing discourses shaped them as 'extraordinary women': patriots, heroines, feminists, and technological change agents. A small, diffuse body of literature documents their enlistments and postings but we know relatively little regarding the way in which multiple identities and variables such as age, marital status, language, ethnicity, nation, region of origin, gender, race, or class intersected to shape war as nursing work. No studies have analyzed who became Nursing Sisters, how these civilian nurses were transformed into military nurses, or how that transformation may have impacted nursing care in both civilian and military settings.

Scope of the Thesis

The purpose of this thesis is to examine the second generation of Canadian Nursing Sisters as nurses, as soldiers, and as women who became part of a large, military-medical-technological system. Gender guided my decisions throughout the research process: what and whom to study, research questions, appropriate periodization, design of the study and methodological debates, the researcher's stance, and choices regarding appropriate sources as

well as interpretive frameworks. Using a feminist perspective informed by theoretical approaches from the history of technology, sociology, and discourse analysis, I conducted a large number of oral history interviews and examined a rich body of previously unexplored sources in an attempt to answer the following questions: Who enlisted as Nursing Sisters, and how did the military transform them into military nurses? What influenced decisions concerning where and how they served? In what technological and military contexts did they practice? How did these contexts shape the nursing care of soldiers? What influenced the transfer of technology to nurses? How did these experiences shape both wartime and postwar civilian nursing practice? How did their shared experiences as military nurses and as soldiers influence their identity as Nursing Sisters after the war? Discourse analysis focuses on the relational dimensions of social categories, and the importance of linguistics and other 'texts' in constructing gendered relationships.[16] It broadens the analysis beyond nurses' material conditions, considers power inequities, and rejects both dichotomy and 'essentialist' thinking. Through demographic and gender analysis, and the use of previously-unexplored sources, this thesis makes a unique contribution to nursing history, women's history, military history, and Canadian history by my focus on Nursing Sisters as professional nurses and soldiers.

Nursing Sisters were the only women serving in the Canadian armed forces throughout the First World War and the first years of the Second World War. As the senior service, the RCAMC also provided nursing service for the Royal Canadian Air Force (RCAF) and the Royal Canadian Navy (RCN) until 1941 when they organized separate but parallel nursing services. Proportionately, there were so few women in comparison to men that the military designated them as Nursing Sisters, regardless of professional or occupational category. The Nursing Sister rank clearly differentiated these women as professionals already fully-prepared in their fields, usually with post-secondary education either in hospital training programs or in universities. Nurses were never part of the Women's Division in any service branch. Instead, they constituted a separate classification subsumed within the medical services, but under the authority of the Nursing Service's Matron-in-Chief. This unique relationship in the military system is clearly and

symbolically represented on the Voluntary Service medal for 1939-1945. There are seven figures on the medal: a man and a woman for each service branch (the RCAMC, the RCAF, and the RCN) and at the top, a Nursing Sister—distinctly 'one of a kind' and not identified with any one branch, but belonging to all three.[17]

The title of Nursing Sister is misleading, therefore, because there were a variety of occupational and professional groups, other than nurses, included in this category. During the Second World War, the Nursing Sister rank included physiotherapist aides (known as "physios"), occupational therapists, dieticians, and home sisters (a type of 'housemother' or housekeeping role). The RCN also included female laboratory technicians as Nursing Sisters. This organizational practice led to confused statistical reporting in the existing historical records--to the extent that we don't really know how many nurses served in the Canadian military during this period. In this study, I will focus primarily on the nurses who were Nursing Sisters between September 1939 and the end of hostilities with Japan in August 1945. These dates are generally accepted as the parameters of the Second World War, from a military perspective. Nurses' wartime experiences, however, both predated the formal Declaration of War, and lasted beyond the signing of Armistices and beyond the closure of the last medical unit in Europe (May 1946). My sources reveal that events of the 1930s shaped a nursing workforce eager to enlist while many wartime injuries and illnesses required nursing care that extended well beyond the formal cessation of hostilities. Once again, this different periodization indicates that traditional historical chronologies fail to reflect women's realities.[18] I argue that these differences are important and therefore I have incorporated analysis of both prewar and postwar nursing practice contexts into my research.

Nevertheless, the time period from September 1939 to August 1945 does serve as a convenient periodization for this study since these were the dates used by the Canadian armed forces to determine nurses' status for military service records. The Canadian military preferred a system of rapid mobilization and demobilization of troops, in contrast to the maintenance of a large number of inactive personnel 'on strength'.[19] As Bill Rawling cogently points out,

"maintaining a full-strength medical establishment for the military in time of peace was out of the question—and there was not so much as a hint within the RCAMC that such should be attempted . . . ."[20] Leslie Newell has documented the extreme disparity between the number of Nursing Sisters who served during the First World War and the number of permanent Nursing Sister positions that were filled during the interwar period.[21] More importantly, the Nursing Sisters themselves used these traditional dates for self-identification and as a criterion for membership in their official organization, the Nursing Sisters Association of Canada.

Finally, some Nursing Sisters served in different settings from their male colleagues. They were posted to all theatres of war (the United Kingdom, Northwest Europe, the Mediterranean, and Hong Kong) as well as in military hospitals across Canada, in Newfoundland, in the United States, and in South Africa. Some nurses (perhaps to circumvent the waiting list) served with the British Army as part of Queen Alexandra's Imperial Nursing Service, while others joined the United States Army Nurse Corps. Not only did they serve in a variety of geographical areas, they also worked in different types of medical and surgical settings: military hospitals, prisoner of war and internment camps, specialty hospitals, casualty clearing stations, advanced surgical units, field dressing stations, field surgical units, hospital ships, and hospital trains. I included as many of these settings as possible in this study, contingent on available sources.

Historiography

Military nurses are situated at an intersection of multiple fields of historical inquiry that overlap one another, such as women's history, military history, medical history, nursing history, and the history of medical technology. Yet they are relatively invisible within each--appearing on the periphery, in the footnotes, or relegated at most to a chapter or two.

One body of literature where military nurses might expect to have a presence is women's history. For the most part, feminist historians have perpetuated male norms regarding what constitutes important historical research by their reticence to study female-dominated professions

such as nursing. The relationships between feminists and nurses have been consistently described as contested and uneasy,[22] which may partially explain why women's historians have demonstrated very little interest in nursing history in general, and why they have typically overlooked nurses as major actors in studies on women and war. American anthropologist Cynthia Enloe, was one of the first feminists to consider military nurses when she studied the militarization of women's lives and asked: Does khaki become you?[23] She examined the variety of ways in which war and military discourse depended on women's support for the recruitment and re-enlistment of men, for sanitary and caring tasks required to keep troops healthy, and for replacement labour that released men for war. Enloe re-visited the topic fifteen years later to consider the insidious and pervasive ways in which civilian as well as enlisted women became militarized, referring to a process by which individuals and whole societies "come to imagine military needs and militaristic presumptions to be not only valuable but also normal." She calls militarization a "process by which a person or a thing gradually comes to be controlled by the military *or* comes to depend for its well-being on militaristic ideas" [emphasis in the original].[24] Enloe raises significant issues pertinent to this thesis, regarding what was gained and what was lost professionally when nurses became integral to the military system.[25]

During the late 1980s and early 1990s, a number of authors published important work on war as a 'gendering activity.' Joan Scott and Ruth Roach Pierson have identified the key debates that have emerged from this feminist literature on women and war. Scott's historiographical essay on war and gender, published in 1987, suggested there is a basic theme with four variations in the literature.[26] The main theme frames war as a 'watershed' experience for women—either positively or negatively. The four variations include: new opportunities that did or did not open for women during war; new political rights for women such as suffrage, based on their wartime participation; female antipathy to war and women as leaders of pacifism movements; and the long and short-term impact of war on women. Scott suggested that these debates are un-resolvable and problematic when considered in isolation from mainstream history

and the wider field of gender history.[27] She called for more attention to state policies related to women and to the metaphoric uses of gender representations in research on women and war.

For her part, Pierson examined the literature on women and war from an international perspective, suggesting that dichotomous metaphors have emerged by which women are portrayed as 'beautiful souls' and men as 'just warriors.'[28] Most of the existing literature on military nurses fits easily into the first category. Pierson identified a more recent shift toward the examination of gendered discourses that expose the contradictions in these images; this is exemplified by Jean Elshtain, who argues that both women and men occupy positions as beautiful souls and just warriors.[29] Elshtain suggests further that nursing "allowed women to get close to that action of which they are not an active part," and that nurses were battle zone witnesses to the spectacle of war.[30]

The collection, *Behind the Lines: Gender and the Two World Wars*, emerged from a 1984 "Women and War" workshop held at Harvard University.[31] Some of the authors challenged the construction of war's gender as stereotypically male. Others examined various wartime roles for women and men--finding that power, economics, and status tended to remain unchanged even in the armed forces. This argument is best represented by Margaret Higonnet's 'double helix' concept that allows for variation, but maintains the relative positions of power held by women and men in the military.[32]

Both Susan Grayzel and Angela Smith have studied women who served during the First World War, with analyses that touch briefly on nurses' experiences. Grayzel produced a comparative study of the porous boundaries between 'war fronts' and the 'home fronts' of Britain and France, in which she argued that the war did not shatter gender relations and identities. She considered nursing (civilian and military, untrained and trained) as one of the roles assumed by the women she studied, arguing that "'[R]econstruction' was a constant and ongoing process from the first day of the war."[33] Smith used post-modern discourse analysis to examine women's private testimonies and published records of various frontline experiences, for the links between warfare and literary development during the First World War.[34] In one chapter, she argued that

military hospitals comprised a 'second battlefield' through a comparison of the published hospital stories of Enid Bagnold, Ellen LaMotte, and Mary Borden. According to Smith, nurses' writings constituted a type of 'accidental modernism' identified by "aesthetic self-consciousness, fragmentation, paradox and uncertainty, dehumanisation, sense of crisis and an engagement with issues of sexuality. . . discovered within the nurses' war narratives, as well as experiments with language and form."[35] In a similar manner, Margaret Higonnet used critical literary theory to compare the memoirs of two nurses (one trained, and one volunteer) who served during the First World War.[36] Higonnet focused on identifying literary consistencies in these writings and links between the two women (Ellen LaMotte and Mary Borden) rather than focusing on nursing practice per se.

Jean Bruce was one of the first Canadian historians to focus on women's experiences during the Second World War. When she began her research in 1979, she found that there was a great historical silence surrounding Canadian women and war service—a silence that persists in relation to nurses more than twenty years later.[37] Bruce sought to document women's activities on the home front, as well as their activities in military and paramilitary organizations. She described her book as a 'montage' of personal stories, statements, and visual images.[38] Her chapter on military nurses is based heavily on one published source, G. W. L. Nicholson's *Canada's Nursing Sisters* (1975), as are three more recent collections and an art book on women who served in the Canadian military.[39] This literature is useful in a limited manner; it tends to be hagiographic and to perpetuate discourses that stereotype nurses as exceptional women. While it includes a number of brief anecdotes submitted by nurses who served during the war, the majority of the stories are practically identical to previously-published accounts by many of the same nurses.

Using the Department of Labour's National Selective Service (Women's Division) records and military files, Ruth Roach Pierson argues that the massive recruitment of women for the war effort was intended for the duration of the war only, in spite of the fact that women declared their motivation to be need for work rather than patriotism. According to Pierson, little permanent

change took place in women's roles after the war.[40] Jeff Keshen presents an alternate perspective based on images and messages in the print media, suggesting that for civilian women who had been recruited for war-related employment, "too much had transpired for too many women to permit things to return to the *status quo ante bellum*."[41] In a later essay, Pierson examined how the induction of women into the armed forces created societal nervousness regarding gender roles--in particular, the preservation of women's femininity and sexual respectability.[42] Teresa Nash's thesis explores images of women as portrayed by National Film Board of Canada films during the war and immediate postwar periods. Her focus on non-traditional roles, however, led her to either overlook or exclude material on military nurses.[43]

A second body of literature in which military nurses could expect to have a presence is Canadian military history—and more specifically, Canadian military medical history. Yet, they seldom appear in mainstream histories, other than as part of statistical tables.[44] These volumes are important, however, for their chronologies and documentation of individuals, major campaigns, and events. Recent military historians have significantly broadened their analyses to include Canadian socio-political and economic factors yet they, too, have ignored military nurses for the most part.[45] Canadian military medical history consists of far less material, beginning with W. R. Feasby's two-volume official history of the Medical Services branch.[46] Feasby, true to the subtitles of each volume and to his professional background as a physician, focused clearly on two aspects: the organizational structure and campaigns that involved the medical services units, and clinical topics such as medical and surgical treatments, epidemiology, research, sanitation and prevention measures, pharmaco-therapeutics, and practice innovations. Nursing Sisters are present in his account but received scant attention except for extra-ordinary events, such as their rescue from a torpedoed ship or being wounded by 'friendly fire.'[47]

In 1975, the Nursing Sisters Association of Canada commissioned an official history written by G. W. L. Nicholson.[48] Two years later, Nicholson published a second commissioned history for the RCAMC.[49] In the first account, nurses are central figures although the scope of history from the Northwest Rebellion to the 1970s, limited the content on the Second World War

nurses to four chapters. Perhaps because Nicholson wrote the nurses' history first, and was therefore familiar with the subject, the RCAMC narrative integrates nurses into portions of that history as well. *Canada's Nursing Sisters* is an organizational history that establishes a good chronology and identifies key Nursing Sister leaders. It includes an abundance of photographs and describes the mobilization and movement of medical units. Nicholson summarized his narrative by quoting from a tribute to Nursing Sisters that referred to them as "pure white womanhood," and by writing, "Of these dedicated women it may be truly said: 'They served and equally.'" [50] Nicholson approached the Nursing Sisters primarily as military women in need of recognition.

Almost all other studies of Nursing Sisters since 1975 have relied heavily or completely on Nicholson's account. One notable exception is Bill Rawling's recent research on Canadian medical practitioners during both world wars, in which he made extensive use of medical units' war diaries to contribute new perspectives to military medical history.[51] Significantly, Rawling included all personnel of the medical units in his study: nurses, physicians, orderlies, stretcher bearers, transport drivers, etc. But he did not address nurses specifically when he argued that medical practitioners exercised considerable autonomy within the medical units, that they sought to balance military and medical demands, and that death itself constituted the main enemy for medical personnel.[52] Typically, RCAF and RCN medical services are missing from most of these accounts although three recent publications contain brief references to RCAF and RCN Nursing Sisters.[53] These histories focus on military aspects related to where nurses served, what they wore, how they fit or didn't fit into military routines, and what they did socially.

In a third body of literature, nursing history, there have been only two major histories of the Canadian nursing profession. John Murray Gibbon and Mary Mathewson published *Three Centuries of Canadian Nursing* at the end of the war in 1947. It is a grand narrative history that includes a brief chapter on the Second World War. *Three Centuries of Canadian Nursing* has been the main source of historical information for several generations of nurses. In 1996 feminist and labour historian Kathryn McPherson published the first book-length analysis of Canadian

nursing history, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990.*[54] She focused on the everyday work of hospital nurses, using the concept of 'nursing generations' as an organizational tool to talk about change in the civilian profession from the end of the nineteenth century through the 1970s.[55] Each nursing generation shared specific historical contexts and work experiences. According to her classification, Second World War military nurses overlapped the 'third generation' of nurses who experienced oversupply and underemployment (1920-1941) and the 'fourth generation' of nurses who witnessed a dramatic growth in hospital services and a strong demand for nurses (1942-1967). Nursing Sisters straddled both generations in interesting ways while their inter-generational position kept them from fitting into either generation well. In this thesis, I build on McPherson's concept of generations in nursing, and on her focus on gender and nurses' work.

A decade ago, Veronica Strong-Boag described the state of nursing history scholarship as developing at a 'snail's pace.' She warned that "Nursing's 'great women' are not 'dressed and ready to go' analytically speaking–in that regard much often remains to be done, particularly with regard to the influence of class, race, and ethnicity. . . ,"[56] with the exceptions of McPherson and Meryn Stuart who used class and gender as analytical concepts to examine public health nursing.[57] By the mid-1990s, McPherson and Stuart found that Canadian nursing history had begun to move away from the study of institutions and elite leaders and to incorporate critical theory in the historical process, although changes did not occur at the same rate, or to the same extent, as in mainstream history.[58] Until recently, nursing history has focused on forging a collective identity and on universalizing experiences, instead of asking pertinent questions that could reveal greater diversity and complexity among nurses. For example, there has been amazingly little research on First Nation women or women of colour in Canadian nursing history.[59] There is almost no research that explores nurses as oppressors in relation to class, race, ethnicity, gender, or sexual orientation–either among themselves as nurses, between nurses and other health care workers, or between nurses and patients. Yet these relationships certainly situate nurses in positions of power which call for alternative analyses.

Two significant accounts from the international nursing literature illustrate a slow shift in nursing history scholarship.[60] Historians Shula Marks and Hilde Steppe have explored differences among nurses based on race, region, class, and ethnicity that have relevance to this thesis and link it to the broader international context that existed during the Second World War. Both authors suggest that these variables fragment (or fracture) nursing's surface sisterhood assumptions. Marks studied the legacy of racialized nursing for post-apartheid South Africa, exposing the process by which Black nurses and White nurses contested professional terrain. Her research raised the possibility of alternative explanations for the South African government's request for Canadian Nursing Sisters during the Second World War. Steppe examined German nurses under the National Socialism and the Nazi regime of Adolf Hitler. Her research analyzed the complexities of nursing's caring ideology, obedience, and the process of becoming an agent of the state, especially during wartime—again suggesting that variables of race and ethnicity constructed nursing practice in important ways depending on which nurses and which contexts are studied.

Jan Bassett's analysis of military nurses and the state of Australian nursing history provides a good summary of American, British, and Canadian military nursing historiography as well: historians have generally either ignored or sanctified military nurses' experiences; feminists have overlooked military nurses as ideologically unsound; and military nursing histories consist mostly of anecdotal collections and chronologies.[61] Indeed, the international literature includes memoirs and collections of personal memories of Second World War nursing, such as Diane Fessler's *No Time for Fear*, Joyce Hibbert's *Fragments of War*, Brenda McBryde's *A Nurse's War* and *Quiet Heroines*, and Gwladys Aikens' *Nurses in Battledress*.[62] Canadian Nursing Sisters Doris Carter and Mary White have published memoirs, and Edith Landells edited a three-volume set of Nursing Sisters' recollections and photographs from 1885 to the mid-1990s.[63] There are also prosopographies that document a particular set of experiences or groups of nurses, such as Elizabeth Norman's various publications on American nurses as prisoners of war on Bataan and nurses who served in Vietnam.[64] There are various organizational histories, such as three

histories of the U. S. Army and Navy Nurse Corps that have been written by Mary Sarnecky, Barbara Tomblin, and Doris Sterner. Juliet Piggott and Penny Starns have produced histories of the Queen Alexandra's Royal Army Nursing Corps (the British nursing service) while Bassett's own history of the Australian Army Nursing Service covers that organization from the South African War to the Persian Gulf War.[65]

Our knowledge about the Second World War Canadian Nursing Sisters must also be informed by the literature on the First World War Nursing Sisters. It includes the published memoirs of Nursing Sisters Mabel Clint, Katherine Wilson-Simmie, and Constance Bruce[66] as well as the published diaries of Nursing Sister Clare Gass and Canadian nurse, Ella Mae Bongard, who served in the American Army Nurse Corps.[67] Susan Mann recently searched out the dispersed portions of the Gass diary in order to analyze and publish it. She identified several abortive attempts to create a record of these nurses during the early postwar period, noting that there are few remaining primary sources for these nurses.[68] Her warning about shrinking sources applies well to the Second World War nurses who are rapidly disappearing. Meryn Stuart is currently examining the First World War Nursing Sisters, arguing that war was a gendering activity that created different expectations regarding new, adventurous roles for nurses. She explains how nurses parlayed their image and war experiences into new careers in public health nursing and access to university education, although ultimately these professional achievements were compromised.[69]

Two unpublished theses also make valuable contributions to the history of Nursing Sisters during the First World War and the interwar periods. Leslie Newell examined nurses' position within the Canadian military system. She concludes that military nursing was professionally and 'culturally' liberating for nurses during the war, but after the war, nurses' roles were extremely limited within the military and alienated them professionally due to their small number and isolation from other nurses. She argues that the introduction of military medical orderlies distanced nurses from 'hands-on' practice and that the system of relative rank prevented them from advancing within the military.[70] Geneviève Allard used previously-created oral histories

to explore nurses' experiences related to enlistment, their living and working conditions, and their professional and social relationships.[71] She suggests that the image of military nurses as "angels" hides the realities of their experiences as women who participated fully in life at the front.

In summary, historians have generally avoided military nurses as subjects of study—including women's historians. The association of nurses with war and killing runs counter to conventional thought, and fosters an interpretive uneasiness among historians that obscures nurses' presence, and war as nurses' work. Most existing accounts treat nurses as patriotic, dutiful, sacrificial, mothering, angelic, courageous, and heroic. War has been portrayed as antithetical to nursing, while nurses have been portrayed as ideal women who epitomized both femininity and pacifism. War has also been portrayed as providing opportunities for nurses on one hand, yet subordinating nurses within military systems on the other hand. Seldom have military nurses been considered as professional nurses working within a military system, or war as nurses' work. Little is known regarding their nursing practice or the manner in which war, medical technology, and gender shaped this practice.

Conceptualizing Military Nurses

To move beyond the portrayal of Nursing Sisters as heroines and angels, and locate military nursing as nurses' work, it is necessary to differentiate the majority of nurses who engaged in ordinary, everyday practice from their more visible leaders. The centrality of nurses' 'technique' and 'hands-on', intimate expertise to the practice of nursing makes it feasible to approach military nursing through the lens of medical technology. McPherson notes that the mastery of nursing techniques provided nurses with marketable skills and expertise that differentiated them from non-professional care givers during the early 1900s.[72] Building on her work, I have argued previously that the acquisition of technological skills differentiated nurses on the basis of skills, providing a measure of job security and occupational space, and increasing the status of nurses during the 1960s to the 1990s.[73] But Second World War military nurses were

especially successful in parlaying skilled nursing practice associated with medical technology into critically needed work opportunities. Indeed, their presence enabled the increased use of medical technology in active theatres of war and moved them ever closer to 'the frontlines.' Nursing became a component of the strategic planning for war that influenced the number of combatants returning to active fighting, as well as the rate of that return. As such, nurses became actors in a much larger complex.

This thesis examines military nursing as part of a 'large technological system,'[74] to broaden the analysis and move beyond technological determinism. Existing history of technology frameworks are oriented toward the in-depth study of an individual technology, while remaining remarkably silent on gender and on war.[75] Ruth Cowan traced the origin of the term 'technology' to the late eighteenth century when it was associated with 'knowledge of the arts' and referred to orally-transmitted craft knowledge. She credited the 1829 publication of a popular book by Harvard professor Joseph Bigelow (*Elements of Technology*), for introducing the term to North America—noting that Bigelow defined it as "the application of the sciences to the useful arts" and that the Massachusetts Institute of Technology enshrined it as part of their name in 1865. Cowan suggested that even at this early date, technology was perceived in relation to something else: to nature, to social status, to skill, to gender, to God, and to politics.[76]

I have adopted a definition of technology based on current practices within the history of technology field, in which technology is broadly conceptualized as complex 'technological systems' that are historically-situated within specific socio-political and economic contexts.[77] According to historian Thomas Hughes, technological systems are both socially constructed and society shaping. They include whatever components are necessary to achieve a common system goal: physical artifacts; organizations, from manufacturing to transportation and banking; scientific components such as books, articles, and university teaching and research programs; legislative and regulatory artifacts; and natural resources.[78] The artifact may be physical or non-physical and all components are interrelated so that changes in one aspect effect changes in the others. Technological systems are constructed by systems builders who hold the balance of

power by controlling as many parts of the system as possible, for as long as possible. While social construction of technology frameworks broaden analysis, they are also limited in their ability to explain how social shaping takes place, how power is distributed and contested, what influence variables of difference, such as class, race, ethnicity, gender, and region might have within the systems, or how to explain change adequately. Focused as they are on system builders, these frameworks deny or minimize the agency of other actors within the system—indeed it is often difficult to locate these actors and their perspectives.

Medical technology in this thesis, therefore, refers not only to specific instruments, equipment, and products. It also includes the skilled application of these tools, the associated nursing care knowledge that enabled innovation and improvisation under wartime conditions, the therapeutic use of self when technology reached its limits, involvement in medical research related to war, military medical policies and regulations, training programs, transportation systems related to medical evacuation, physical and psychological screening tools, organizational tools for sorting patients and documenting care—to name but some of the elements that comprised this large technological system.[79] Nurses have always engaged in myriad activities performed on, and with, patients' bodies that required the skillful use of equipment and instruments as well as the development of related knowledge and expertise in managing such procedures. Military nurses extended these activities as part of a large technological system mobilized for war. In doing so, they entered an all-male domain with a long tradition of hierarchical power and formalized authority.

I privilege gender as a necessary category of analysis in this thesis because it permeates both medical technology and war. The key defining characteristic of the Nursing Sisters was their femininity, and the manner in which it superseded professional identity. Nursing Sisters were women first, and nurses second, according to the prevailing military practice that classified all serving women as Nursing Sisters regardless of occupational category and denied professional status to men who were fully-qualified as nurses. Gender analysis exposes the multiple ways in which power was unequally distributed within this military-medical technological system, as well

as within the Nursing Sisters community. As an analytical tool, gender shifts the research approach from simply 'adding military nurses' to history, to interpreting history through military nurses' experiences. It provides a rich theoretical framework for the examination of additional, multiple, intersecting variables such as class, race, ethnicity, language, marital status, and age. It has the capacity to expose both the "fundamental differences that divide gendered subjects" and the "historically specific processes that unite people into a shared gendered consciousness."[80] Gender always situated the Nursing Sisters in relation to military men (medical orderlies, medical officers, and military officers), with a pervasive and mediating influence on their roles and relationships. It structured nurses' military rank, personal lives, and professional work—both differentially and deferentially.

Gender analysis requires the researcher to consider differences that shape the material world, relationships, and experiences according to unequal power dynamics. It led me to examine how the nursing workforce was incorporated into the military and how it shaped nurses' work there, as well as how nurses used gender to negotiate space and privilege, socially and professionally, within a traditionally male domain. I consider what nurses gained as well as what they lost when they incorporated the military into nursing practice. If war reconfigured some aspects of gendered relationships within the military-medical-technological system, were those changes transferred to the postwar and nonmilitary settings?

Finally, I use the sociological concept of 'symbolic community'[81] to illuminate some Nursing Sisters' persistent identity as military nurses after the war. Much of the literature on community and identity comes from sociological research focused on nation building. Sociologists and historians have broadened their concepts of community considerably since the 1980s, to include relationships that extend beyond regional boundaries (or spatial structures), to include social structures.[82] A. P. Cohen argues that community is a mental construct. Pointing out that there are more than ninety discrete definitions of community in the social sciences literature, Cohen emphasizes community as constructed meaning, and particularly, the meaning of boundaries that distinguish its membership.[83] He asks how symbols are created, how a

community constructs its public face, how it remembers its past, and how it uses that past for present integrity. I build on these understandings of community to argue that medical technology, gender, and war intersected to facilitate the formation of a symbolic community and a social memory as military nurses, by many of the Second World War Nursing Sisters.

Although the Nursing Sisters entered into a completely male domain at the beginning of the war, and they became essential components of the military-medical-technological system, they were clearly intended to be military nurses only on a temporary basis. Yet this relatively-brief episode, consisting of less than six years for most of them, shaped an enduring identity that became increasingly meaningful for many of them. That identity evolved and served a variety of purposes, both privately and publicly.

Methodology

Historical research is always contingent on access to primary sources but women's history presents additional challenges associated with women's relative invisibility within traditional records and documents. Research on the Nursing Sisters is particularly challenging during this period due to their relatively small number, their integration into medical services that subsumed nursing, a lack of attention from official military historians who were assigned the task of preserving records for military history,[84] and a paucity of written documents created by military nurses. In addition to these challenges, the examination of rank-and-file nurses' work is further removed from public view by the private, intimate nature of their work which involved patients' bodies, as well as by the nature of war that interspersed periods of waiting for patients with intense periods of rapid admissions, surgeries, and evacuations and left little time for the creation of records. Nurses were admonished not to keep diaries nor take photographs "in case they would fall into the hands of the enemy"[85] and, with some exceptions, they did not do so. Nursing Sisters (NS) frequently reminded me that while in an active theatre of war, there was little space or time for discretionary items. As NS Margaret Van Scoyoc wrote, they "were limited to what we

could carry in our back pack. This included such items as a skirt, two shirts, one pair of oxfords, stockings, toilet articles, and lingerie."[86]

To partially address these methodological challenges, I have used two major primary sources for this thesis in addition to conventional archival sources, contemporary professional literature, and the Nursing Sisters' own memoirs and letters. The two most important sources were ones that I constructed specifically for my research: oral history interviews and a Nursing Sisters database created from contemporary military personnel records. These two significant sets of data are different but complementary. Both sources have been shaped by those who created them, and both sources present specific methodological challenges (Table 1.1). Oral history represents a qualitative approach, focused on in-depth interviews, and is limited by the number of participants that can be included realistically in a study. The military records made it possible to use a quantitative approach and describe the larger population more completely; to analyze conceptual variables related to my theoretical framework such as gender, race, ethnicity, age, marital status, religion, language, and more; and to compare the interviewed nurses to the larger group, for the purpose of generalizing my findings.

TABLE 1.1. COMPARISON OF ORAL HISTORIES AND PERSONNEL FILES

ORAL HISTORY	DEMOGRAPHICS
Qualitative Method	Quantitative Method
25 Interviews Each interview is between 45 – 180 minutes in length, with an average length of 90 minutes.	1145 Nursing Sisters Personnel Records This represents approximately 24% of the population and 26% of those who were nurses; N = 1052 nurses.
Selected by the researcher from participants who volunteered initially	Selected randomly by last name, according to letter sampling techniques
Retrospectively created in 2001	Contemporary creation during the war
Required ethics approval and informed consent	Required archival approval and anonymity

Creating Oral History

Two things became clear in my early research decisions regarding how to study the Second World War Nursing Sisters. Some of the women were still living but time was running out due to their advancing age and declining health. They were typically between 82 and 96 years of age at the time of the interviews. A significant number of them lived in the Ottawa, Montreal, Kingston, and Toronto areas. Thus, oral history appeared to be an ideal method for 'giving voice' to this group of women because it would permit me to examine their war experiences directly. I conducted interviews with twenty-five Nursing Sisters across Canada (Appendices 6 and 8). The number of interviews was determined by the number of Nursing Sisters available, their memory and health status, as well as consideration of how many interviews would be adequate in order to achieve saturation of the interview data generated. These twenty-five interviews, in addition to thirty interviews from other collections (Appendix 7), constituted a substantial body of evidence for analysis.[87]

Major debates in the oral history literature can be organized according to three areas: the nature of the evidence, the degree to which the narrator represents the larger group under study, and issues concerning the relationship between the interviewer and the narrator. Debates on the nature of the evidence include, for example, oral history's appropriateness as a source, the weight of oral history evidence compared to documentary sources, subjectivity versus objectivity of the data, the construction of memory, and debates on 'facts' versus 'mentalities'.[88] Nadia Fahmy-Eid and Denyse Baillargeon have made significant contributions to these debates on women's history and subjectivity.[89] Baillargeon provides an excellent critique of oral history as a method--in particular, her comparison of the presumed objectivity of empirical knowing with the presumed inferiority of subjective memory. She successfully argues that written records are no more 'factual' and no less constructed (or subjective) than oral history. Since my interview participants were all in their mid-80s to mid-90s, I had an additional issue to consider—their long-term memory recall.[90]

Debates related to the narrator's degree of representation typically concern the number of interviews required, sample selection, individual narratives versus collective explanations, as well as debates on theoretical approaches such as structural versus post-structural analysis.[91] To date, historians have focused the most attention on the first two areas, noting many parallels between oral history and other types of primary sources while concluding that the similarities outweigh the differences. Both sources require equal rigor and consideration of the multiple subjectivities inherent in the creation and interpretation of the source.

Debates on the relationship between the interviewer and the narrator involve issues of power. The intentionality of the relationship is what distinguishes oral history from other oral sources.[92] The historian prepares for the interview, with particular objectives in mind. Yet, in actual practice, the interview becomes an interactive process as both interviewer and narrator co-create the data through a variety of ways. As Allan Futrell and Charles Willard argue, "seeing texts solely as the creations of narrators (and seeing interviewers as passive recorders) is untenable in the context of viewing interviews as social interactions."[93] Whether acknowledged or not, power differentials are operative in the interviewer-narrator relationship, and they are influenced by gender, class, ethnicity, race, sexual orientation and in my case, professional affiliation. The level of control shifts during the process of creating the oral history record; control is contested and negotiated throughout the interview. Although oral history has the potential to document previously-overlooked missing perspectives of persons who have been marginalized in traditional historical accounts, its inherent power inequalities may also maintain marginality.[94] Power between the interviewer and the narrator is seldom shared, regardless of intention to do so. The interviewer chooses which persons will be interviewed and what the questions will be. Indeed, one of the strengths of this source is the opportunity to focus on questions and perspectives which are not usually represented in traditional documentary sources. The narrator, however, controls the type and amount of information that is either disclosed or withheld, and constructs that information from his or her particular perspective. Ultimately, the historian exerts final control over analysis and publication.

Historians disagree regarding the role of the narrator beyond the interview, and it is the disciplinary training of the researcher and choice of theoretical frameworks guiding the research that influence power decisions. Paul Thompson suggests that oral history "allows us, indeed obliges us, to test [our interpretations] against the opinion of those who will always . . . know more than ourselves." [95] Some researchers attempt to do this by permitting narrators to verify the contents of the interview, to clarify points, and to correct material in the transcript. Katherine Borland argues that it is similar to "being robbed of [one's] own history" if these options are not extended to the narrator and she asks, "Whose history is it?"[96]

Feminism is one theoretical perspective that developed within a marginalized population, claims particular interest in issues related to power and its origins, and offers particular strengths for oral history with women.[97] In adopting a feminist stance, I made decisions regarding each phase of the research process that are reflected in my research plan and in the forms that I developed for the study (Appendices 2, 3, 4, 5, and 9).[98] As a feminist historian, I acknowledge multiple simultaneous identities that are fluid and shifting related to the Nursing Sisters that I interviewed. I interact with these women primarily as a white, middle-class, American-Canadian, English-speaking woman who shares professional nursing status with the narrators--yet I am privileged by age and academic status. In some ways, I am an 'insider' to the nursing world yet I am also an 'outsider' to the narrators' military world and do not share their unique Nursing Sisters' community in the way that they do. My different identities shift situationally—not only according to my self-perception and how others perceive me in a particular context, but also according to which identity is most instrumental. During interviews, for example, sometimes it was more useful to put on my 'nursing cap' as an insider when asking about medical technology. At other times, it was more useful to remain an outsider when I needed to clarify military terms, procedures, and issues. The participants also made decisions and shifted identities during the course of our interviews. Sometimes I was permitted insider status and made privy to contested experiences. At other times, Nursing Sisters indicated clearly that there were experiences that they would not share with me, and I respected those boundaries.[99]

As a professional nurse, it is useful to speak the medical jargon and be able to probe 'hidden' areas of nursing practice that might be otherwise overlooked. Shared understanding can be deceptive however, as language and experience is historically contingent and I live in a different historical context. I may presume to understand practices and terms that have changed significantly and I need to be aware of this. As a non-military nurse, I may bring fewer preconceptions of that experience but I may also overlook important issues. These limitations are not unique to oral history, however, as similar debates apply to the military personnel records.

Creating the Nursing Sisters Database

The second major category of sources consists of the military nursing records for the Department of National Defence, which I used to construct a database for demographic analysis. Initially, I intended these personnel records merely to support my interviews and represent the larger population of Nursing Sisters. By the time I finished extracting thirty-four variables from each of 1145 records, however, I found this source to be extremely valuable in unexpected ways. It provided an alternative method for a more comprehensive analysis of rank-and-file nurses than would have been possible using oral history alone. Random sampling and the large number of records increased my ability to generalize from the findings, while access to important demographic variables enabled me to study characteristics of these military nurses that have never been available before now, such as age, ethnic origins, parental occupations, dependents, training schools and graduation dates, posting patterns, pre-enlistment experience, and post-war plans.[100] Personnel records contributed important information from a majority of the Second World War Nursing Sisters who are no longer living, or who are not available for interview due to where they live, poor health, or memory loss. Because the records were selected randomly, they also represent a broader range of Nursing Sisters than I would have been able to interview individually. In spite of the strengths associated with these records, there are important limitations to acknowledge.

These records are valuable because they were created during the period under study and have been preserved in order to document the federal government's obligation to veterans who served in the war. That obligation influenced the type of information collected, as well as the consistency of soliciting certain information because it was used to establish veterans' eligibility for benefits, particularly those based on length of service, on postings to specific theatres of war, and on pre-existing conditions such as medical status, education, training, and employment. The records contain many types of forms that were completed by many different persons, at different times, with opportunity for inaccuracies and inconsistencies—myriad ways in which these records have been constructed by those who created the documents. Many records were incomplete, to greater and lesser degrees, because of missing forms.[101]

Standardized forms are useful for collecting consistent information from a large number of people, but they are limited by their structure. Forms create silences through what is asked and what is not asked, as well as how answers are recorded and by whom. For example, the question on religion did not provide an option for 'none.' The question on marital status did not provide options for non-traditional relationships. Approximately half of the forms asked for the occupation of the applicant's father (but only if the father was alive), while there was no corresponding query regarding the mother's occupation. The other half of the forms did not even ask for the father's occupation. Likewise, I found different information recorded for the same question in different parts of the record, requiring decisions as to which information was more likely to be accurate. At times, I could corroborate responses with another part of the same record. Wherever possible, I searched for the applicant's own words and privileged those responses. For example, the "Nursing Service Information" form was almost always available. It was typically filled out and signed by the applicant as noted by comparison of the hand-writing. Among other information contained in this form, were the name and location of training schools, graduation dates, courses taken after graduation, and a summary of her prior experience—information considered important to record accurately because it pertained to nurses' postings and available practice expertise.

Documentary sources such as the military records appear to constitute more objective, reliable, and therefore, more accurate data. But there are important issues to consider when using them, such as who created them, their characteristics, the access restrictions imposed, and the sampling method used (Appendix 11). Each of these issues also concern power and privilege, requiring choices regarding inconsistencies and omissions, silences, and reliability.

Archival Sources

In addition to oral histories and the military records, I have used a variety of documents, photographs, letters, diaries, scrapbooks, census records, and audiovisual material located in both public and professional archives. The Archives of Ontario holds the records of the Registered Nurses Association of Ontario, providing excellent material for analysis of wartime nursing issues from a civilian, professional perspective. I used records, photographs, and audiovisual material pertaining to the military medical units at the National Archives of Canada and at the Department of National Defence Directorate of History and Heritage. These materials included Nursing Sisters' oral histories, war diaries of a large number of medical units, private collections of letters and scrapbooks belonging to Nursing Sisters, military records, and statistical reports. In addition, I used records, artifacts, and literature from the Canadian Nurses Association which are now held at the National Archives of Canada, the Canadian War Museum, the Canadian Museum of Civilization, and the Canadian Institute for Scientific and Technical Information.

Military documents and records were important sources for establishing the contexts in which Nursing Sisters practiced although they revealed surprisingly little of their actual practice. According to Tim Cook who examined the role played by one of the most influential of the designated Army historical officers, C. P. Stacey, the Army Historical Section produced a mass of documentary evidence: 200,000 CMHQ subject files, 20 million sheets of paper, and 132,000 war diaries.[102] There are over five-hundred war diaries pertaining to medical units of the Second World War. A survey of three of these diaries, representing different types of units (a general

hospital unit, a casualty clearing station, and a field surgical unit) reveals that they assume an operational and accounting focus. Depending on the recorder and the choices of material appended as attachments to the monthly installments, these diaries can obscure as much as they reveal. Edwidge Munn notes this variation as well, in her critique of archival military sources: "la rédaction obligatoire de son journal à un officier et la narration des événements est d'autant plus étoffée que le rapporteur se sent en verve."[103] Cook concludes that "Clio's soldiers were not simple scribes or passive archivists. . . . They actively sought out the war record, influencing . . . how the war would be captured and ultimately codified in print."[104] He argues that Stacey actively directed the production of the war records, circulated them for revision, and exhibited a high degree of self-censorship—even in the field, during active campaigns. The focus for official records was on the grand narrative and not on the private soldier.[105] Little wonder that Nursing Sisters seldom appear in them, except as names on lists of transfers in and out of medical units.

I selected seven oral histories from the RNABC collection, three from the AARN collection, six from the National Archives of Canada, one from McMaster University, and fourteen from the Margaret M. Allemang Centre for the History of Nursing (Appendix 7). Many of these oral histories lack a clear focus, and require the researcher to 'read against the grain.' Since a key component of oral history lies with the intentional relationship between an interviewer and narrator, for the specific purpose of co-participating in examination of a topic, the storage and retrospective use of these interviews and transcripts for analysis and interpretation beyond the intent of the original research becomes an important methodological issue. Julie Cruikshank insists that interviews are "meant to be heard in the particular context in which they are told. They are not documents to be stored for later retrieval . . . . Events are anchored to place and people use locations in space to speak about events over time."[106] I believe, however, that these oral history collections remain valuable for corroboration and comparison to other primary sources, as well as for their ability to fill in gaps related to practice settings in which there were no Nursing Sisters available to interview.[107]

I consulted a variety of photographs from both public and private collections. Like any other source, they require the researcher to understand the provenance and purpose for which they were originally created. Most of the photographs were produced by official war photographers for public relations in support of the war effort, although some of the Nursing Sisters had personal photos. Official public relations photographs tended to photograph Nursing Sisters as part of large medical unit group photographs, either with or without medical officers present. They are also frequently portrayed in social situations such as having tea with dignitaries, embarking or disembarking while carrying heavy back packs, sightseeing, biking in England, or getting married to officers. These photographs send clear messages about nurses' safety and well-being for the home communities especially. A small number of the most useful photographs show nurses at work in different settings, some of the available medical technology in use, and occasionally even interactions between nurses and patients. Even when patients with wounds are subjects in the photographs, they have been carefully posed to minimize the injuries. Patients are typically further along in their recovery, well-dressed, and appear quite comfortable. More often than not, the nurse is peripheral to the action—either assisting or observing the medical officer. Each strategy helps to create 'silences' regarding unspeakable and in this case, invisible realities of military nursing.

Professional Literature

A substantial body of contemporary professional literature is available for examination of medical and nursing practice during the war period. Two particular Canadian journals were pertinent to this thesis. The *Canadian Nurse* has published continuously since 1904, and it is the official voice of the Canadian Nurses Association. In this capacity, it represents the perspectives of nursing leaders more than rank-and-file nurses. Historians can, however, glean alternate perspectives from reports of local nursing organizations, 'letters from the front,' news features and profiles of Nursing Sisters, communications from the Canadian Nurses Association regarding the wartime nursing shortages, and occasionally, updates on new medical technology being used

overseas. I analyzed this journal for a ten-year period, from 1938 to 1948, consistent with my stance that for nurses, this timeframe is more reflective of their engagement in the war effort and its aftermath. From the ebb and flow of related articles over this decade, it is also clear that this was the period of greatest interest in the Nursing Sisters, and in various issues associated with the transitions between military and civilian nursing.

The *Journal of the Canadian Medical Services* was a unique publication that only published from November 1943 to January 1947, although it had a predecessor during the First World War.[108] The *Journal of the Canadian Medical Services* met a stated need for medical practitioners to share common experiences, challenges, updates related to medical practice, and news.[109] One of its co-editors was W. R. Feasby who served with No. 15 Canadian General Hospital, and edited the official history of the Canadian Medical Service after the war.[110] The journal's contents consist mainly of clinical topics, news from Canada, and abstracts from other contemporary clinical literature to update the medical officers. Nursing Sisters had a relatively prominent place in the journal initially but they were soon marginalized, appearing as brief lines in the news sections and then finally, they all but disappeared from the journal's pages. Here again, however, historians can 'read against the grain' for glimpses of these nurses and their work.

Published and Unpublished Memoirs and Letters

The final category of sources consists of published and unpublished memoirs and letters. Presently, there are only two published, book-length memoirs and a collection of letters by the Second World War Nursing Sisters in addition to an anthology of their recollections.[111] I was able to interview both of the women who wrote memoirs and interestingly, found somewhat different perspectives from those expressed in their books. Both women felt their narratives had been partially shaped by editors, and both women had far more to say about practice than emerged in their memoirs. This may have been related to a common nurse's and women's perception that what we do is insignificant—until someone really asks about it directly.

There are also unpublished accounts, in the form of letters, diaries, and anecdotes that have been either retained by individual Nursing Sisters or deposited in scattered, private archives. I believe more of these may emerge in the future. I used two sets of letters deposited in public archives as well as private diaries and accounts that were provided to me for research. Although the letters were created during the war and have a temporal advantage, they were also constructed for specific purposes by the nurses who wrote them to their families and friends. Nurses were careful not to violate censorship regulations, and to send mainly positive messages home.[112]

Overview of the Chapters

Each of the chapters in this thesis considers the Second World War Nursing Sisters from a particular perspective. In Chapter 1, I situate nurses within the professional, technological, and military contexts of the interwar years. I consider their working conditions, the socio-political and economic settings of the 1930s, and the demographics of the Nursing Sister population to illuminate who became military nurses and what factors influenced their selection by the armed forces. In Chapter 2, I explore the position of Nursing Sisters within the Canadian military medical system, as an expandable and expendable workforce. I discuss their expansion to all three branches of the Canadian forces, to the Allied forces, to all theatres of war, and to military hospitals across Canada as well as issues of risk and danger. Chapter 3 considers the transformation of military nurses as "officers and ladies", and the contingent nature of gender and class boundaries within the armed forces. In chapter 4, I examine the Nursing Sisters as professional nurses within a large military-medical-technological system through analysis of their work and the impact of medical technology on the care of military personnel. I consider the continuities, as well as changes in relation to prewar civilian practice; how gender influenced technological roles; and particular innovations that expanded nursing practice. I analyze how these experiences did, or did not, become part of postwar professional nursing practice. In

Chapter 5, I consider the multiple ways by which Nursing Sisters constructed an enduring female community based on shared experiences and identity as military nurses. I build on concepts from anthropology and sociology to explore how gender operated to shape a symbolic community through discourse, rituals, symbols, and social memory.

The prewar period was especially significant for the Nursing Sisters because they enlisted as fully-trained professionals with an extensive period of preparation behind them, and they had experienced the Depression in particularly gendered ways, as women and as nurses. The next chapter analyzes the contexts and events that created a pool of readily-available labour for the military. War effectively "saved" nurses from dire circumstances by providing them with work, a measure of security, travel, status, female networks, and proximity to men who were serving in the armed forces.

Endnotes

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[1] Roger Cooter, "Medicine and the Management of Modern Warfare: An Introduction," in Roger Cooter, Mark Harrison, and Steve Sturdy, eds., *Medicine and Modern Warfare* (Amsterdam and Atlanta, Georgia: Rodopi, 1999): 4.

[2] G. W. L Nicholson, *Seventy Years of Service: A History of the R.C.A.M.C.* (Ottawa: Borealis Press, 1977): 138.

[3] G.W.L. Nicholson, *Canada's Nursing Sisters* (Canada: Samuel Stevens Hakkert & Company, 1975): 116-118; W. R. Feasby, ed. *Official History of the Canadian Medical Services, 1939-194,* vol. I: *Organization and Campaigns* (Ottawa: Queen's Printer, 1956): 311-312. C. P. Stacey, *Official History of the Canadian Army in the Second World War*, vol. 1*: Six Years of War: The Army in Canada, Britain and the Pacific* (Ottawa: Queen's Printer, 1955): 3, 43, and 118-122. For the American situation, see Stella Goostray, *Memoirs: Half a Century in Nursing* (Boston: Boston University Mugar Memorial Library, 1969): 126-127 and Mary T. Sarnecky, *A History of the U.S. Army Nurse Corps* (Philadelphia: University of Pennsylvania Press, 1999). Goostray, a recognized leader of the American nursing profession, describes the 'shock' and 'fear' of the profession related to U.S. President Roosevelt's recommendation to amend the Selective Service Act for the induction of nurses into the armed forces. From January to June 1944, professional organizations protested and strategized to prevent the conscription of nurses. Kalisch and Kalisch give an excellent presentation of the congressional process that led to actual passage of the bill to draft American nurses. Only the signing of the Armistice several days after passage prevented its enactment. See Phillip A. Kalisch and Beatrice J. Kalisch, "The Women's Draft: An Analysis of the Controversy over the Nurses' Selective Service Bill of 1945," *Nursing Research* 22, no. 5 (September-October 1973): 402-413.

[4] Nursing was one of several women's occupations that sought professional status at the beginning of the twentieth century. Leaders claimed scientific underpinnings, differentiated between 'trained' and 'untrained nurses,' and campaigned for control over the training and credentialing of nurses as well as for state registration of practitioners throughout much of the first two decades in Canada. For a contemporary discussion of whether nurses were professionals or not, see George M. Weir, *Survey of Nursing Education in Canada* (Toronto: University of Toronto Press, 1932): 51-65. According to Weir, they were professionals in spite of definitional constraints. Also see the discussion in Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996): 6-7 and 20-21. By the time of the First World War, trained Canadian nurses from recognized hospital training schools had effectively established themselves in the few available military nursing positions. Their training established them as professional nurses according to their time frame, while relative rank as officers established them as professional soldiers according to the accepted distinction between officers and 'other ranks'. I use the term 'quintessential women' in reference to a prevailing, idealized image of every woman as a nurse and nursing as an essentialized, nurturing function of every woman, although the discourse is problematic. The international Red Cross poster, "The Greatest Mother in the World," portrays this image vividly, as Meryn Stuart points out in "War and Peace: Professional Identities and Nurses' Training, 1914-1930," in *Challenging Professions: Historical and Contemporary Perspectives on Women's Professional Work*, eds. Elizabeth Smyth, Sandra Acker, Paula Bourne, and Alison Prentice (Toronto: University of Toronto Press, 1999): 172.

[5] Irene Lavallee, personal communication with the author on 25 July 2001.

[6] McPherson, *Bedside Matters*; Barbara Melosh, *"The Physician's Hand": Work, Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982); and Susan M. Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (New York: Cambridge University Press, 1987).

[7] Nicholson, *Seventy Years of Service*: 46-51. Eight of these original ten nurses also returned to South Africa briefly, in 1902, as part of the third Canadian Contingent. There is also an unpublished paper in the author's possession by Cameron Pulsifer, Historian at the Canadian War Museum, and titled "Georgina Fane Pope and the Beginnings of Canadian Military Nursing."

[8] M. Leslie Newell, "'Led by the Spirit of Humanity': Canadian Military Nursing, 1914-1929," unpublished Masters Thesis (Nursing), University of Ottawa, 1996. Newell cites the "Report of the Department of Militia and Defence for the Dominion of Canada for the year ending March 31, 1921," p. 28.

[9] Nicholson, *Seventy Years of Service*: 57.

[10] See Stuart, "War and Peace": 172.

[11] This figure is over-reported by at least 190 nurses, however, when referring only to nurses who served with the Canadian Expeditionary Force. See "History of Nursing Service Correspondence, 1923," MG 30, E45, file XIV, NAC. In a letter from Matron-in-Chief RCAMC Margaret McDonald to W. R. Landon on 12 May 1922, McDonald provided summary statistics for Nursing Sisters, and her total of 3141 nurses included the 190 nurses who served with the Imperial Nursing Service—which implied that only 2951 Nursing Sisters served with the Canadian Expeditionary Force. G.W.L. Nicholson cited MacDonald as his source when he used the figure as 3141, and thus, he over-reported the number of First World War Nursing Sisters in his book, *Canada's Nursing Sisters*: 98.

[12] McPherson, *Bedside Matters:* 19. McPherson refers to nursing 'generations', as a concept to "capture the specific sets of political and economic conditions that have defined nurses' experiences in the health-care system." I build on this concept by adapting it to Canadian military nurses, and their specific experiences as shaped by the larger political and economic contexts in which they served.

[13] When the Canadian Expeditionary Force ceased to exist on 31 Dec 1921, the medical services re-organized to a peace time establishment of 77 medical units, 382 medical officers, and 12 NS. The number of NS increased to 14 by 1931. See M. Leslie Newell, "Led by the Spirit of Humanity": 4 and 69; Nicholson, *Canada's Nursing Sisters*: 44-45 and *Seventy Years of Service*: 114; and Bill Rawling, *Death Their Enemy: Canadian Medical Practitioners and War* (Ottawa: author, 2001): 55.

[14] Stacey, *Six Years of War*: 50 and 52.

[15] Kathryn McPherson, "'The Case of the Kissing Nurse': Femininity, Sexuality, and Canadian Nursing, 1900-1970," in *Gendered Pasts: Historical Essays in Femininity and Masculinity in Canada*, eds. Kathryn McPherson, Cecilia Morgan, and Nancy M. Forestell, pp. 179-198 (Don Mills, Ontario: Oxford University Press, 1999): 181.

[16] Kathryn McPherson, Cecilia Morgan, and Nancy M. Forestell, eds., *Gendered Pasts: Historical Essays in Femininity and Masculinity in Canada* (Don Mills, Ontario: Oxford University Press, 1999): 3.

[17] One of the best illustrations of this medal can be found in colour on the front cover of J. L. Granatstein and Peter Neary, eds., *The Good Fight: Canadians and World War II* (Toronto: Copp Clark, 1995).

[18] Margaret R. Higonnet and Patrice L.-R. Higonnet, "The Double Helix," in *Behind the Lines: Gender and the Two World Wars*, eds. Margaret Randolph Higonnet, Jane Jenson, Sonya Michel, and Margaret Collins Weitz, pp. 31-47 (New Haven: Yale University Press, 1987): 46.

[19] The military distinguished between personnel on active service or 'on strength', and the quota authorized on paper, or 'established' strength. The armed forces seldom maintained full establishments since it was extremely costly to pay salaries for troops not actively deployed.

[20] Rawling, *Death Their Enemy*: 116.

[21] See Newell, "Led by the Spirit of Humanity."

[22] Among the many authors who discuss this uneasiness are: C. Vance, "An Uneasy Alliance: Nursing and the Women's Movement," *Nursing Outlook* 33, no. 6 (1985): 281-285; Sheila Bunting and Jacquelyn C. Campbell, "Feminism and Nursing: Historical Perspectives," *Advances in Nursing Science* 12, no. 4 (1990): 11-24; and Susan M. Reverby, "Other Tales of the Nursing-Feminism Connection," *Nursing and Health Care* 14, no. 6 (June 1993): 296-301. For a comprehensive examination of this literature, see Joan I. Roberts and Thetis M. Group, *Feminism and Nursing: An Historical Perspective on Power, Status, and Political Activism in the Nursing Profession* (Westport, Connecticut: Praeger Publishers, 1995).

[23] Cynthia Enloe, *Does Khaki Become You? The Militarisation of Women's Lives* (Boston: South End Press, 1983).

[24] Cynthia Enloe, *Maneuvers: The International Politics of Militarizing Women's Lives* (Berkeley: University of California Press, 2000): 3.

[25] Enloe, *Maneuvers*: 199 and 218.

[26] Joan W. Scott, "Rewriting History," in *Behind the Lines: Gender and the Two World Wars*, eds. Margaret Randolph Higonnet, Jane Jenson, Sonya Michel, and Margaret Collins Weitz, pp. 21-30 (New Haven: Yale University Press, 1987).

[27] Scott, "Rewriting History": 25.

[28] Ruth Roach Pierson, "Beautiful Soul or Just Warrior: Gender and War," *Gender & History* 1, no. 1 (Spring 1989): 77-86.

[29] See Jean Bethke Elshtain, *Women and War* (New York: Basic Books, 1987): 10-11. Elshtain challenges the formulation of rigid, gendered stereotypes stating "women are not immune to the battle call of Mars."

[30] Elshtain, *Women and War*: 184-185.

[31] Margaret Randolph Higonnet, Jane Jenson, Sonya Michel, and Margaret Collins Weitz, eds. *Behind the Lines: Gender and the Two World Wars* (New Haven: Yale University Press, 1987).

[32] Margaret R. Higonnet and Patrice L.-R. Higonnet, "The Double Helix": 33-34.

[33] Susan R. Grayzel, *Women's Identities at War: Gender, Motherhood, and Politics in Britain and France during the First World War* (Chapel Hill, N.C.: University of North Carolina Press, 1999): 244.

[34] Angela K. Smith, *The Second Battlefield: Women, Modernism and the First World War* (Manchester and New York: Manchester University Press, 2000): 7-8.

[35] Smith, *Second Battlefield:* 72.

[36] Margaret R. Higonnet, *Nurses at the Front: Writing the Wounds of the Great War* (Boston: Northeastern University Press, 2001).

[37] Jean Bruce, *Back the Attack: Canadian Women during the Second World War—at Home and Abroad* (Toronto: Macmillan of Canada, 1985): viii.

[38] Bruce, *Back the Attack:* 124-139. Bruce used Nicholson's book, *Canada's Nursing Sisters,* as the main source for her content on military nurses.

[39] These collections typically contain brief references to Nursing Sisters. See, for examples: Carolyn Gossage, *Greatcoats and Glamour Boots: Canadian Women at War, 1939-1945* (Toronto: Dundurn Press, 1991); Lisa Bannister, producer, *Equal to the Challenge: An Anthology of Women's Experiences during World War II* (Canada: Department of National Defence, 2001); and Barbara Dundas, *A History of Women in the Canadian Military* (Montreal: Art Global, 2000).

A third anthology consists of seven volumes of anecdotes and recollections of both men and women who served during the Second World War by Jean Portugal, *We Were There: The Navy, the Army, and the RCAF: A Record for Canada,* vol. 1-7 (Shelburne, Ontario: The Battered Silicon Dispatch Box, 1998).

[40] Ruth Roach Pierson, *Canadian Women and the Second World War,* Monograph No. 37 (Ottawa: Canadian Historical Association, 1983) and *"They're Still Women after All": The Second World War and Canadian Womanhood* (Toronto: McClelland and Stewart, 1986).

[41] Jeff Keshen, "Revisiting Canada's Civilian Women during World War II," *Histoire social/Social History* 30, no. 60 (November 1997): 242. Keshen did not consider the situation of nurses specifically although they would certainly have been present in the statistical data on university enrolments.

[42] Ruth Roach Pierson, "Wartime Jitters Over Femininity," in *The Good Fight: Canadians and The Second World War,* eds. J. L. Granatstein and Peter Neary, pp. 141-168 (Mississauga, Ontario: Copp Clark, 1995).

[43] M. Teresa Nash, "Images of Women in National Film Board of Canada Films during World War II and the Postwar Years, 1939-1949," PhD thesis, McGill University, 1982.

[44] Canada has a large body of Second World War military history beginning with three volumes of official history: C. P. Stacey, *Official History of the Canadian Army in the Second World War,* vol. I, *Six Years of War: The Army in Canada, Britain, and the Pacific* (Ottawa: Queen's Printer, 1955) and vol. III, *The Victory Campaign: The Operations in North-West Europe, 1944-1945* (Ottawa: Queen's Printer, 1960); G. W. L. Nicholson, *Official History of the Canadian Army in the Second World War,* vol. II*: The Canadians in Italy, 1943-1945* (Ottawa: Queen's Printer, 1957); Leslie Roberts, *There Shall be Wings: A History of the Royal Canadian Air Force* (Toronto: Clarke, Irwin & Company, 1959); Brereton Greenhous, *Official History of the Royal Canadian Air Force,* vol. III*: Crucible of War, 1939-1945* (University of Toronto Press, 1986); Tony German, *The Sea is at Our Gate: The History of the Canadian Navy* (Toronto: McClelland & Stewart, 1990).

[45] J. L. Granatstein, *Canada's Army: Waging War and Keeping the Peace* (Toronto: University of Toronto Press, 2002) and *Canada's War: The Politics of the Mackenzie King Government, 1939-1945* (Toronto: Oxford University Press, 1975); Desmond Morton, *A Military History of Canada,* 3rd ed. (Toronto: McClelland & Stewart, 1992); J. L. Granatstein and J. M. Hitsman, *Broken Promises: A History of Conscription in Canada* (Toronto: Oxford University Press, 1977); Peter Neary and J. L. Granatstein, *The Veteran's Charter and Post-World War II Canada* (Montreal and Kingston: McGill-Queen's University Press, 1998); Brian Loring Villa, *Unauthorized Action: Mountbatten and the Dieppe Raid* (Toronto: Oxford University Press, 1989); Norman Hillmer, Bohdan Kordan, and Lubomyr Luciuk, *On Guard for Thee: War, Ethnicity, and the Canadian State, 1939-1945* (Ottawa: Canadian Government Publishing Centre, 1988); and Jeff Keshen, comp., *Age of Contention: Readings in Canadian Social History, 1900-1945* (Toronto: Harcourt Brace Canada, 1997). See also: Mark Zuehlke, *Ortona: Canada's Epic World War II Battle* (Toronto: Stoddert, 1999) and Michael Benedict, ed., *Canada at War from the Archives of Maclean's,* vol. II*: On the Battlefield—Two World Wars that Shaped a Nation* (Toronto: Penguin Canada, 2002).

[46] W. R. Feasby, ed., *Official History of the Canadian Medical Services, 1939-1945,* vol. I*: Organization and Campaigns* (Ottawa: Queen's Printer, 1956) and *Official History of the Canadian Medical Services, 1939-1945,* vol. II: *Clinical Subjects* (Ottawa: Queen's Printer, 1956).

[47] Feasby, *Official History of the Canadian Medical Services,* vol. 1: 313.

[48] Nicholson, *Canada's Nursing Sisters.*

[49] Nicholson, *Seventy Years of Service.*

[50] Nicholson, *Canada's Nursing Sisters*: 228-229.

[51] Rawling, *Death Their Enemy.*

[52] Rawling, *Death Their Enemy*: 8-9.

[53] See Harold M. Wright, *Salute to the Air Force Medical Branch on the 75th Anniversary Royal Canadian Air Force* (Ottawa: author, 1999); Rita Donovan, *As for the Canadians: The Remarkable Story of the RCAF's 'Guinea Pigs' of The Second World War* (Ottawa: BuschekBooks, 2000); and Stanley T. Richards, *Operation Sick Bay* (West Vancouver, B. C.: Cantaur Publishing, 1994).

[54] McPherson, *Bedside Matters.* An earlier article based on the same research was published as "Science and Technique: Nurses' Work in a Canadian Hospital, 1920-1939," in *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, eds. Dianne Dodd and Deborah Gorham (Ottawa: University of Ottawa Press, 1994), pp. 71-101.

[55] McPherson, *Bedside Matters*: 19-20.

[56] Veronica Strong-Boag, "Making a Difference: The History of Canada's Nurses," *Canadian Bulletin of Medical History* 8 (1991): 234.

[57] See Kathryn McPherson, "Nurses and Nursing in Early Twentieth-Century Halifax," Master's thesis, Dalhousie University, 1982 and "Skilled Service and Women's Work: Canadian Nursing, 1920-1939," PhD thesis, Simon Fraser University, 1990 as well as Meryn Stuart, "Ideology and Experience: Public Health Nursing and the Ontario Rural Child Welfare Project, 1920-1925," *Canadian Bulletin of Medical History* 6(1989): 111-131.

[58] Kathryn McPherson and Meryn Stuart, "Writing Nursing History in Canada: Issues and Approaches," *Canadian Bulletin of Medical History* 11, no. 1(1994), pp. 3-22. More recent scholarship has included: Nicole Rousseau and Johanne Daigle, "Medical Service to Settlers: The Gestation and Establishment of a Nursing Service in Québec, 1932-1943," *Nursing History Review* 8 (2000), pp. 95-116; Johanne Daigle, Nicole Rousseau and Francine Saillant, "Des traces sur la neige: La contribution des infirmières au développment des régions isolées du Québec au Xxe siècle," *Recherches féministes* 6, no. 1(1993): 93-103; Denise Baillargeon, "Gouttes de lait et soif de pouvoir: Le dessous de la lutte contre la mortalité infantile à Montréal, 1910-1953," *Canadian Bulletin of Medical History* 15, no. 1(1998), pp. 27-57 and "Care of Mothers and Infants in Montreal Between the Wars: The Visiting Nurses of Metropolitan Life, Les Gouttes de Lait, and Assistance Maternelle," translated by Susan Joss in *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, eds. Dianne Dodd and Deborah Gorham, pp. 163-181 (Ottawa: University of Ottawa Press, 1994); Agnes Calliste, "Women of 'Exceptional Merit:' Immigration of Caribbean Nurses to Canada," *Canadian Journal of Women and the Law* 6, no. 1(1993): 85-102 and "Antiracism, Organizing, and Resistance in Nursing: African Canadian Women," *Canadian Review of Sociology and Anthropology* 33, no. 3 (August 1996): 361-390; McPherson, *Bedside Matters;* Stuart, "War and Peace"; and Karen Flynn, "Proletarianization, Professionalization, and Caribbean Immigrant Nurses," *Canadian Woman Studies/Les Cahiers de la Femme* 18, no. 1 (1998): 57-60.

[59] In addition to Calliste and Flynn, see Barbara Keddy, "Black Nurses in Nova Scotia: Telling Their Stories," *Registered Nurse* (May-June 1997): 9-11 and Jocelyn Hezekiah, *Breaking the Glass Ceiling: The Stories of Three Caribbean Nurses* (University Press of the West Indies, 2000).

[60] Shula Marks, "The Legacy of the History of Nursing for Post-apartheid South Africa," in *Nursing History and the Politics of Welfare*, eds. Anne Marie Rafferty, Jane Robinson, and Ruth Elkan, pp. 28-44 (London and New York: Routledge, 1997); Hilde Steppe, "Nursing Under Totalitarian Regimes: The Case of National Socialism," in *Nursing History and the Politics of Welfare*, eds.

Anne Marie Rafferty, Jane Robinson, and Ruth Elkan, pp. 10-27 (London and New York: Routledge, 1997).

[61] Jan Bassett, *Guns and Brooches: Australian Army Nursing from the Boer War to the Gulf War* (New York: Oxford, 1992): 1-2.

[62] Diane Burke Fessler, No *Time For Fear: Voices of American Military Nurses in World War II* (East Lansing: Michigan State University Press, 1996); Joyce Hibbert, *Fragments of War: Stories from Survivors of World War II* (Toronto: Dundurn Press, 1985); Brenda McBryde, *A Nurse's War* (London: Chatto & Windus, 1979) and *Quiet Heroines: Nurses of the Second World War* (Saffron Walden, Essex: Cakebreads Publications, 1989); and Gwladys M. Rees Aikens, *Nurses in Battledress: The World War II Story of a Member of the Q. A. Reserves* (Halifax, Nova Scotia: Cymru Press, 1998) and *Before and after the Battles: From Wales to Canada via Two World Wars* (Halifax, Nova Scotia: Cymru Press, 2001).

[63] Doris V. Carter, *Never Leave Your Head Uncovered: A Canadian Nursing Sister in World War Two* (Waterdown, Ontario: Potlatch Publications, 1999); Mary M. White, *Hello War, Goodbye Sanity* (Canada: author, 1992); and Edith Landells, ed., *The Military Nurses of Canada: Recollections of Canadian Military Nurses*, vols. I-III (White Rock, B. C.: Co-Publishing, 1995-1999), hereafter as, *Military Nurses of Canada.*

[64] Elizabeth M. Norman and Sharon Elfried, "The Angels of Bataan," *Image: The Journal of Nursing Scholarship* 25, no. 2 (Summer 1993): 121-126; Elizabeth M. Norman, *Women at War: The Story of Fifty Military Nurses Who Served in Vietnam* (Philadelphia: University of Pennsylvania Press, 1991); "How Did they all Survive? An Analysis of American Nurses' Experiences in Japanese Prisoner-of-War Camps," *Nursing History Review* 3(1995): 105-127; and *We Band of Angels: The Untold Story of American Nurses Trapped on Bataan by the Japanese* (New York: Random House, 1999).

[65] Mary T. Sarnecky, "Nursing in the American Army from the Revolution to the Spanish-American War," *Nursing History Review* 5 (1997): 49-69 and *History of the U. S. Army Nurse Corps* (Philadelphia: University of Pennsylvania Press, 1999); Barbara Brooks Tomblin, *G. I. Nightingales: The Army Nurse Corps in World War II* (Lexington, Kentucky: University Press of Kentucky, 1996); Doris M. Sterner, *In and out of Harm's Way: A History of the Navy Nurse Corps* (Seattle: Peanut Butter, 1997); Juliet Piggott, *Queen Alexandra's Royal Army Nursing Corps* (London: Leo Cooper, 1975); Penny Starns, *March of the Matrons: Military Influence on the British Civilian Nursing Profession, 1939-1969* (Peterborough: DSM, 2000) and *Nurses at War: Women on the Frontline, 1939-45* (Stroud, Gloucestershire: Sutton Publishing, 2000); and Bassett, *Guns and Brooches.*

[66] M. B. Clint, *Our Bit: Memories of War Service by a Canadian Nurse* (Montreal: Barwick Limited, 1934); Katherine M. Wilson-Simmie, *Lights Out! A Canadian Nursing Sister's Tale* (Belleville, Ontario: Mika Publishing Company, 1981); and Constance Bruce, *Humour in Tragedy: Hospital Life behind Three Fronts by a Canadian Nursing Sister* (London: Skeffington & Son, 1918).

[67] Susan Mann, ed., *The War Diary of Clare Gass, 1915-1918* (Montreal & Kingston: McGill-Queen's University Press, 2000 and Eric C. Scott, ed., *Nobody Ever Wins a War: The World War I Diaries of Ella Mae Bongard, R.N.* (Ottawa: Janeric Enterprises, 1997).

[68] Mann, *The War Diary of Clare Gass*: xxxvii.

[69] Stuart, "War and Peace": 186-187.

[70] Newell, "Led by the Spirit of Humanity": vii-viii.

[71] Geneviève Allard, "Des anges blanc sur le front: l'expérience de guerre des infirmières militaires Canadiennes pendant la première guerre mondiale," *Bulletin D'Histoire Politique* 8, nos. 2-3 (hiver-printemps 2000): 119-33 and "Les infirmières militaires Canadiennes pendant la première guerre mondiale," Master's memoire, Faculté des Lettres, l'Université Laval, 1996.

[72] McPherson, "Science and Technique."

[73] Cynthia Toman, "'Body Work': The In-corporation of Medical Technology by Nurses," in *Women in a Knowledge-Based Society: Proceedings of the 12th International Conference of Women Engineers and Scientists*, CD-ROM (Ordre des ingénieurs du Québec, 2002) and "Blood Work: Canadian Nursing and Blood Transfusion, 1942-1990," *Nursing History Review* 9 (2001): 51-78.

[74] Thomas P. Hughes, "The Evolution of Large Technological Systems," in *The Social Construction of Technological Systems*, eds. Wiebe E. Bijker, Thomas P. Hughes, and Trevor J. Pinch (Cambridge, Massachusetts: MIT Press, 1989): 51.

[75] Alex Roland's historiographical essay on technology and war highlights trends and issues in the literature including technological determinism, inappropriate periodization, and presentism. Interestingly, he said nothing about the absence of gender analysis. See "Technology and War: The Historiographical Revolution of the 1980s," *Technology and Culture* 34, no. 1 (1993): 117-135.

[76] Ruth Schwartz Cowan, *A Social History of American Technology* (New York: Oxford University Press, 1997): 203-204.

[77] This approach builds on multiple concepts from Wiebe E. Bijker, Thomas P. Hughes, and Trevor J. Pinch, *The Social Construction of Technological Systems: New Directions in the Social History of Technology* (Cambridge, Mass: MIT Press, 1989) and Michel Callon's work, "Some Elements of a Sociology of Translation: Domestication of the Scallops and the Fishermen of St. Brieuc Bay," in *Power, Action and Belief: A New Sociology of Knowledge?* ed. John Law (London: Routledge and Kegan Paul, 1986): 196-233 and "The Sociology of an Actor-Network: The Case of the Electric Vehicle," in *Mapping the Dynamics of Science and Technology: Sociology of Science in the Real World,* eds. Michel Callon, John Law, and A. Rip (Basingstoke: Macmillan, 1986): 19-34. More recent work that applies Actor-Network theory includes John Law and John Hassard, Eds., *Actor Network Theory and After* (Oxford: Blackwell Publishers, 1999).

[78] Hughes, "The Evolution of Large Technological Systems": 51.

[79] Hughes, "The Evolution of Large Technological Systems": 53-54.

[80] McPherson, Morgan, and Forestell, *Gendered Pasts:* 4-5.

[81] A. P. Cohen, *The Symbolic Construction of Community* (New York: Tavistock Publications, 1985): 9, 12-15, and 118.

[82] For a good introduction to this literature, refer to: Cohen, *The Symbolic Construction of Community*; Charles Wetherell, Andrejs Plakans, and Barry Wellman, "Social Networks, Kinship, and Community in Eastern Europe," *The Journal of Interdisciplinary History* 24, no. 4 (Spring 1994): 639-663; Benedict Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism*, rev. ed. (New York: Verso, 1991); John C. Walsh and Steven High, "Rethinking the Concept of Community," *Histoire sociale/Social History* 32, no. 64 (November 1999): 255-273); and Jenéa Tallentire, "Strategies of Memory: History, Social Memory, and the Community," *Histoire sociale/Social History* 67 (Spring 2001): 197-212.

[83] Cohen, *The Symbolic Construction of Community*: 7, 9, and 12.

[84] Tim Cooke, "Clio's Soldiers: Charles Stacey and the Army Historical Section in the Second World War," *Canadian Historical Review* 83, no. 1 (March 2002): 29-57.

[85] Pauline Lamont Flynn, audio-taped interview with author at Ottawa, Ontario on 3 April 2001. Margaret Van Scoyoc, audio-taped interview with Lisa Weintraub at Montreal, Québec on 4 June 1984, Concordia University Oral History Collection, ISN 167825, National Archives of Canada. Susan Mann and Meryn Stuart found that a similar policy regarding diaries and letters applied to the First World War Nursing Sisters as well.

[86] Margaret Van Scoyoc, letter to author, 11 March 2002.

[87] According to standards supported by the Canadian and American Oral History Associations, the number of interviews is less significant than the number of interview hours, because some informants contribute more extensively than others. I anticipated initially that forty to fifty interview hours would be adequate for this study. My experience with twenty-five Nursing Sisters and 33.6 interview hours indicated that I had reached saturation, and further interviews were not likely to add significantly new information. I purposefully selected the additional thirty oral histories to address practice settings, such as hospital ships and trains, or geographical areas where I had been unable to find Nursing Sisters to interview (Appendix 7). These additional interviews also confirmed that I had reached saturation with my own interviews. See Donald A. Ritchie, *Doing Oral History* (Toronto: Maxwell Macmillan Canada, 1995).

[88] Examples of these debates may be found in: Joan Sangster, "Telling our Stories: Feminists Debates and the Use of Oral History," in *The Oral History Reader*, eds. Robert Perks and Alistair Thomson, pp. 87-100 (London: Routledge, 1998); Henry W. Hodysh and R. Gordon McIntosh, "Problems of Objectivity in Oral History," *Historical Studies in Education* 1 (1989): 137-147; Paul Thompson, *The Voice of the Past: Oral History* (Oxford: Oxford University Press, 1978); Allan W. Futrell and Charles A. Willard, "Intersubjectivity and Interviewing," in *Interactive Oral History Interviewing*, eds. Eva M. McMahan and Kim Lacy Rogers, pp. 83-106 (Hillsdale, New Jersey: Lawrence Erlbaum Associates, Publishers, 1994); and Trevor Lummis, "Structure and Validity in Oral Evidence," in *The Oral History Reader*, eds. Robert Perks and Alistair Thomson, pp. 273-283 (London: Routledge,1998).

[89] Nadia Fahmy-Eid, "Histoire, objectivité, et scientificité: jalons pour une reprise du débat épistémologique," *Histoire sociale/Social History* 24, no. 47 (1991): 9-34; Denyse Baillargeon, "Histoire orale et histoire des femmes: itineraries et points de rencontre," *Recherches feministes* 6, no. 1 (1993): 53-68.

[90] There is excellent literature available on the relation between long-term memory and oral history. One of the most valuable discussions between a cognitive psychologist whose expertise is memory storage and an oral historian is found in Marigold Linton, "Phoenix and Chimera: The Changing Face of Memory," in *Memory and History: Essays on Recalling and Interpreting Evidence*, eds. Jaclyn Jeffrey and Glenace Edwall, pp. 69-88 (Lanham, Maryland: University Press of America, 1994). I used key informants for referrals, and assessed individuals' memory during my initial contact, prior to the interview. It became clear during many interviews that nurses were re-living and seeing their experiences vividly. For example, Nursing Sisters Lamont and Bayly used such phrases as: "I can see it all now," and "It's like being on the ward now. I see it." Refer to Pauline Lamont Flynn, audio-taped interview with author at Ottawa on 3 April 2001; and Lois Bayly Tewsley, audio-taped interview with author at Ottawa on 11 June 2001.

[91] Sources for these debates include: Susan N. Geiger, "Women's Life Histories: Method and Content," *Signs: Journal of Women in Culture and Society* 11, no. 2 (1986): 334-351; Prins, "Oral History;" and Thompson, *Voice of the Past.*

[92] Normand Fortier, Guide to Oral History Collections in Canada/Guide des fonds d'histoire orale au Canada (Ottawa: Canadian Oral History Association Journal, 1993): xiii.

[93] Futrell and Willard, "Intersubjectivity and Interviewing": 85.

[94] This inequality may limit access to narrators, the development of rapport between the participants, the content of the interview, and whose voice is privileged in the analysis. The interview process itself, can 'silence' a narrator by the presence of a tape recorder or video recorder, by questions that are not asked, by the degree of privacy and who owns the interview setting, and by the amount of time available. Silence and voice are contingent as well, on the level of trust and confidentiality established between the participants: Who will have access to the information? Is there permission to quote? What is at risk for participants? Will the participant be permitted to review the tape, video, or transcript? If so, will the content be altered, if

requested? For excellent discussions of oral history and power, see: Sangster, "Telling Our Stories": 93; Franca Iacovetta, "Post-Modern Ethnography, Historical Materialism, and Decentring the (Male) Authorial Voice: A Feminist Conversation," *Histoire sociale/Social History* 32, no. 64 (1999): 291; Sherna Gluck and Daphne Patai, "Introduction," in *Women's Words: The Feminist Practice of Oral History*, eds. Sherna Gluck and Daphne Patai, pp. 1-5 (New York: Routledge, 1991); and Kristina Minister, "A Feminist Frame for the Oral History Interview," in *Women's Words: The Feminist Practice of Oral History*, eds. Sherna Berger Gluck and Daphne Patai, pp. 27-42 (New York: Routledge, 1991): 29.

[95] Thompson, *Voice of the Past*: 149.

[96] Katherine Borland, "That's Not What I Said": Interpretive Conflict in Oral Narrative Research," in *The Oral History Reader*, eds. Robert Perks and Alistair Thomson, pp. 320-332 (London and New York: Routledge, 1998): 330.

[97] Susan N. Geiger, "What's so Feminist about Doing Women's Oral History?" *Journal of Women's History* 2, no. 1 (Spring, 1990): 305-318.

[98] I have sought to avoid exploitation and marginalization in the identification and selection of participants for the study through the way they have been recruited and approached for consent, the timing and setting of the interviews, the degree of interactivity between the interviewer and the narrator, choices regarding the type of questions asked, decisions around withdrawal of consent and content, as well as decisions regarding whose perspective is privileged, what is at risk for the narrator, and to what extent confirmation by participants has been sought during analysis.

[99] Iacovetta also discusses this issue of insider-outsider status related to the group under study. Her arguments support my stance that "I am neither a total insider...nor a total outsider to both those worlds." See "Post-Modern Ethnography": 285.

[100] The records are restricted and I received access only under specific conditions that governed how I used them. Findings can only be reported as aggregate data and any specific details have to be used in a manner that renders the individuals anonymous. There were limits on the total number of files available, the method of sampling, and the number of files I could review per month.

[101] Only three files had to be rejected because the folder contained too little content. The least complete records appeared to be situations where nurses had transferred to the South African Army (and supposedly, their records remained there) or where nurses enlisted in the United Kingdom (and forms may not have been forwarded to Canada on their return). As well, many of the records were badly damaged by flooding. In some cases, a note in the file simply stated the material had been destroyed by flooding. In other cases, files had been dried but are now in an extremely fragile state, with pages stuck together and crumbling.

[102] Cook, "Clio's Soldiers": 55.

[103] Edwidge Munn, "À la recherche de sujets et de sources d'archives en histoire militaire: quelques conseils d'usage," *Bulletin d'histoire politique* 8, nos. 2-3: 50.

[104] Cook, "Clio's Soldiers": 52.

[105] Cook, "Clio's Soldiers": 35-36, 39, 47, and 52.

[106] Julie Cruikshank, "Oral Tradition and Oral History: Reviewing Some Issues," *The Canadian Historical Review* 75, no. 3 (September, 1994): 409.

[107] Frequently, interview tapes are destroyed after the transcripts have been verified, leaving only the written transcripts for research. Tapes and transcripts are usually maintained under secure, restricted access conditions according to the governing consent and ethics procedures. While these procedures are intended to protect the narrator, they also defeat the original purpose of giving 'voice' when those tapes are destroyed. Interviews cannot be re-constructed, and without the tapes, it is difficult to corroborate or re-interpreted the evidence from different perspectives.

Historians are also obligated to understand the multiple ways in which power is inherent in this process, and how it may have shaped the interview being consulted.

[108] The *Bulletin of the Canadian Army Medical Corps* published eight issues between 1918 and 1919.

[109] See the opening remarks co-written by the heads of medical services for the Army, Navy, and Air Force and the Department of Pensions and National Health in the first issue: "Prologue," *Journal of the Canadian Medical Services* 1, no. 1 (November 1943): 1-4. In the second issue, an unidentified author linked this journal (calling it "Chapter II") to a First World War medical services journal, the *Bulletin of the Canadian Army Medical Corps* (published briefly in 1918 and 1919, and referred to as "Chapter I"). See "Twenty-five Years Ago," *Journal of the Canadian Medical Services* 1, no. 2 (January 1944): 92.

[110] Feasby, *Official History of the Canadian Medical Services, 1939-1945.*

[111] Memoirs include Doris Carter's, *Never Leave Your Head Uncovered* and Mary White's, *Hello War, Goodbye Sanity.* Elsie Dunnett Sage's letters, which she wrote to her family, were published by her husband as: W. D. M. Sage, *Battlefield Nurse: Letters and Memories of a Canadian Army Overseas Nursing Sister in World War II* (Vancouver: Sage Family Publications, 1994). Edith Landells has published a three-volume anthology of military nurses' recollections and photographs that includes nurses and non-nurses from the Riel Rebellion to the 1990s, who served with Canadian and allied armed forces. See Landells, *Military Nurses of Canada*, vols. I-III.

[112] Many Nursing Sisters spoke and wrote in their accounts about the need to self-censor their letters and to maintain silence for national security as well as to satisfy military requirements. For two such examples, see: Evelyn A. Pepper, Gaëtane (LaBonté) Kerr, Harriet J.T. Sloan, and Margaret D. McLean, "'Over There' in World War II," *Canadian Nurse* 62, no. 11 (November 1966): 32; Margaret Fletcher, letter to her family of 20 February 1945, Margaret Fletcher fonds, SCO42, University of Victoria Archives and Special Collections, Victoria, British Columbia.

CHAPTER 1

ENLISTING NURSES FOR A "STRANGE PRIVILEGE" AS "HAPPY WARRIORS"

Members of the second generation of Nursing Sisters had trained and worked as nurses during the Great Depression of the 1930s. Like other Canadians, they coped with varying degrees of deprivation and uncertainty, and like other women, they experienced the Depression in particularly gendered ways.[1] For many of them, nursing comprised a second or even third occupational change in the search for economic security. Kathryn McPherson has described the situation succinctly: "While their brothers rode the rails looking for work and handouts, rural women went to nursing school." There hospitals provided room, board, and skilled training for three years.[2] This strategy only worsened the post-graduate employment situation however, as the profession struggled to cope with oversupply and underemployment in relation to the public's ability to pay for nursing care. The socio-political and economic context of the Depression not only influenced nurses' training and work opportunities. It also frequently left them with long-term social and financial obligations when family members required support during this period that preceded the emergence of social welfare measures.

The professional, technological, and military contexts of the 1930s are equally as important as the social context, for understanding who became Nursing Sisters. Nursing had evolved rather recently from an untrained occupation, to a charitable service, to a respectable women's profession. But through the 1920s and 1930s, there was continued controversy around the adequacy of pay and working conditions that culminated in a jointly-commissioned study on the state of nursing education in Canada. The Canadian Medical Association and the Canadian Nurses Association, concerned with working conditions and the standardization of nurses' training, hired the Head of the Department of Education at the University of British Columbia, George Weir, to conduct the study. The Weir survey was a comprehensive, eighteen-month

study conducted between November 1929 and July 1930. It was published in 1932, as the *Survey of Nursing Education in Canada*, and became popularly known as the Weir Report. This report provides extremely valuable data on the state of nursing education and on the profession, since students comprised the majority of the hospital workforce. Weir included a full range of practice settings and roles for both student and graduate nurses in his analysis.[3] The Weir Report is a good source for understanding nurses' work experiences prior to the Second World War. Medical technology became increasingly prevalent in hospitals during this period, and nurses shifted from domestic to technological roles as a basis for their claims to scientific legitimacy and professional status.[4] Meanwhile, the Canadian military system languished during the interwar years under the economic constraints, policies, and isolationism of the Mackenzie King government. With a small reserve and even smaller permanent nursing force, the armed forces continued to rely on civilian nurses to fill the ranks whenever the need arose.

This chapter considers these interconnected social, professional, technological, and military contexts, along with some of the strategies that nurses developed to enhance their opportunities for enlistment during the Second World War. Personnel records and oral histories demonstrate that the Nursing Sisters were a relatively homogeneous group, while also revealing important diversities and changes over the course of the war years. Nurses, who enlisted at the beginning of the war, had extensive nursing experience and familial obligations. They were determined to participate in the war. Since nurses followed the soldiers and the action of war while shifting roles and re-constituting boundaries, key military events also influenced their enlistment. Thus, nurses had significantly different experiences depending on when and where they served.

I argue that social, professional, technological, and military contexts of the 1930s shaped Canadian nurses as a large, readily-available, feminine workforce. Nurses used their technical skills and "postgraduate courses,"[5] as well as personal and political influence, to enhance their chances for selection as Nursing Sisters—anticipating that military nursing would provide them with work and permit them to fulfill family responsibilities. One physician, speaking at the 1940

Canadian Nurses Association biennial meeting in Calgary, described nurses' contradictory position aptly when he told them, "Like the Happy Warrior, your training has taught you to go in company with pain and fear and bloodshed—a strange privilege."[6]

Civilian Workplaces and the Need for Work

Hospitals grew in size and public acceptance during the first half of the twentieth century. Their need for a cheap, dependable workforce was met by opening training schools for nurses wherein students exchanged extended hours of labour for education, room, and board. At one large teaching hospital, for example, student nurses comprised seventy-five to eighty per cent of the nursing staff in 1924[7] and sixty-nine per cent of the workforce in 1944.[8] Hospitals typically hired only a small number of graduates as supervisors, educators, and 'specials' for privately paying patients with more complex care than students could manage in regular workloads.

The majority of nurses worked in private homes after graduation, through the reference of a physician or local nursing registry, and paid by the patient or patient's family. Historian Kathryn McPherson observed that the proportion of nurses in private duty, as reported in the 1931 Canadian census and in the Weir report (1932), ranged from 35% to 43% of all employed nurses. For many graduate nurses, private duty nursing constituted only a brief period of employment prior to marriage, after which they 'retired' from nursing.[9] The relationship between choice and a nurse's decision either to marry or to nurse, remains unclear. Nurses may have chosen differently, if employment conditions had been stable and the pay adequate for self-support.

There were 1.5 million Canadians, or 30% of the population, on relief by 1933 as unemployment and welfare programs endeavoured to stretch dwindling resources that were already highly inadequate at the best of times.[10] Family members were held responsible for the support of parents and siblings, regardless of their own marital status or ability to be self-sufficient. They were expected to contribute financially and welfare entitlements were adjusted accordingly.[11] And, as historian Veronica Strong-Boag pointed out, girls of all classes were held

equally accountable for the economic claims of their families.[12] Nurses had both a moral and a legal responsibility to their parents and siblings, even when it was difficult to find sufficient work for self-support. Nursing Sisters typically completed a form entitled, "Particulars of Family of an Officer or Other Rank of the Canadian Army (A.F.) or R.C.A.F. (on Active Service)". This form requested the number of dependents and the amount of financial support that had been provided by soldiers prior to enlistment. It was used to determine a soldier's eligibility for the "Dependent's Allowance" benefit. One nurse poignantly wrote on her form, that she was her dependent mother's only relative, and while she would have liked to support her mother, she had not been able to do so "because [her] nursing salary was not big enough."

According to Weir, the urgent problem to solve during the 1930s was: "How shall the gap between the needy patient and the needy nurse be bridged?", while acknowledging that the "interests of the nurse, who obviously is entitled to a respectable livelihood in return for services rendered, must also be considered."[13] He concluded that approximately 40% of the private duty nurses in Canada were almost continuously unemployed and another 20% were only employed intermittently. McPherson's analysis reveals the discrepancy between wages and living expenses for private duty nurses whose annual average income was grossly inadequate to meet the cost of living.[14] The Depression proved devastating for private duty nurses, as few people could afford their services and there was little work to be had.

Nursing historian Barbara Keddy noted that as private duty work became increasingly scarce during the Depression, nurses joined the ranks of the unemployed. They frequently took non-nursing jobs (as waitresses or sales clerks) when available or returned to their parental homes.[15] Nurses reported long waiting periods between 'cases' (often two to four weeks in length) and some recalled as few as five days of work in a month. Nursing registry policies sought to regulate the number of days allotted per nurse so that any available work might be shared among more of them.[16] Some hospitals reduced the number of hours per shift from twelve to eight as a strategy to distribute work among more nurses.[17] One Nursing Sister wrote about her prewar

private duty experience in which she combined construction work with nursing, finding that laying steel reinforcements for concrete and reading blueprints was easy and her wages were higher.[18]

The Weir Report documented these social conditions as well as pervasive economic issues in private duty nursing. He called it a 'starved life' and concluded that the private duty nurse "probably loses more than she gains from her personal freedom in nursing . . . . In a short time she loses touch with the latest or most approved nursing techniques and is on the highway to becoming a professional discard or the victim of an inferiority complex."[19] Gertrude LeRoy Miller described the working and living conditions shared by nurses and patients alike, during her years as a Red Cross Outpost nurse in the 1930s. She wrote in her memoir about isolation, loneliness, dependence on the community, poverty, hardiness, improvisation, and autonomy in practice as well as the construction of meaning and community that could develop through the experience.[20]

More than half (51.7%) of the Nursing Sisters in my database of 1052 military nurses indicated they had been engaged in private duty nursing prior to enlisting. NS Eva Wannop graduated in 1939, and did private duty nursing to earn money for a university public health nursing course. She earned $5.00 for a twelve hour shift, but said, "If you had an alcoholic patient, it was $10.00. So it was more lucrative to get an alcoholic patient so that the money would accumulate--so we could get down to university."[21] USANC Betty Riddell labeled private duty nursing "dreadful," recalling that her dad "plucked [her] out" of her third "alcoholic case" where she felt more like a guard than a nurse.[22] Since her only other employment offer paid only $30.00 a month without room or board, she decided to leave Canada for work in a hospital at Duluth, Minnesota.[23] NS Muriel McArthur did private duty but she didn't get called for many patients because she had trained in Toronto and the local hospital near Barrie, Ontario "had a sort of unwritten rule that they called people that they knew—[the hospital] knew about their work."[24]

Student nurses, who comprised the majority of most hospital nursing staffs, found working conditions increasingly intolerable. Indigent patients crowded the public wards, taxing both human and material resources and sometimes provoking desperate attempts to create change—such as the 1939 nurses' strike at St. Joseph's Hospital in Comox, British Columbia. There were experiments with hourly and group nursing fees as well as efforts to reduce student enrollment to stem the rising number of unemployed graduate nurses.[25] Nurses who did find positions as graduates in hospitals reported that their wages varied from $25.00 to $65.00 a month plus room and board. Nursing Sisters frequently reported on enlistment that their previous civilian salaries were in the range of $55 to $75 per month.[26] Some nurses went to the United States in the search for work. NS Lois Bayly went to Albany, New York while USANC nurse, Betty Riddell, crossed the river daily to work in Detroit, Michigan after working previously in Duluth, Minnesota.[27]

By 1940, as the wartime economy began to influence a rise in salaries and the beginning of a period of full employment for nurses in Canada, the *Canadian Nurse* reported nurses' average annual income as $941 or $78.42 per month for employed nurses. The journal compared that income to an average annual income of $927 for a male wage-earner and $559 for a female wage-earner, during the same period.[28] These salaries are substantiated by the 1941 census that reported 40.8% of employed nurses earning between $450 and $949 annually with another 26.7 %, presumably supervisory and administrative nurses, earning between $950 and $1949 annually.

Prewar human resources were taxed not only by the prevailing working conditions, but also by the changes in medical technology that were influencing the nature of nursing care. The core of nursing always involved a variety of roles that supported patients and their families through illnesses, trauma, and surgery. Much of this work required the skilful, timely use of a variety of equipment and machines. Nurses valued technological skills highly and indeed, these skills were central to their collective sense of self.[29] As hospitals became repositories for technology which was either too expensive, too difficult to transport between private homes, or

too seldom used by individual physicians, physicians relied increasingly on nurses' constant presence at the bedside and their growing familiarity with medical technology such as x-rays, hydrotherapy, electrical therapy, specimen collection, and thermometry.[30]

Prior to the 1940s, many nursing techniques focused on preparing the equipment and the patient, assisting in procedures, and cleaning up after procedures. Technologies were shared between physicians and nurses, but in gendered ways that limited nurses' control and decision making.[31] As McPherson pointed out, nurses perfected and routinized techniques for counter-irritants, medications, enemas, douches, catheters, lavages, poultices, packs, stupes, and foments—not only to claim scientific status but also to create parameters of safety for patient care and student learners. They sterilized equipment and supplies, followed elaborate instructions for isolating infectious patients, and developed skills in "feeding patients, assisting them with ablutions, and maintaining the cleanliness of bed and patient alike."[32] Technological changes within the hospital were beginning to cause nurses to worry about losing their skills by engaging in private duty nursing after graduation. They perceived hospital nursing as an environment in which it was easier to maintain and update skills.[33] The Nursing Sisters Database indicates that graduate nurses sought and acquired additional skills through courses in operating room technique, x-ray technique, tuberculosis nursing, teaching, and supervision. These extra courses frequently served to enhance their credentials in the competition to become military nurses when positions arose.[34]

Military Workplaces during the Interwar Period

There were extremely rare nursing service vacancies in the Permanent Forces during the interwar years. The First World War medical units had demobilized by 1920, and the Nursing Sisters found themselves in a different position than the Medical Officers who were assigned to regiments, sanitary stations, and field ambulances--units that continued to exist. Many physicians combined on-going military responsibilities with their return to private practice. But nurses were

assigned to specific hospital units that ceased to exist once the care of soldiers was transferred to the Department of Pensions and National Health hospitals in Canada. Initially, some nurses found positions with these civilian establishments but the number of positions continued to decline as soldiers were released back into civilian life.[35]

The permanent force medical services, known as the Royal Canadian Army Medical Corps (RCAMC), planned for an establishment of twenty-five Nursing Sisters after 1919. There were several re-organizations between 1920 and 1936, as the RCAMC attempted to cope with reduced manpower and funding, and Canada attempted to survive several recessions and the Depression. According to the re-organization of 1930, a very small core of permanent force Nursing Sisters would be supplemented by a larger, non-permanent reserve force of Nursing Sisters designated as the Canadian Army Medical Corps (CAMC) with an establishment of 1110. This re-organization was never implemented however. Existing literature is ambiguous regarding how many military nurses served during the interwar years. Variations can be explained by which re-organization is referenced, whether the positions established on paper have been differentiated from the number of nurses actually "taken on strength," and whether the permanent force nurses are distinguished from the reserve force nurses. Sources varyingly report the number of interwar RCAMC Nursing Sisters as between five and twenty-five, with the number of CAMC Nursing Sisters reported as between 127 and 400.[36] Leslie Newell used annual reports of the Department of Militia and Defence for the Dominion of Canada and compared them to personnel records of the Nursing Sisters held at Canadian Forces Base Borden. Newell's careful analysis of these sources suggests that the number of RCAMC Nursing Sisters who served during the interwar years ranged only between five and fourteen (in 1931), while CAMC Nursing Sisters ranged between 127 (in 1923) and 399 (in 1925). In 1939, the CAMC reserve list held 363 names—far short of the 1110 positions established on paper.

For Nursing Sisters, however, what really mattered were permanent positions in the armed forces, but these were very limited. Permanent positions meant full-time, paid work and years contributed toward retirement pensions. Reserve positions basically constituted lists of

names for call up in emergencies or for duty at a summer training camp—training that was greatly curtailed during the recurring economic recessions of the 1920s and 1930s. CAMC Nursing Sisters had to depend on private duty employment (or a very flexible employer) in the interim, and hope for a vacancy in the RCAMC. In 1924, for example, five reserve Nursing Sisters were 'called out' to nurse soldiers during an influenza outbreak at the Royal Military College in Kingston, Ontario.[37] Newell argues that RCAMC Nursing Sisters were used primarily as supervisors and administrators in postwar settings. They taught first aid to 'other ranks' who then became medical assistants and stretcher bearers. The introduction of hospital orderlies and the certification of more than 50% of them in first aid actually worked to nurses' disadvantage since it also reduced the need for military nurses during peace time.[38]

The interwar years brought massive funding and personnel cuts to the armed forces. Not even Prime Minister R. B. Bennett's (1930-1935) scheme to deal with massive unemployment and labour unrest by converting military camps to labour camps changed the employment situation of military nurses. The military establishment benefited primarily through Bennett's plan that focused on the construction of airfields and the repair of fortifications at Halifax and Québec, but medical services were handled by using reserve nurses and civilian hospitals.[39] NS Elizabeth Pense was a reserve nurse who cared for unemployed men in the relief labour camps. She claimed there was a ratio of "five Army patients to fifty unemployed patients," and described "lots of pneumonia" among those arriving right off the trains.[40] The only summer camp with field training opportunities for the medical units was held in 1938, on the eve of another war, at Camp Borden. No equipment had been added or updated since the First World War and units were expected to use British supplies if, and when, Canada entered the next war.

In the same period, however, it became increasingly clear that another war was likely to erupt. The RCAMC plan relied on civilian nurses to 'fill the ranks' together with a small core of permanent force Nursing Sisters, and a slightly larger number of reserve Nursing Sisters who were inadequately trained from the perspective of military nursing. Like physicians, nurses shared the advantage of being fully trained professionals along with the disadvantage of

inexperience under wartime conditions. In 1930, physicians formed a special section within the Canadian Medical Association. It was called the Military Section and it developed out of a concern to balance military and civilian needs for medical care during wars, and to prepare for medical eventualities such as bacteriological and chemical warfare.[41] But Newell suggests that Nursing Sisters were too few, too powerless, and too isolated from one another and from civilian professional nursing, to create any substantial changes related to military nursing practice.[42]

The Canadian Nurses Association and the Canadian Red Cross shared concerns over civilian shortages that might result when a large proportion of nurses entered the military.[43] Jointly, they created a Reserve List that was maintained from 1926 into the early years of the Second World War—identifying nurses who were available to serve in an emergency, either within or outside of Canada. The Officer Commanding for each military district was supposed to have a current list of those nurses available in his district. 'The List' brought its own set of problems however, as nurses faced a necessity to move around in the search for employment, and as the majority of nurses married and retired from nursing. It was difficult to keep the List current and/or to locate the persons on it, as Bill Rawling humorously explains.[44]

In spite of the constraints on military nursing during the interwar years, a small group of Nursing Sisters can be identified through Canadian Forces Base Borden archival records. One document contains the names of twenty-three Nursing Sisters along with related demographic information and record of postings.[45] This record tracked dates and postings for the purpose of establishing service tenure and salary increments. Eleven of the twenty-three Nursing Sisters in this book transferred directly from active service with the CEF to the postwar permanent force in July 1920. At least nine of these women remained in the RCAMC for an extensive period, retiring with military pensions after careers that spanned sixteen to twenty-eight years. Seven of them served at least twenty years. Clearly, the remaining twelve Nursing Sisters were replacements for the original nurses as they retired, and they did not represent increases to the overall nursing strength.[46] They ranged in age from 26 to 46 on enlistment. The original eleven nurses had already served with the CEF for a number of years and nine of them were over 35 years of age

when they enlisted with the RCAMC. The majority had trained in either Ontario or Québec (although six trained in the United States), graduating primarily between 1898 and 1915.

These interwar Nursing Sisters comprised the remnant of the first generation of Canadian military nurses, along with retired First World War Nursing Sisters. They formed the Overseas Nursing Sisters Club (1920), which re-organized as the Overseas Nursing Sisters Association (1932),[47] where they fostered a vision and memory of wartime nursing service among contemporaries. As historian Susan Mann carefully noted, they maintained a relatively unbroken silence toward outsiders.[48] But they did maintain a continuity of military nursing that welcomed the second generation of Nursing Sisters into their ranks in 1939, and to whom they passed the torch.

Cynthia Enloe has asked if the 1930s were a postwar or prewar experience for American society; she suggests that the interwar generation constituted a valuable pool of potential recruits based on their experience as the children of the First World War, referring to their socialization as children toward ideological expectations that made war a foregone conclusion.[49] In a similar manner, one could also ask if interwar military nursing was a postwar or prewar experience. Forty-six Nursing Sisters died from enemy action and disease while serving during the First World War,[50] and Canadian military nurses had earned a commendable reputation as officers, receiving many meritorious medals and awards. Although the RCAMC offered very few opportunities for nurses during the interwar years, at the end of the 1930s, military nursing could be attractive, highly-desirable, ideal work.

Indeed, the civilian nursing profession built on the Nursing Sisters' legacy to assure the Canadian government in August 1939 that, that should the need arise again, "there would be an immediate rush by nurses to answer 'The Call' for their professional services" and nurses would answer, "'Ready, aye Ready' to any emergency call . . . ."[51] This confidence was not misplaced, and Canadian nurses did responded overwhelmingly when that call came on 1 September 1939. The severe working conditions of the 1930s, combined with a precedent of military nursing that

included officer status and benefits, had socialized nurses to expect full participation in the Second World War. The main issues were: which nurses, and how would they be selected?

Enlisting the "Right" Kind of Nurse

From a demographic perspective, the composition of any national military force reflects that nation's population to a limited degree. There are multiple factors that influence and skew enlistment in favor of the privileged classes while exploiting persons disadvantaged by education, race, or gender: the prevailing socio-economic conditions, whether enlistment is voluntary or conscripted (and who is deemed to be exempt), eligibility criteria, and strategies employed by potential recruits to either achieve or to avoid enlistment—depending on the perspective. Conscription had threatened Canadian national unity during World War I, first bringing down the Liberal government and then creating a crisis within the Conservative government that narrowly averted dissolution through a most unusual election and the formation of a coalition Union government.[52] This 'special' election (1917) became known popularly as the Soldiers' Vote and it granted suffrage to serving soldiers, including the Nursing Sisters, through the Military Voters Act while the Wartime Elections Act gave enfranchised mothers and wives of soldiers also —all women who were likely to vote in favour of conscription. Thus nurses were among the first Canadian women to gain the right to vote in national elections.

William Lyon Mackenzie King had served in the Liberal party since the time of Sir Wilfrid Laurier and was Prime Minister for three periods: 1921-1926, 1926-1930, and 1935-1948. He understood first-hand the dangers of conscription as well as the probable need for large numbers of Canadian troops in a second large-scale war. His politics were those of diplomatic 'appeasement' and of 'depletion' of the armed forces—partially to avoid Canadian involvement in distant wars, and to fulfill his election promise of no conscription.[53] The contexts of the Second World War rapidly altered this stance, leading to a plebiscite in 1942 that released the Prime Minister from his promise and permitted the gradual introduction of conscription—first for home defense only, then for overseas. The shift was such a threat to national unity that King became

well-known for his promise: "Not necessarily conscription, but conscription if necessary."[54] Nurses were exempt from conscription for at least two reasons: they volunteered far in excess of the numbers required for the RCAMC, and by 1942, the Canadian civilian nursing 'glut' had turned into a nursing 'shortage' of increasing national concern.

It is significant that while conscription was never necessary for Canadian nurses, in the United States, a protracted struggle took place between Congress, the American Nurses Association, and the military. In spite of measures that included the introduction of special training programs such as the Cadet Nurse Corps in 1943, raising the age limit to permit older nurses to enlist, eliminating the marriage bar, increasing nurses' pay, and improving nurses' status, the United States Army was unable to meet their requirements for military nurses on a voluntary basis.[55] The bill for conscription passed the House of Representatives in March 1945, and narrowly missed approval by the Senate in April. The Surgeon General called for a second attempt, but before that could happen, the massive recruitment efforts mounted by the Army, Red Cross, and American Nurses Association proved successful. In May 1945, the War Department withdrew their request for a draft, just days prior to V-E Day and the end of war in Europe.[56] Although the Canadian civilian health care system experienced a severe shortage of nurses by the mid-1940s, the armed forces never did and military nursing remained completely voluntary.

Multiple factors influenced which nurses were ultimately successful in becoming Nursing Sisters. First, there were basic eligibility requirements established by the *King's Regulations and Orders for the Canadian Militia (1939).*[57] These eligibility criteria shaped the composition of the armed forces along lines of class, race, gender, ethnicity, age, and marital status. Canadian politics were organized around deeply-rooted traditions linked to the two founding nations, as French and British, Catholics and Protestants.[58] Central and Prairie Canada depended heavily on immigrants for settlement and development but dominant immigration policies granted 'preferred status' to British and Northern Europeans over Asians, Blacks, and Jews prior to the Second World War. Canada remained a predominantly white, Protestant, English-speaking nation with strong British connections. Although the Statute of Westminster (1931) granted Canada full legal

status in matters of foreign policy and war, Canadian demographics assured the Parliamentary support that came on 10 September 1939--a week after Britain's Declaration of War. All members of the Armed forces were required to be British subjects, excluding some immigrants who were unable to meet requirements.

The military relied on the civilian nursing profession to train and credential a pool of the 'right kind' of nurses for recruitment. Thus the demographic profile of military nurses closely reflected the civilian nursing workforce, except for the relative absence of French Canadian nurses.[59] Other criteria could possibly be argued, manipulated by political influence, or deliberately misrepresented (such as age, for example). But the professional qualifications could not. No applicant was accepted until there was verification of her registration number and good standing with a provincial professional association. In addition, Nursing Sisters had to be physically fit, less than forty-five years of age for the non-permanent force, and either single or a widow without children.[60]

Since Nursing Sisters enlisted as fully-trained graduate nurses, these requirements reflected and reinforced a second set of criteria, namely the pre-existing class, race, gender, age, and marital status requirements of schools of nursing. During this period, schools of nursing effectively excluded Blacks and First Nations, as well as most men, Asians and Jews--with few exceptions.[61] A very small number of Jewish women gained entrance to training schools such as the Montreal Women's General Hospital (formerly known as the Reddy Memorial Hospital). In addition, the military gendered nursing as female, although there were no policies that specified gender in the *King's Regulations*. A small number of men trained as nurses during this period, particularly at psychiatric hospitals in Ontario and Alberta, but the armed forces required men as combatants who could go where women were not permitted to go—onto the battlefield.[62] Men were combatants, not nurses.

A third influence on the selection of nurses for the armed forces involved employer and clergy references, followed by a rigorous interview with the district commanding officer and physical fitness tests. In addition, the RCAF investigated the applicant's family background and

home setting while an initial training period screened out women perceived to be 'difficult to manage'. Nurses, who were discharged within the first six months (1.5%), were typically described as 'not suited' to the military, 'didn't fit in,' or 'unable to adjust to discipline.'[63]

The nursing profession itself exerted a fourth set of influences on the composition of the military nursing services. Untrained women, typically from the middle- and upper-classes, had volunteered in large numbers as assistant 'nurses' during World War I, precipitating controversies within and without the military.[64] Some of these controversies developed because volunteer nurses were not under military control, frequently lacked substantial training, and were perceived to threaten trained nurses as a potentially de-skilling agent within the health care system. In addition, trained nurses had volunteered for the Canadian Army Medical Corps in numbers that far exceeded available positions.[65] Thus, at the beginning of the Second World War, there was a great concern "to avoid a rush of volunteers such as occurred in the last war," and a great determination to avoid the use of volunteer assistant nurses in the Canadian military.[66] Volunteer nurses, such as Volunteer Aid Detachments, did not work in Canadian military medical units overseas. There were very few of them in military hospitals within Canada, and that was only toward the end of the war when civilian hospitals became anxious over the growing nursing shortage. With the volunteer question resolved, attention turned to development of an equitable means for enrolling civilian nurses.

The Canadian Nurses Association, in conjunction with the Canadian Red Cross and the RCAMC, negotiated a process of recruitment for the armed forces at the beginning of 1939 that they felt would take civilian nursing needs into account as well as military needs. They surveyed nurses through their provincial associations for their availability in any emergency service that might arise. It was called the Plan for National Enrolment of Nurses for Emergency Service (popularly known as 'the List') and administered jointly. Nurses could only enroll if they were members in good standing with their provincial associations, assuring that only fully-qualified persons were on the List. They had four options: Class A nurses were available for both war and disaster; Class B nurses enrolled for war only; Class C enrolled for disaster only; and Class D

nurses (those over age 45) formed a reserve group for the first three categories. Classes A, B, and C had a set quota of 3000 each.[67] The lists were then forwarded from the Provincial Nurses Associations to each military district with the intent that only nurses who applied in their particular military district and were also on the List would be called up for the next steps of the selection process. The *Canadian Nurse* did advise nurses, however, to include any special professional qualifications with their application[68] and it reported in October 1939, that more than 3000 enrolled nurses were "now ready to be called upon for service in an orderly manner and without delay."[69] NS Fran Oakes was one of these nurses. She completed post-graduate courses at the Montreal General and Toronto General hospitals and had over ten years of experience when she became one of the first nurses in the RCAF:

> We didn't know we were the first nurses . . . . You see we were on war and disaster at home or abroad . . . . When we first graduated as nurses, you were given this piece of paper: were you willing to serve at home or abroad, in war or in disaster. . . . They contacted you; they gave you a post card. And I went to London and a little colonel (who wasn't as tall as I was) . . . told me they had 999 well-qualified, experienced Army nurses. And they didn't need me. So I went back and minded my own business. And then, I got called in the Air Force. Because when we signed up for war and disaster, it wasn't for any [particular] service.[70]

Each provincial association had a quota proportional to the number of nurses registered in their province—assuring that no one area or hospital would be depleted of nursing staff, unlike the situation during the First World War, when large teaching hospitals formed whole medical units that went overseas together. By 1940, all provinces except Québec and New Brunswick had exceeded their quota, and 4080 nurses had volunteered for the various categories of war service. Of these, only 150 nurses had been called up for active service.[71] The Association of Registered Nurses of the Province of Québec disagreed that they had not met their quota, and reported that with a total of 4064 members in good standing, there were 1040 names (25%) on their Enrolment list, and 900 of those were willing to serve in the military.[72]

In spite of the efforts made to assure that military enlistment was representational, the List soon fell into disuse—partially due to the difficulties of maintaining it accurately, partially due to Commanding Officers' propensity for independent decisions, and also because nurses

themselves circumvented the process.[73] In September 1940, Colonel Potter (Director General Medical Services) told the CNA he could not assure the use of the List since applicants were screened and selected in the local districts.[74] It was often the case that district Medical Officers requested nurses whom they knew and had worked with in civilian hospitals—especially surgeons who developed preferences for individual operating room nurses familiar with their techniques. NS Helen Rendall recalled how one physician at Toronto General Hospital went through the Medical Arts building over Labour Day weekend as the call to mobilize medical units was issued, and recruited nurse Agnes Neill to be the Matron of No. 15th CGH along with forty TGH nurses.[75] NS Betty Brown went right from the operating room of the Winnipeg General Hospital to Fort Osborne Barracks where there was a small operating room. "The surgeon was one of our doctors from Winnipeg General and he wanted a scrub nurse from his hospital, of course. So I was taken on strength immediately."[76] In a similar manner, NS Doris Carter met a surgeon whom she knew from her training hospital. He told her, "I've got your name on my hospital, and I'm going to be chief surgeon." After that meeting, she received her call up.[77]

NS Dorothy Surgenor thought she would never get into the military because she graduated in 1943 and there were very few positions available—only as reinforcements. She received unexpected help through inside influence, while working at Ste-Anne-de-Bellevue in the operating room during 1945. As she recalled, "I said I wanted to get into the Navy or into the Forces. [The surgeon] was a naval doctor and he said, 'Oh, I think I can help you along those lines.' So the next thing I knew . . . I landed up in Halifax."[78] NS Betty Hamilton thought her appointment was partially influenced by the doctor she worked for at the Royal Alexandra Hospital in Edmonton, as did NS Mary Bower who credited a physician in Calgary for getting her into the Army.[79]

It was generally understood that the military medical units wanted nurses with at least two years of post-graduate experience. NS Beatrice Cole Hunter, however, received a phone call within two months of graduation from the Regina General Hospital in 1944—asking her if she was interested in enlisting. She asked the recruiter if they were calling all the new graduates since

she had not applied and was surprised to be at the interview. Told that they had been advised to phone her, she didn't find out until after the war that one of her patients (First World War Captain/Nursing Sister MacDonald) had recommended her.[80]

Other nurses, however, submitted multiple applications to the same branch or to different branches in order to increase their chances for selection. According to her personnel records, one nurse applied to (and was accepted) three times.[81] Some nurses applied in different districts where they thought there might be openings. NS Hallie Sloan applied to the Navy, the Air Force, the South African force, and the Army. When all branches replied they had plenty of people 'waiting in line,' she returned to nurse in her home community of Regina (where there were vacancies in the quota for that military district). There she received the call for an interview and ultimately, her appointment to the RCAMC. NS Lois Bayly had to give up work in New York and return to Canada in order to get accepted.[82] As NS Mary Bower said, "We all were trying to get in the Army or Air Force or anything. We tried to go to Africa! Anything to get in the armed forces."[83]

An unknown number of Canadian nurses felt the waiting list was too long. They enlisted as members of the Queen Alexandra's Imperial Military Nursing Service (QAIMNS) in England or the United States Army Nurse Corps (USANC), like Betty Riddell who saw the sign "Uncle Sam needs you!" every day when she crossed the river to work in Detroit. She said, "I went in one day and asked them if they would take Canadians. I almost didn't get back. They wanted to hold me."[84] Still others served with the South African Military Nursing Service (SAMNS). NS Isabel Morrison enlisted with the RCAMC and immediately volunteered for the South African special draft of Canadian nurses in 1942. After serving one year there, she returned to complete her war service with the RCAMC.[85] Not all SAMNS Nursing Sisters began as members of the RCAMC and not all SAMNS were accepted into the RCAMC after serving in South Africa. The Matron-in-Chief of the RCAMC Nursing Service, Elizabeth Smellie, made it clear in a letter to the Department of National Defence that, "many [nurses] were on the Reserve list with no immediate

prospect of being called, and were glad to go to South Africa. They should not be considered before those who have been waiting a long time, with no opportunity to serve as yet."[86]

Some nurses took civilian positions at military hospitals, hoping that proximity and being 'known' to the Commanding Officer would facilitate the process. Air Commodore J. W. Tice (Director of Medical Services, RCAF) expressed his concern over this practice, noting that in some instances the nurses were not 'suitable' for appointment and it should be made clear that civilian positions on RCAF bases are "without any undertaking as to subsequent appointments."[87] Nurses occasionally enlisted in the Women's Divisions as hospital assistants, stating they had been advised to do so and that they could re-muster as Nursing Sisters at a later date. This practice was considered unacceptable for two reasons: Nursing Sisters were completely separate from the Women's Divisions of the Army, Navy, and Air Force (with different rank, pay, and administration), and this practice contributed to a civilian nursing shortage because it circumvented established plans to balance the need for nurses.[88] Nurses also used personal and familial influence that included letters mentioning mutual acquaintances and letters to their Members of Parliament inquiring about the delay in appointments. They capitalized on relationships where fathers or brothers were serving members of the forces, as in the cases of many under-aged or under-experienced nurses that appeared in the personnel records.

When NS Elizabeth Doe received her call up, it was 1 April 1943. Being cautious, she asked the man to call back after noon to make sure it was not an April Fools' joke.[89] NS Margaret Roe declined her call up at first because she had not expected it to come so soon. Other nurses had waited years. Since Roe had not given notice at the hospital where she was working, she asked the RCAMC to call her back in one month and she would accept. They did, and she did.[90]

By 1941, editorials in the *Canadian Nurse* reveal that concern for meeting the needs of the military had given way to concern for meeting civilian nursing needs. The medical and nursing leadership took measures to prevent the armed forces from enlisting nurses currently employed, to prevent nurses from leaving the country for employment (particularly in the United States), and to increase the number of students in training. They were not above using direct

interference to prevent a nurse from successful enlistment when her skills and experience were required in the civilian profession. In October 1942, for example, a request was made to the Associate Minister of National Defence, C.G. Power that prevented public health nurses from enlisting because of the "greater danger of epidemics in certain provinces where there are very large numbers of men in small areas." The letter referred to venereal disease outbreaks in areas where soldiers were mobilizing and the need for nurses to follow up on infected cases. Although policies required that a public health nurse have an official release from the provincial Minister of Health before she could enlist, this letter noted that nurses were generally "dissatisfied" if permission was denied.[91]

Thus, both nurses and their civilian employers could influence military enlistment. Both used a variety of strategies that ultimately shaped the composition of the military Nursing Service, regardless of the careful plans to make the armed forces representative of the Canadian nursing population, and to give nurses equal opportunities for selection. As I will illustrate, additional factors emerged during the war that also influenced enlistment, such as the military's needs for particular skills or knowledge that enabled some nurses to circumvent waiting lists and quota.

Professional Anxieties: Too Many or Too Few Nurses?

Ethel Johns, the Editor of the *Canadian Nurse*, noted that a slower mobilization during the Second World War had allowed civilian nurses more time "to fill the gaps and dislocation of services" in contrast to the Great War. She challenged readers to consider service on the home front just as real a sacrifice as "spectacular" service overseas, relying on the image of old soldiers from World War I: "Now it begins to look as though we must fill up the ranks of the 'Old Contemptibles' again. After all, we did keep the wheels turning, even though they squeaked horribly at times."[92] In similar manner, Marion Lindeburgh who was President of the Canadian Nurses Association (1942-1944), used images of war to depict home front nursing: "[N]urses are soldiers too whether serving overseas or on the home front. The professional nurse . . . displays

the marks of the good soldier. She will not desert the ranks at a time of crisis, nor will she seek shelter, leaving others to face the hardships and the struggle."[93] Even public health nurses adopted the rhetoric of 'soldiering' on the home front in relation to the civilian Air Raid Precautions program (ARP)—publishing a poem using such imagery.[94]

Both provincial and national associations were keenly aware of the dual challenges to support war activities and to stabilize nursing services.[95] They were also very cautious regarding calls to increase the number of students in training (and ultimately the number of graduate nurses) in light of recent employment difficulties during the Depression. Their preference was to make full use of existing nursing resources, to limit the number of military nurses, and to place restrictions on civilian nurses for the duration of the war.

The number of Canadian graduate nurses at the end of 1939 is somewhat unclear since not every nurse was a member of the Canadian Nurses Association, and the Canadian census of 1941 took place after a renewed recruitment of nurses and may well have over-reported the actual number of nurses in practice. Nurses were members of their provincial associations and through those organizations, members of Canadian Nurses Association. In fact, some nurses belonged to more than one provincial association, in order to work in more than one province. Provincial associations also varied in their requirements. In Ontario, for example, registration was voluntary and neither all graduate nurses nor even all employed nurses were members of the RNAO. Then there were retired nurses and married nurses who may well have identified themselves as nurses for the Canadian census. The Canadian Nurses Association reported membership totals of 16,758 in 1940, 18,266 in 1942, and 19,137 in 1943,[96] while the 1941 census reported 27,114 active graduate nurses and 11,907 student nurses for a total of 39,021 nurses.[97] Interestingly, since the armed forces required applicants to be members of their provincial associations, membership increased dramatically and peaked during 1945 in Ontario. But this was only a temporary trend. Nurse leaders complained that once military nurses were accepted into the armed forces, they did not maintain their professional memberships.

Initially, the RCAMC supplied all of the medical and nursing services not only for the Army but also for the Royal Canadian Navy (RCN) and the Royal Canadian Air Force (RCAF). All Nursing Sisters enlisted with the RCAMC until 1941 and 1942 when the RCN and RCAF organized their own medical services and recruited their own Nursing Sisters. At that point, small groups of RCAMC nurses re-mustered to the RCAF and RCN and together with new recruits formed the first nursing services in each.

During the first years of the war, the Canadian forces were relatively inactive in England and the RCAMC took in Nursing Sisters slowly. The initial gradual buildup of forces through 1941 was easily managed by the civilian nursing profession, bringing welcome relief to the conditions of the 1930s. The total number of Nursing Sisters increased by 110% in 1942, in preparation for the opening of a second front (the failed Dieppe Invasion) and by at least another 55% in 1944, in preparation for the invasion of Northwest Europe (Table 1.3). The profession became increasingly concerned about a shortage of nurses by 1942, although in reality, the number of Nursing Sisters (not all of whom were nurses) still remained quite small in relation to the total number of Canadian nurses (3.7%). The armed forces could scarcely be blamed for creating a shortage. Table 1.2 tracks the total number of appointments made per year. However, it does not reflect the cumulative number of nurses serving, nor the attrition.

TABLE 1.2.
RCAMC, RCAF, AND RCN NURSING SERVICE APPOINTMENTS, 1939-45[98]

Year	RCAMC	RCAF *	RCN	SAMNS	Total
1939	151				151
1940	369	4			373
1941	380	Not available	7	80	467
1942	659	Not available	100	221	980
1943	687	241	114		1042
1944	1140	389	82		1611
1945	270	412	38		720

* RCAF figures are cumulative in contrast to the other services.

Before embarking on a massive recruitment campaign to deal with an emerging shortage, the Canadian Nurses Association needed better information on the nursing population and their availability for civilian and military positions. Kathleen W. Ellis (with Suzanne Giroux as her French Associate) became the Canadian Nurses Association's Emergency Nursing Adviser effective January 1942, to survey the provinces' nursing needs. Ellis proposed ten recommendations that the Canadian Nurses Association adopted at the June 1942 Annual General Meeting as its guideline for the next several years.[99] In December 1942, Lindeburgh alerted nurses to the danger that if the profession did not assure effective distribution of nursing services throughout Canada, the federal government would do so by way of the National Selective Service of the Department of Labour and its Canadian Medical Procurement and Assignment Board.[100] The Canadian Nurses Association had representation on this board as did the Canadian Hospital Council. They participated in the National Health Survey that took place in March 1943 parallel to the National Selective Service registration of all Canadian women under twenty-five years of age for the war effort.[101]

Interestingly, the registration of graduate nurses included everyone under the age of sixty-six, active or inactive, married or single in contrast to the parameters set for the National Selective Service.[102] The Canadian Nurses Association and Canadian Hospital Council then had access to both sets of data (from their own National Health Survey and the National Selective Service registration) as well as information forwarded from the armed forces. They used these combined sources to analyze the nursing situation in Canada and make decisions on nursing education and nursing practice that set constraints on nurses' work mobility.[103]

These sets of data provide detailed information regarding the intentions of civilian nurses to enlist (Table 1.3), the actual pattern of application to the armed forces (Table 1.4), and the proportion of nurses already enlisted (Table 1.5), as of March 1943. In 1943, there were 52,483 civilian nurses reported by the survey. Of these, 3741 (7.1%) nurses had already applied to enlist, and 8306 (15.8 %) nurses signified a willingness to enlist if needed, while 29.6% did not

indicate their availability. As well, almost one-quarter (20.5%) of those who had already applied to the armed forces, had applied to more than one service branch while 4.4% of these nurses had applied to all three branches.

TABLE 1.3.
AVAILABILITY OF NURSING PERSONNEL FOR THE ARMED FORCES, MARCH, 1943[104]

PROVINCES	AVAILABLE		NOT AVAILABLE	UNSPECIFIED	TOTAL
	Not applied	Applied			
Prince Edward Island	62	28	244	56	390
Nova Scotia	466	253	1210	1010	2939
New Brunswick	318	125	1057	502	2002
Québec	890	568	3815	2561	7834
Ontario	3845	1555	11335	7149	23884
Manitoba	611	236	1194	922	2963
Saskatchewan	506	214	1483	698	2901
Alberta	619	299	1544	1138	3600
British Columbia	982	462	3015	1478	5937
Yukon / Northwest Territories	7	1	12	13	33
CANADA	8306	3741	24,909	15,527	52,483

After factoring in the attrition of Nursing Sisters, the Armed Forces reported 2008 nurses in Canada and overseas, as of March 1943. This number represents only 3.7% of the reported number of active Registered Nurses (Table 1.5). The remaining 12,047 nurses who had already applied, or were willing to apply, constituted a formidable reserve nursing workforce for the Canadian military. There would be no difficulty obtaining Nursing Sisters.[105] Furthermore, military nurses during the Second World War comprised a much smaller proportion of the total number of Canadian nurses than Geneviève Allard reported for the First World War Nursing Sisters (37%).[106]

TABLE 1.4. NURSING PERSONNEL APPLYING FOR ENLISTMENT BY SERVICE AND PROVINCE, MARCH 1943[107]

PROVINCE	SERVICE							
	Army	Navy	Air Force	Navy + Army	Navy + Air Force	Army + Air Force	Navy + Army + Air Force	Total
Prince Edward Island	18	3	2	1	4	0	0	28
Nova Scotia	137	59	21	14	5	8	9	253
New Brunswick	72	22	11	7	1	9	3	125
Québec	283	89	79	42	16	34	25	568
Ontario	801	255	186	105	34	106	68	1555
Manitoba								
Saskatchewan	93	28	34	11	5	26	17	214
Alberta								
British Columbia	230	73	64	27	14	33	21	462
Yukon / Northwest Territories	1	0	0	0	0	0	0	1
CANADA	1869	604	502	223	95	282	166	3741

TABLE 1.5. TOTAL CANADIAN NURSING PERSONNEL, BY PROVINCE AND ENLISTMENT STATUS, MARCH 1943[108]

Provinces	Number of Civilian Nurses	Number of Military Nurses	Total Number	Percent Enlisted
Prince Edward Island	391	43	434	9.9
Nova Scotia	2939	151	3090	4.9
New Brunswick	2002	111	2113	5.3
Québec	7834	317	8151	3.9
Ontario	23884	735	24619	3.0
Manitoba	2963	179	3142	5.7
Saskatchewan	2901	138	3039	4.5
Alberta	3600	110	3710	3.0
British Columbia	5937	224	6161	3.6
Yukon / Northwest Territories	33	-	33	0
CANADA	52483	2008	54491	3.7

The perceived looming nursing shortage was much more likely due to other considerations than enlistment in the armed forces. The interim report of Emergency Nursing Adviser Ellis identified problems of mal-distribution: 950 nurses were practicing outside of the province in which they were registered; 625 nurses were working in the United States; a 10.9% increase in the actual number of hospital beds; a 21.6% increase in bed utilization; replacement of experienced personnel who had enlisted with less skilled workers; particular health care sectors such as mental hospitals, sanatoria, and rural areas that were inadequately staffed; discrepancies in the number of working hours between settings; salary disparities between health care settings; and compared to other women's work, discrimination against married nurses.[109] The final report revealed a large gap between the total number of registered Canadian nurses and the number in active practice (22,136) or potentially available for practice (16,818). An additional 27,044 nurses reported that they were "employed other than as nurses," of which 93% stated they were housewives and mothers.[110] It is interesting that women who had left the profession continued to identify themselves as nurses, even though married nurses were not generally hired until later during the war. If the proportion of Nursing Sisters is then compared to this revised figure, they would still only comprise 8.3% of the total active nursing population.

Nonetheless, the Canadian Nurses Association called for constraints on nurses' mobility and employment options, out of fears that the situation would worsen. They negotiated with the Armed Forces to ensure that currently employed nurses would not be eligible for enlistment. Nurses in certain specialties such as public health nursing, were prohibited from joining up. An appeal was made to Matron-in-Chief Elizabeth Smellie not to deplete the hospital training schools of all their instructors and supervisors. Nurses who were determined to pursue careers as Nursing Sisters, however, found these constraints challenging but not impossible to circumvent.

As of May 1943, and in conjunction with the National Selective Service, the Canadian Nurses Association was involved in decisions on all labour exit permits requested by Canadian nurses: "It was felt that only in very special circumstances could requests for permits from nurses in group one [defined as registered nurses actively engaged in nursing in Canada applying to go

to the United States] be given consideration; this would include nurses asking permission to go to the United States for post-graduate study during the duration." [111] Problems related to nurses in three other categories were referred to the individual provincial associations: 'potential' student nurses applying to schools of nursing in the United States, married nurses who claimed they could not find work in Canada, and appeals from industries in other countries for Canadian nurses. Exceptions were made for nurses over fifty-five years of age, nurses with 'indifferent health,' and potential students "of special religious faiths and coloured students who cannot be placed in Canada."[112]

Changing Needs for Nurses During the War

Socio-economic conditions of the 1930s had shaped the context in which Nursing Sisters trained and entered the workforce while leaders of the profession influenced the selection process, but events of the war itself constituted a third influence on the number of military nurses.[113] In contrast to the First World War of 1914-1918, the Canadian forces (and their medical units) entered the war as Allies rather than as British soldiers recruited abroad—with full responsibility for meeting medical needs of Canadian troops. Defence Scheme No. 3 guided pre-war plans, providing for a field force for overseas operations and a War Book with details for its organization but little else. The King government sought to create a stronger sense of identity and cohesiveness through strategies that assured equitable burden as well as equitable opportunity (depending on one's perspective) in the different geographic regions. From the beginning, there were careful plans for proportional representation by population in the Canadian Active Service Force, including the medical services.[114]

Initial commitment called for two military divisions (approximately 50,000-60,000 all ranks) in support of the British Army as well as extensive involvement in the British Commonwealth Air Training Plan with forty-eight air training centers scattered across Canada.[115] By the summer of 1940, German expansion into Belgium, the Netherlands, and France resulted

in the formation of two more divisions, the National Resources Mobilization Act (NRMA), and the end of the 'Phony War' with transition to 'Total war.' Recruitment after the initial mobilization had been gradual and strictly voluntary through this first phase until the passage of the NRMA that required all persons, their services, and their property to be available "as deemed necessary or expedient for securing the public safety, the defence of Canada . . . , efficient prosecution of the war, or for maintaining supplies or services essential to the life of the community."[116] The conscription of men began with the NRMA—at first for service within Canada only, but after the 1942 plebiscite on conscription, for overseas as well.

The main medical needs during this first phase of the war involved screening recruits, administering immunizations, and managing communicable illnesses that resulted when large numbers of young men were transported from across Canada to live together in large communal settings. A relatively small number of medical units in Canada and England, with limited nursing staff, were sufficient for these needs.

Between the summer of 1940 and the summer of 1943, the Allied forces experienced a second phase of the war which brought devastating air strikes during the Battle of Britain, the defeat of British forces in Hong Kong, and the failed Dieppe Raid. There were five Canadian divisions (100,000-125,000 all ranks) overseas and with the exception of two battalions (1975 soldiers)[117] whose remnants became prisoners of war in Hong Kong after December 1941, Canadian troops were primarily posted for the defense of England and in preparation for the invasion of Northwest Europe.

Medical units increased correspondingly with Canadian involvement, particularly in preparation for an expected number of casualties from Dieppe. Hospital units remained in England during this phase and plans focused on evacuation of the wounded by ships and trains from the continent to military hospitals in England located near the coast. A small medical team (including two Nursing Sisters) accompanied the Canadian troops sent to Hong Kong. They worked within British hospital units, and were there only three weeks when the Japanese attacked Pearl Harbour and overran Hong Kong in December 1941. The two Canadian Nursing

Sisters were among those taken as prisoners of war. They spent the next twenty-one months in a Japanese prison camp and a civilian internment camp.[118]

From the perspective of the medical units, the second phase involved more trauma, surgical care, and increased experience working under the conditions of war. It exposed problems to be resolved prior to participation in a major campaign, and provided training opportunities (also known as 'schemes') in northern England and Scotland. Two years of 'waiting' in England had contributed to restlessness among the Canadian forces, and a demand for active involvement in a theatre of war.

A third phase of the war involved Canadian participation in opening a second front, with the campaigns in Sicily and Italy (beginning in July 1943), followed almost a year later with the massive Allied invasion of Northwest Europe (June 1944). These two involvements brought the medical units to peak strength and moved Nursing Sisters ever closer to the frontlines as they followed the troops—sometimes in rapid advances, and across long distances. The third phase involved different settings in the Mediterranean and Europe (North Africa, Sicily, Italy, France, Holland, Belgium, and Germany), different working conditions (frequently under canvas and requiring great mobility), and innovations in treatments, along with changes in policy that favoured younger, less experienced nurses.

A final, fourth phase of involvement was quite short in duration. In May 1945, 1412 Nursing Sisters volunteered for the Pacific Campaign as the war in Europe drew to a close.[119] They returned from overseas early (joining others who were serving in Canada) to prepare for embarkation to the South Pacific and for very different working conditions. Plans and embarkation leaves were suddenly disrupted by the surrender of Japan after atomic bombs were dropped on Hiroshima (6 August) and Nagasaki (9 August). By the cessation of hostilities on 14 August, a total of 1,086,343 Canadians had served in the armed forces, with 42,042 recorded deaths.[120] For medical units, this last phase involved closing down hospital units and moving patients steadily closer to England, and then home to Canada. For many patients and for many

nurses, there were still long months, or even years, of serial surgeries, recovery, and rehabilitation after the Armistice.

Almost all Nursing Sisters were posted initially in Canada, typically for at least six months. Some served their entire time there, either by choice, or because there were no vacancies overseas. RCAF nurses served at most of the air training centres across Canada, often in small, relatively isolated units of only a few beds and often with little backup support. They also served at large training camps like the one at St. Thomas, Ontario. Several small groups of RCAF nurses served in England at East Grinstead in Sussex which specialized in the care of burn patients (often pilots wounded during bombing assignments flown out of Britain), with No. 6 Bomber Command in southern England at York, Odiham, and Bournemouth. In addition, two Nursing Sisters with No. 52 RCAF Mobile Field Hospital were the first Canadian nurses to land in Normandy thirteen days after D-Day (6 June 1944).[121] RCN Nursing Sisters also served primarily in Canada with the exception of a small number who were posted to the *RCNH Avalon* in Newfoundland and the *HMCS Niobe* in Scotland. And finally, a group of 302 nurses responded to the call for volunteers to serve in South Africa.[122] They carried the same title of Nursing Sister and wore the same uniform of the RCAMC but once they left Canada, these nurses did not receive commissions and they served under the South African military authority. Their postings were primarily in South Africa although nurses who extended their original one-year contracts were posted to the Middle East, North Africa, and Italy as well.

Events of the war brought changes in the number of patients, the types of injuries and/or illnesses to be treated, and the settings in which care was given. Medical units gained experience as well as new technology with which to experiment. They became important components of the strategic planning for campaigns that required effective management of human resources to minimize war 'wastage,' and whenever the military planned for major campaigns, the recruitment of nurses increased. Eligibility criteria could be altered or even ignored, whenever nursing skills were needed on the frontlines.

Profile of the Second World War Nursing Sisters

Myriad influences shaped the composition of the armed forces nursing services, and they must be taken into account when analyzing who became Nursing Sisters, as well as how and why demographics varied. As I pointed out earlier,[123] there is considerable ambiguity regarding the number of Nursing Sisters who served during the Second World War. I have based the demographic analyses in this thesis, on data extracted from 1145 personnel files (the Nursing Sisters Database or NSD) as sampled from RCAMC, RCN, RCAF, and SAMNS records. After adjusting for multiple enlistments and the small number of Nursing Sisters who re-mustered as members of other service branches,[124] and comparing existing archival and secondary sources, I estimate the total number of Second World War Canadian military nurses as 4381 (Table 1.6). Therefore, the 1052 nurses in the NSD represent 24% of the estimated total number of military nurses.

TABLE 1.6. TOTAL NUMBER OF SECOND WORLD WAR CANADIAN NURSING SISTERS, BY SERVICE AND SOURCE, AS REPORTED AFTER THE WAR[125]

Service Branch	Gibbon and Mathewson (1947)	Feasby (1956)	Nicholson (1975)	National Archives of Canada and the Directorate of History and Heritage Sources	Nurses only (adjusted for redundancy)
RCAMC	3649	----	3656	3656	3352
RCAF	373	481	481	447	411
RCN	458	325	343	343	316
SAMNS	300	300	300	302	302
Total	4780		4480	4748	4381

As discussed previously, gender superseded occupational classification in the military medical units. Physiotherapy had been part of the First World War medical care, but it only emerged as a distinct profession after the war, with the establishment of the Canadian Physiotherapy Association (1920). It was not until the mid-1940s, that Physiotherapy Aides received RCAMC and RCN commissions.[126] The RCAF preferred to use civilian physiotherapists, delaying their enlistment until 1944, and enlisting them as part of the Women's Division rather

than as Nursing Sisters. By the end of the war, there were only seven RCAF Physiotherapy Aides.[127] The Military Hospitals Commission had hired civilian Dieticians during the First World War, but they were not commissioned into the armed forces until mid-1940. All of the service branches had Dieticians. The RCAF placed a great deal of emphasis on nutrition to optimize the physical functioning of pilots, but like the RCAF Physiotherapy Aides, Dieticians were also part of the Women's Division. By August 1943, Occupational Therapists were accepted for enlistment in the RCAMC and the RCN medical services. Home Sisters were a part of the RCAMC and RCN nursing services from the beginning, and the RCN also included female laboratory technicians as Nursing Sisters.[128] Home Sisters came from various backgrounds and occupational experiences; they were chosen for their "adaptability, resourcefulness, and diplomacy . . . good educational background, pleasing personality, knowledge and experience in household management, and ability to direct as well as work with others."[129] They were responsible for the care and household management of Nursing Sisters' living quarters.

The RCAF may have had less need to enroll these additional groups of women because its medical units operated primarily in Canada, where civilian employees were readily available. But nurses' rank and status became such a contested issue in the RCAF that it seems there was also a determination to keep other women out. In contrast, the RCAMC operated some 117 hospitals in Canada, 25 hospitals overseas, 2 hospital ships, various hospital trains, a small number of air ambulances, and a variety of mobile medical units that were deployed in several theatres of war.[130] With such a large organization and the need for staffing flexibility, it was essential for the RCAMC to have full control over their own personnel.

There were no legal restrictions on the title of Nursing Sister. When RCAF Matron Jean Porteous inquired of the Canadian Nurses Association, if Occupational Therapists and Physiotherapy Aides could be called Nursing Sisters, General Secretary Kathleen Ellis replied that there was no objection to them having the same title because it was not a civilian title and "it only concerned the military."[131] There has been little or no research on these occupational groups who also carried the title of Nursing Sisters. The RCAMC was the only service to clearly

document their presence in their summary postwar statistics: 64 Dieticians, 64 Occupational Therapists, 58 Home Sisters, and 104 Physiotherapist Aides (Table 1.7).[132]

TABLE 1.7. SECOND WORLD WAR NURSING SISTERS, BY OCCUPATION AND SERVICE, NSD (N = 1145)

Occupational Category	Service	Number of Nursing Sisters
Dieticians	RCAMC	21
Dieticians	RCN	1
Home Sisters	RCAMC	22
Occupational Therapists	RCAMC	15
Physiotherapy Aides	RCAMC	33
Physiotherapy Aides	RCN	1
Registered Nurses	RCAF	18
Registered Nurses	RCAF, SAMNS	1
Registered Nurses	RCAMC	964
Registered Nurses	RCAMC and RCAF	2
Registered Nurses	RCAMC and SAMNS	27
Registered Nurses	RCN	21
Registered Nurses	SAMNS	19

The inclusion of non-nurses in the Nursing Sister rank proved problematic, however, when the public could not distinguish professional status clearly, as happened during air raids in England. In another incident at the *HMCS Niobe* in Scotland, unit policy required one RCN Dietician to take her turn "on call" for emergencies at night. As NS Elizabeth Dean said:

> So I was put on call, too. I said, "Well, that's fine. I can go down and make a cup of coffee or do something like that." And the first time I was on call, a couple of Navy ratings . . . had had a real fight in a bar. And one of them was shot. So my kitchen became a morgue. And the others had to be surgically looked after and the matron decided, "Well, I don't think Elizabeth should go on call because she is not much use." Well my kitchen was used![133]

While Table 1.7 illustrates the distribution of Nursing Sisters and nurses among the four military nursing services according to various secondary and primary sources, Table 1.8 illustrates the distribution of nurses by service within the NSD and suggests that the statistics

generally reported in the existing literature overestimate the number of nurses who served during the Second World War. Analysts typically neglect to examine the data as a whole, and they miss the impact of multiple enlistments and re-mustering to other services when relying simply on the number of enlistments tallied through monthly and annual reports. In the NSD, for example, 2.9% of the nurses served in more than one branch during the war. In a second example, the official list of SAMNS nurses indicates that at least 69 of the 302 Nursing Sisters (22.8%) served in one of the other Canadian military nursing services as well.[134]

TABLE 1.8. DISTRIBUTION OF NURSES WITHIN THE CANADIAN ARMED FORCES NURSING SERVICES, NSD (N = 1052)

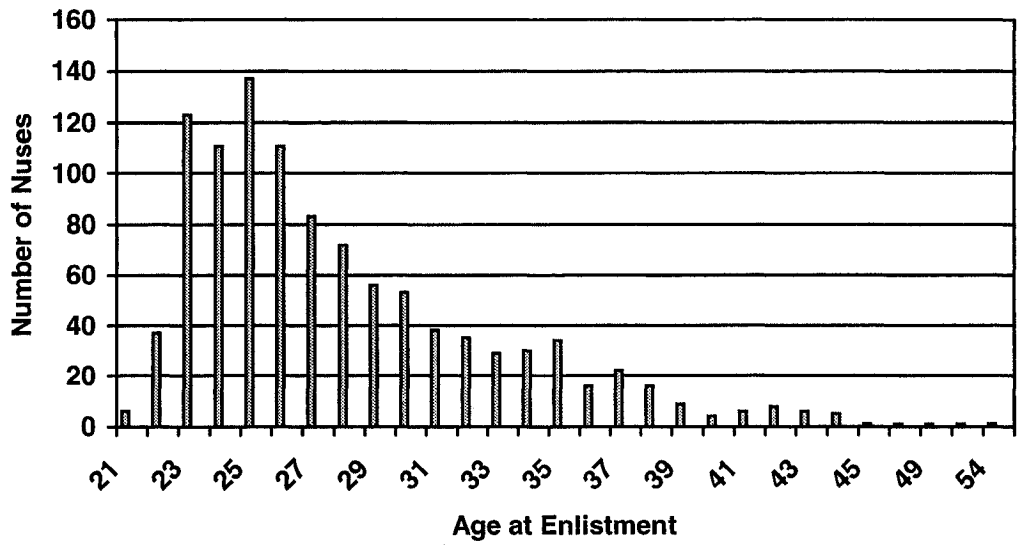
	RCAMC	RCAMC and SAMNS	SAMNS	RCN	RCAF	RCAF and SAMNS	RCAMC and RCAF
Number of Nurses	964	27	19	21	18	1	2
Percentage	91.6	2.6	1.8	2.0	1.7	0.1	0.2

Initial eligibility criteria required Nursing Sisters to be 25-45 years of age for the non-permanent forces although the minimum was lowered to 23 years in May 1942, and to 21 years in September 1943. The upper limit increased to 55 years during the same period.[135] In addition, Nursing Sisters were supposed to be at least 25 years old in order to go overseas, but that was also dropped, to 23 years. With an abundance of nurse applicants, the armed forces could afford to be selective and they were particularly interested in experienced nurses with teaching and supervisory abilities—characteristics that were not necessarily well-developed yet in new graduates but present in nurses who had been in practice longer.

The military anticipated the need for a much larger nursing service, as plans developed during 1943 for a massive European invasion. There were now sufficient experienced nurses in place that younger nurses could be accepted as reinforcements to established units where they could be mentored in military nursing roles. As a result, the average age shifted downward after 1943. Before 1943, only 0.9% of them were 21-22 years old at enlistment while after 1943, 3.6% of the nurses were 21-22 years old. Prior to 1943, 9% of the nurses were over the age of 35 and

overall, 3.2% of them were at least 40 years old. The two oldest nurses were 52 and 54 years old respectively (Figure 1).

Figure 1. Distribution of Second World War Canadian Military Nurses by Age at Enlistment, based on the NSD (N = 1028)



NS Pauline Lamont recalled that she enlisted on her twenty-third birthday[136] while NS Ella Beardmore described how she applied to enlist every time she went to Toronto, with the same response that she was too young, until she finally got a phone call of acceptance.[137] NS Doris Taylor was also among the younger nurses when she enlisted in October 1943. She remembered her first meeting with Matron Kennedy-Reid, who had returned from Italy to become the Matron of No. 23 Canadian General Hospital where Taylor was posted: "[E]verybody was so much younger. That's the first thing that she mentioned. . . . But you needed to be pretty strong to go through all that. This is one thing about war. People don't know--when you're young . . . because they think, 'well, this is going to be a big lark.' They don't really know."[138]

The nurses tended to be older on average than the Dieticians, Physiotherapist Aides and Occupational Therapists, but younger than the Home Sisters (Table 1.9). This can be understood in the context of their professional training requirements. Nursing schools generally required

applicants to be at least 18-19 years old with junior matriculation as the minimum education for admission and training programs extended over three full years.[139] In addition, the armed forces preferred a minimum of two years experience post-graduation. Finally, many nurses took post-graduate courses to enhance their applications and these courses often extended from six to twelve months in length. The youngest age at which most nurses could acquire full credentials was 21-22 while those with post-graduate courses and the requisite experience were typically 23-25 years old. But given the abundance of applicants, the armed forces could opt for even more experienced nurses resulting in a higher average age.

TABLE 1.9. SECOND WORLD WAR CANADIAN NURSING SISTERS BY OCCUPATION AND AVERAGE AGE ON ENLISTMENT, NSD (N = 1145)

Occupation	Number	Average Age on Enlistment	Minimum Age on Enlistment	Maximum Age on Enlistment	Standard Deviation
Registered Nurses	1052	28.03	21	54	5.02
Physiotherapist Aides	34	26.08	20	42	6.07
Dieticians	22	26.95	22	36	4.23
Home Sisters	22	33.04	25	45	5.66
Occupational Therapists	15	23.26	19	32	3.59

In contrast, Physiotherapist Aides and Occupational Therapists became eligible for university programs at a younger age than nursing students could enroll in training programs, and they had no comparable experience requirements placed on them before enlistment. Some of these women completed the internship component of their training as part of their military service. They enlisted, therefore, at a younger age than nurses who had to be fully qualified with two years of additional experience after graduation, with some exceptions.

Nurses in their late forties and early fifties brought many years of experience to the nursing service—including previous war experience, as was the case with the two oldest women who had served as Nursing Sisters during World War I. Diversity in practice settings and roles,

both in Canada and overseas, accommodated a wide range of ages. Analysis of age, according to the NSD, indicates that these military nurses (40.8%) were born during World War I, trained during the Depression (between 1933 and 1937), and graduated into the nursing workforce at one of the worst employment periods (between 1936 and 1939). As children of the First World War, this generation of nurses had lost one or both parents, likely due either to the war or to the Influenza Epidemics (1918-1919). More than 30% of them reported the death of one or both parents while 8.5% of them indicated that they supported dependent relatives—parent(s), sibling(s), or relative(s) who had raised them in lieu of parents (Table 1.10).

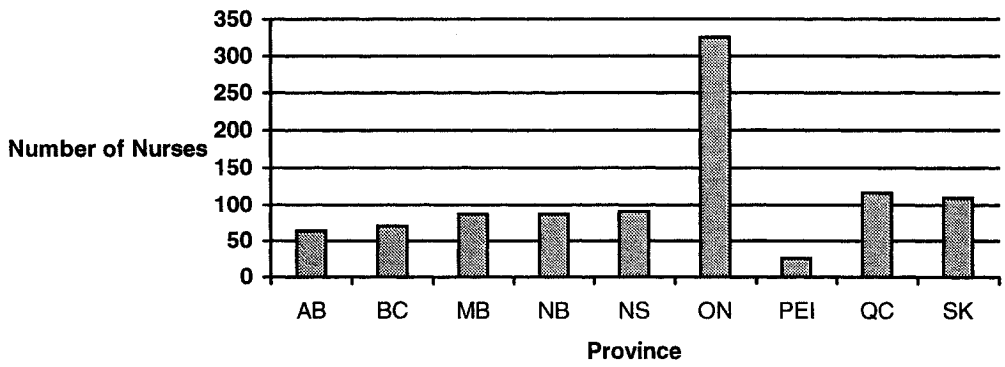
TABLE 1.10. PARENTAL DEATHS AND DEPENDENT SUPPORT PROVIDED BY SECOND WORLD WAR CANADIAN MILITARY NURSES, NSD (N = 1052)[140]

Deaths	Number	Percent of NSD	Number Supporting Dependents	Percent Supporting a Dependent	Average Amount Contributed for Support per Month
Father	166	15.8%	1	0.1%	$20.00
Mother	68	6.5%	12	1.1%	$27.88
Both	83	7.9%	71	6.7%	$34.27
Total	317	30.1%			
			Sibling(s) 2	0.2%	$30.00
			Undesignated 3		$30.00
			Total 89	8.5%	

These nurses needed to work—not simply 'to fill a gap' between school leaving and marriage, but for personal survival and to meet family commitments. The range of support varied from $5.00 to $90.00 with an average of approximately $30.00 per month, according to the personnel records. This must be evaluated in comparison to average civilian nursing salaries during the 1930s. In spite of the recommendations made by both the Weir Report and the Canadian Nurses Association, the Depression had exerted downward pressure on nurses' salaries. The need to support dependents constituted a significant commitment for nurses—one that a regular military nursing salary of $150 per month plus food, lodging, clothing, and medical care made easier.

Nurses welcomed the opportunities available in the military, but the nursing profession and hospitals were equally concerned about civilian needs for nursing care. Articles in the *Canadian Nurse,* as well as studies by the Canadian Hospital Council and the Canadian Nurses Association continually expressed a dual obligation both to support the war effort, and to 'stabilize nursing services' at home. While district military officers did not consistently use available resources, such as the Emergency List supplied by the civilian profession, there were quotas for each military district in the attempt to equalize losses to civilian hospitals. Quotas were proportional to the provincial population and nursing needs, but they failed to recognize that a large portion of nurses trained in hospitals outside of their home provinces, and that they often registered in those provinces as well as in their home communities after graduation. Nurses could, therefore, apply to the armed forces in more than one geographic area. Figures 2 and 3 illustrate differences between nurses' province of origin and their place of enlistment.

Figure 2. Second World War Canadian Military Nurses, by Birth Province, according to the NSD (N= 974)



More nurses enlisted in the provinces of British Columbia, Ontario, and Québec, partially because they graduated from large and well-known training schools in Vancouver, Toronto, and Montreal. Nurses frequently wrote their registration exams in the province where they trained, and since registration in a provincial association was required for enlistment, they could then apply to the military in that same province. Nurses did, however, register in several provinces to

enhance their employment opportunities, as well as their enlistment possibilities with multiple applications in provinces where quotas were not yet filled.

Ontario-born nurses (31%) comprised the largest proportion of military nurses by far, with Saskatchewan-born nurses (10.4%) nearly equaling the proportion of Québec-born nurses (11%) as the second largest group. By province of enlistment, Ontario nurses comprised the largest group again (35.6%) with Québec nurses (16.7%) as the second largest group. The Maritime and Prairie regions, with the exception of Alberta, had substantially higher percentages of enlisted nurses overall (4.5 to 9.9%), partially reflecting regional economic disparities.

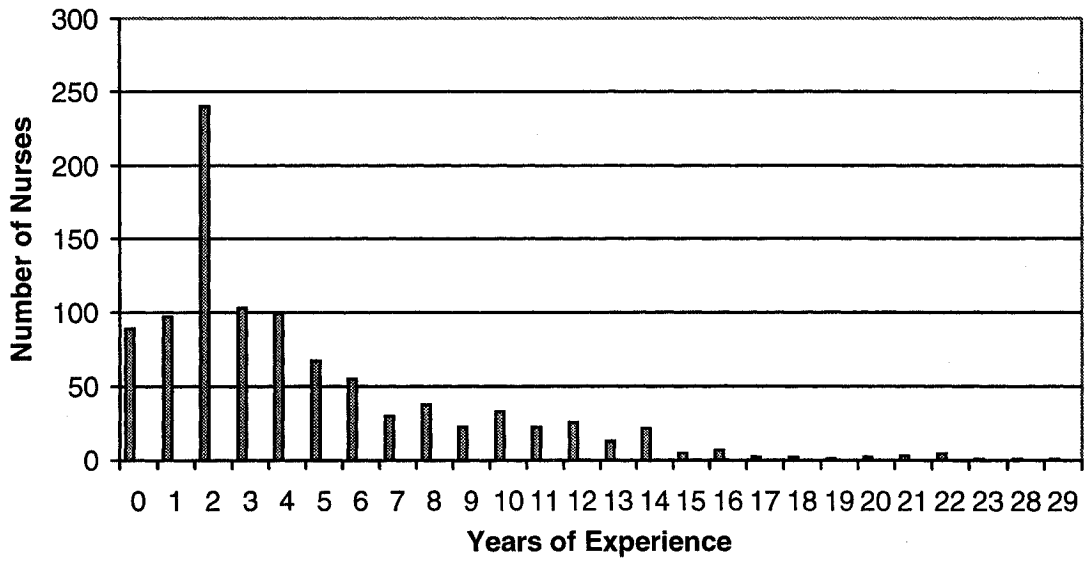
Figure 3. Second World War Canadian Military Nurses, by Place of Enlistment, according to the NSD (N = 1049)



Although the armed forces required at least two years of experience initially, some nurses evaded this restriction either by personal influence or because the military needed a particular set of skills. The majority of nurses, however, brought a wide range of experience--from none, in the case of nurses who enrolled as reinforcements towards the end of the war, to 29 years of experience that included teaching, supervision, and administration of hospitals. Nurses had an average of 4.7 years experience, according to the NSD (Figure 4). When younger nurses

became eligible after 1944, the level of experience also dropped substantially. Few of these nurses had any post-graduate courses, and 24% of them had less than the minimum two years of experience post-graduation. At the other end of the range, 13.6% of the military nurses had ten or more years of experience.

Figure 4. Second World War Canadian Military Nurses, by Years of Experience, according to the NSD (N = 988)



The vast majority of post-graduate nurses reported experience in both private duty and general duty nursing--areas of work that were similar. Nurses preferred private practice, but they needed to take cases both in the home, and in the hospital, where they 'specialed' patients too complex or unstable for the student nurse workforce to manage, as well as wealthy patients who could afford to hire a private nurse for hospital care, creating a two-tiered health care system. Indeed, hospitals hired relatively few graduate nurses to work as teachers, supervisors, and administrators for the large cadres of student nurses. At least 80.4% of the nurses in the NSD engaged in general duty and private duty nursing, to some extent. Patterns indicate that nurses were already a flexible workforce that shifted between practice settings and specialty areas—

wherever work could be found. The boundaries were relatively fluid and, except for public health, nurses required little additional preparation (Table 1.11).

TABLE 1.11. SECOND WORLD WAR CANADIAN MILITARY NURSES, BY EXPERIENCE PRIOR TO ENLISTMENT, NSD (N = 1052). [141]

Type of Experience	Number of Nurses	Percent
General Duty Nursing	235	22.3
General Duty Nursing and Private Duty Nursing combined	106	10.1
General Duty Nursing combined with other nursing except for Private Duty	555	52.8
Private Duty Nursing	185	17.6
Private Duty Nursing combined with other nursing	253	24.0
Public Health Nursing	16	1.5
Public Health Nursing combined with other nursing	52	4.9
Operating Room Nursing	18	1.7
Operating Room Nursing combined with other nursing	130	12.4
Psychiatric or Mental Nursing	18	1.7
Teaching (as Nursing Instructor)	2	0.2
Teaching combined with other nursing	29	2.8
Supervising	20	1.9
Supervising combined with other nursing	180	17.1
X-ray technician	17	1.6
Previous military nursing (with the SAMNS or during the First World War)	17	1.6

Nurses used additional formal education as well as post-graduate work experiences to enhance their chances for selection as Nursing Sisters. NSD data indicate that many nurses were life-long learners. Not only did they bring diverse educational backgrounds into training, but they also pursued "post-graduate" courses in specialty areas following the completion of basic training. McPherson suggests that the profession capitalized on a trend for more girls to complete high school education during the 1930s. As nursing programs increased the minimum

age for entry, young women used this interim period between leaving high school and the start of training to develop a variety of work skills.[142] In his study on the making of a Canadian middle-class through educational strategies, Paul Axelrod also found a small proportion of nurses (1.1%) among other university students in 1935 who "quietly endured a Depression economy, hoping to use their education as an instrument of survival," and armed themselves with "credentials expected to pay rewarding dividends at some point."[143]

Nurses of this period used a variety of educational paths to build career ladders. For many Nursing Sisters, secretarial courses paved the way for teaching certificates that in turn, covered the expenses associated with nurse training programs during the Depression, when both clerical and teaching jobs were increasingly reserved for men. Nursing was a 'safe' and socially-acceptable field of employment for women--with little competition from men. Successful completion of other educational programs was viewed as an asset when applying to a school of nursing. A surprising number of nurses in the NSD (6.2%) had Teaching Certificates and teaching experience prior to entering nurses' training (Table 1.12). Veronica Strong-Boag notes the importance of courses for working and middle class women during the 1930s. Business colleges and courses were well-established in the early 1900s, and by 1920, women had access to readily available, and overwhelmingly female, courses in typing, shorthand, stenography, and bookkeeping.[144] Business courses and teaching certificates provided good backgrounds for myriad education, supervisory, and administrative roles that frequently became part of graduate nurses' responsibilities.

TABLE 1.12. SECOND WORLD WAR CANADIAN MILITARY NURSES, BY ADDITIONAL PRE-NURSING EDUCATION, NSD (N = 1052)			
Type of course	Subject Area	Number	Percent
Business, Commercial, or Secretarial	Stenography, Typing, Accounting	81	7.7
Post-graduate courses (certificate programs, 3-12 months in length)	Operating Room Technique, Teaching, Supervision, Obstetrics, Pediatrics, Dietetics, Tuberculosis Nursing, Industrial Nursing, Public Health Nursing, Mental Nursing	238	22.6
Teachers' College	Public School Teaching	65	6.2
Agriculture College	Household, Home Economics	3	0.3
University courses	Non-degree, general arts or science	18	1.8
University, degree	Bachelor of Arts	10	1.0
University, degree	Bachelor of Science (including 1 Bachelor of Science in Nursing)	14	1.3
Note: At least 37 nurses completed more than one type of course after nurses' training and 394 or 37.5% reported having completed at least one additional formal education credential.			

It was also a common practice for nurses to take post-graduate courses after the completion of their basic training—not only to gain additional skills, but also to consolidate recently-acquired skills and knowledge.[145] Courses in Operating Room Technique, Obstetrics, Pediatrics, Tuberculosis Nursing, Industrial Nursing, Mental Nursing, and Dietetics supplemented basic training and created a more flexible, more experienced workforce. Larger teaching hospitals, such as the Montreal General, the Toronto General as well as the Montreal Neurological Institute for mental nursing, typically offered these courses which consisted of three to twelve months of specialized training. Teaching, Supervision, and Public Health Nursing were typically "post-graduate," certificate (one-year) and diploma (two-year) programs available at several universities, such as the University of Toronto, McGill University, or the University of British Columbia. This trend toward increased post-graduate education escalated during the war, once hospitals perceived a nursing shortage in specialized areas, and the government demonstrated a willingness to fund these post-graduate courses in a major way, as I will demonstrate.

One conspicuous, although not surprising, characteristic of the Nursing Sister population was its exclusive gender construction. Canadian modern nursing had been stereotyped as "women's work" since at least the 1880s, and the entire Second World War military nurse population was female. As one, undated recruitment brochure from the Canadian Nurses Association summarized: "You will not, as in other professions or business, be handicapped by having to compete with men for top positions—nursing is a woman's profession, and women hold top positions."[146] Few men challenged that convention during the 1920s and 1930s (as both McPherson and Weir noted).[147] By 1940, the Ontario Hospital at Hamilton conducted a training course for male nurses that included an affiliation at the Toronto General Hospital, and other Ontario Hospital sites followed suit--enrolling a total of 40 male students on four sites.[148] The 1941 Canadian Census reported 153 male nurses and 73 male student nurses,[149] but no males served in the armed forces Nursing Services until 1967, due to a military policy that prohibited male nurses.[150] NS Estelle Tritt confirmed the absence of males in the nursing service although she had a ward master at No. 7 CGH who was a trained nurse and had been denied rank.[151] Author Stanley Richards pointed out that some male nurses enlisted in the RCN early in the war and served as Sick Berth Attendants (SBAs) on naval ships.[152] But services as a SBA was not the equivalent of serving as a professional nurse, nor did it carry the rank and status granted to Nursing Sisters. When the RCN Nursing Service was formed in 1941, it was an all-female organization just as the other armed forces nursing services were.

Apprenticeship training reinforced nursing as women's work, since hospital schools of nursing only admitted women to their programs, with few exceptions such as the Victoria General Hospital in Halifax, Nova Scotia and psychiatric hospitals in Alberta and Ontario.[153] Hospital schools required student nurses, and graduate nurses who were hospital employees, to live in residence. Even when men gained access to these training programs and were registered in Alberta and Ontario, registration could still be denied to them in other provinces, as happened with the Association of Nurses of the Province of Québec prior to December 1969.[154] Without provincial registration, nurses could not join the military.

Initially, Nursing Sisters were also unmarried or widowed without children as set out in the *King's Regulations and Orders for the Canadian Militia, 1939.* They had to sign an 'undertaking' on enrollment that they would not request permission to marry within their first year of service. This undertaking also stated that, should a nurse marry while overseas, "I acknowledge that I relinquish all claims, if any, which I may have to be returned to Canada at the public expense, and undertake to make no claim for transportation pertaining to such return." In addition, nurses could not marry without permission of their commanding officer and they had to resign their commissions on marriage.[155] Table 1.13 illustrates the marital status of nurses, on and during enlistment, according to the NSD. This data is corroborated by the official RCAMC statistical summary that reported 83.4% of the Nursing Sisters as single, 0.3% as married, 1.0% as widowed, 0.1% as divorced, and 15.1% as having married in the service.[156]

TABLE 1.13. SECOND WORLD WAR MILITARY NURSES, BY MARITAL STATUS, NSD (N = 1052)

Marital Status	Number	Percent
Single	876	83.3%
Divorced	2	0.2%
Married prior to enlistment	3	0.3%
Widowed	8	0.8%
Married, widowed, and re-married while enlisted	1	0.1%
Widowed, re-married, and divorced	1	0.1%
Married during period of service	161	15.3%
TOTAL	1052	

The marriage bar caused a great deal of consternation and discussion between 1939 and the changes made during 1943. Schools of nursing admitted only unmarried or widowed women and in civilian practice, graduate nurses who married were expected to resign their positions as well.[157] Thus the armed forces' policy was consistent with social expectations and all three service branches developed the same regulations. As the need for nurses increased and the war

continued, however, the obligatory resignation upon marriage became both unenforceable and problematic. One nurse signed the undertaking in June 1942, and requested permission to marry only four months later. When permission was denied, the nurse married without permission, and only informed her commanding officer two days after the marriage.[158] Marriage without permission carried the possibility of court martial, as well as the loss of benefits such as medals, war gratuities, and educational credits. Only intervention by Matron-in-chief Smellie prevented these serious steps from taking place in this particular case.

With an abundance of nurses on the waiting list, there was little incentive to alter the marriage policy during the first years of the war. According to RCAMC statistics, Nursing Sisters were being discharged at an increasing rate, primarily as resignations for the purpose of marriage: two in 1939; twenty-five in 1940; fifty in 1941; and seventy-four in 1942. In January 1943, Matron-in-Chief Smellie wrote a memo that stated: "[A]ppointments of Nursing Sisters are not now automatically relinquished on marriage and the Nursing Sister would have to request her discharge if desired."[159] In 1943, RCAMC discharges stabilized at sixty-two as more married nurses chose to remain in service. Table 1.14 illustrates the low rate of marriage during the first four years of war and the results of marriage policy changes in 1943. Three cases exemplify how these changes in marriage policies affected individual nurses. One nurse married in 1922, divorced, re-married in 1938, and became a widow prior to enlisting. Another married in 1942 and was forced to resign due to the current policy on marriage. When she became a widow, she re-enlisted and re-married in 1944. Her military career was interrupted but restored when widowed. A third nurse married after the policy change. She chose to remain in the service, where she became a widow and then, re-married in 1944.

TABLE 1.14. SECOND WORLD WAR CANADIAN MILITARY NURSES, BY YEAR OF MARRIAGE, NSD (N = 1052)		
Date of Marriage	Number of Nurses	Percent
1939	0	0%
1940	0	0%
1941	3	0.3%
1942	3	0.3%
1943	31	2.9%
1944	39	3.7%
1945	57	5.4%
1946	3	0.3%
1922 and 1938	1	0.1%
1942 and 1944	1	0.1%
1943 and 1944	1	0.1%
No date indicated	22	2.1%
Total	161	15.3%

Married nurses presented additional problems because of their repeated requests for postings near spouses, and because of pregnancies that required them to be 'boarded out' of the service. The Director Medical Services (Air) summed up his opinions in a 1943 memo: "Nursing Sisters rarely give as wholehearted service to the RCAF following marriage for the reason that their interests have changed and they naturally would prefer to live with their husbands." He went so far as to document the changes in attrition rates after marriage with statistics.[160]

The armed forces were losing experienced military nurses just at the time when plans were developing for two major offensive campaigns in 1943 and 1944. The problem was discussed at a Matrons' Conference in Ottawa during May 1943. Matron-in-Chief Smellie reiterated that although married nurses were not being admitted to the forces, if nurses married after enlistment, they would now have the option of remaining in the service as long as they were "medically fit" (read not pregnant) or the option of retiring 'on compassionate grounds' upon marriage.[161] In July 1943, a Department of National Defence Memorandum noted that "if nurses

coming into the service feel that they must refrain from marriage during their service, very few nurses of the proper age could be induced to enter the Army, and one year "undertaking not to marry" was all that [could be] demanded of them."[162] Other policies governed married nurses overseas in such a manner that marriage became a career limiting move.[163] In general, nurses delayed marriage until the end of the war was in sight, or until they had little to lose in terms of nursing opportunities. Only 0.6% of the military nurses married prior to 1943, with an additional 2.9% marrying during 1943 and 9.4% marrying between 1944 and 1946. By the end of the war, at least 15.3% had married (Table 2.13).

The Canadian Nursing Sisters were a greatly homogeneous group in relation to race, ethnicity, origin, religion, and language. There are various challenges associated with discussions of race and ethnicity as socially-constructed and historically-situated concepts. One issue concerns the use of ostensibly objective data such as census information and attestation papers, versus self-identification with racial or ethnic groups. A second issue relates to what was at stake in claiming racial or ethnic origins. Membership in particular groups often carried contested meanings, and could work for, or against, the individual. Decisions to disclose one's ethnic origins or one's ability to speak a non-dominant language assured social acceptance through an emphasis on "sameness" with the dominant group, or conversely, to highlight "difference" as an asset to the military system. For example, based on the NSD sources, some nurses spoke German or Ukrainian, and identified their ethnicity as such, while other nurses avoided ethnic identification through the use of the term "Canadian" although there was no official Canadian citizenship status until 1947.

A third issue involves how to determine race or ethnicity. Author Constance Backhouse provides an excellent analysis of the complexity of race. Her research demonstrates the difficulty in determining what constitutes racial identity and how it changes over time and in different contexts as well as the difficulty of purity and degree (or how much of what changes the designation).[164] Backhouse used census classifications and legal case studies that called race into question in particular ways, noting that the 1901 census asked for Canadians to indicate their

"race" while the 1951 census asked about "origins" instead. Around the 1930s, anthropologists began to dismantle the construct of race and to use ethnicity as a "better concept to explain differences by social, political, economic, and geographic factors than by biology." [165] Backhouse concludes that race was a valid categorization in Canada although, "certain groups might move in and out of specific racial groupings, depending on a multiplicity of factors such as class, geographic location, language, behaviour, culture, or physical attributes." What remained glaringly constant, she concludes, was the continued utilization of race as a "phenomenon to differentiate some people from others."[166] Race functioned as an explanatory variable of difference supporting inequitable distribution of resources, status, and power over others. Indeed, it is clear in the NSD that access to the nursing profession, and therefore to military nursing, was racially restricted.

Historian John Herd Thompson argues that place of birth is an excellent indicator of ethnicity, and that the 1921 Canadian census data demonstrated only two main divisions in Canada: the Canadian and British-born, and the real foreigners who were designated as "Born in Other Foreign Countries".[167] In order to study race and ethnicity, I combined information from the attestation papers related to place of birth, citizenship, language, and religion—since no one category adequately represented these concepts. There were at least two versions of the attestation form, with slight variations and occasional information gaps. According to the NSD, all nurses claimed either "Canadian" or British citizenship—an essential criterion for military service. Examination by place of birth, parents' place of birth and/or citizenship, religion, and spoken languages, however, reveals greater diversity (Tables 1.15, 1.16, 1.17, and 1.18). Missing ethnic groups provide as much or more important information as those that are represented, revealing systemic bias against Black, Asian, and First Nations' women. The 1941 *Census* identified the racial origins, but not necessarily the birthplaces, of employed nurses as 72% British, 20.1% French, and the remaining 7.9% as German, Italian, Jews, Dutch, Polish, Russian, Scandinavian, Ukrainian, with only seven "Indians" and thirty Asians. There were no categories that represented Black nurses.[168]

Author Scott Sheffield has studied racism related to military recruitment policies and First Nations men during the war. Although I found no First Nations nurses in my research, Sheffield's findings are important for understanding different ways in which military policies could discriminate. Initially, recruitment policies were explicitly racist in that personnel had to be of "pure European descent and of the White Race" for the RCN and similarly, of pure European descent with parents who were British subjects for the RCAF and the Army.[169] By 1943, during the heart of the conscription crisis, the Committee of the Privy Council required the forces to accept persons of any racial origin. But there were still formidable barriers in the form of education requirements and health standards that First Nations peoples found difficult to meet. Apparently, the Army offered the best chance for acceptance but even there, decisions were made at the local and district level. According to Sheffield, "It should not be assumed that these policies were administered uniformly or that the Army was especially eager for First Nations recruits."[170] He points out that 75% of Native children completed only one to three grades of formal schooling during the 1930s and few ever achieved Junior Matriculation (completion of grade 12 in Ontario or grade 11 in the rest of Canada).[171] The lack of educational opportunities would certainly have prevented First Nations women from entering nurse training programs, even though these programs were less blatantly discriminatory.

Analysis of military nurses' place of birth indicates that the vast majority (92.6%) were born in Canada while an additional 4.7% were born in Britain and immigrated as children with their families (Table 1.15). The remainder were born in Europe (Belgium, Denmark, Sweden, Italy, and Czechoslovakia), South America (Argentina and Peru), Asia (in China as missionaries' children), Russia, and South Africa.

TABLE 1.15. SECOND WORLD WAR CANADIAN MILITARY NURSES, PLACE OF BIRTH, NSD (N = 1052)		
COUNTRY	NUMBER OF NURSES	PERCENT
Argentina	1	0.1%
Belgium	1	0.1%
Canada (Alberta)	63	6.0%
Canada (British Columbia)	70	6.7%
Canada (Manitoba)	87	8.3%
Canada (New Brunswick)	87	8.3%
Canada (Nova Scotia)	90	8.6%
Canada (Ontario)	326	31.0%
Canada (Prince Edward Island)	26	2.5%
Canada (Québec)	116	11.0%
Canada (Saskatchewan)	109	10.4%
TOTAL BORN IN CANADA	974	92.6%
China	1	0.1%
Czechoslovakia	1	0.1%
Denmark	1	0.1%
England	31	2.9%
Ireland	4	0.4%
Italy	1	0.1%
Newfoundland	7	0.7%
Peru	1	0.1%
Russia	1	0.1%
Scotland	14	1.3%
South Africa	1	0.1%
Sweden	3	0.3%
USA	9	0.9%
Wales	1	0.1%

Nurses' birthplace may obscure a level of ethnicity that becomes more apparent with the examination of parental birthplaces (Table 1.16). Since one of the attestation forms did not request information on parents' birthplace, 558 records in the NSD (53%) did not provide it. Analysis of the 494 records (47%) that did provide this information indicates that only 60.7% of the fathers and 63.8% of the mothers were Canadian-born while an additional 22.5% of fathers and 20.4% of mothers were born in Britain. Thus, many Nursing Sisters had very strong British

ties and at least 40% were first-generation Canadians. In 1940, Ethel Johns wrote in the *Canadian Nurse* about both professional roots and personal roots, ignoring the French-Canadian nursing heritage altogether: "Although we Canadian nurses have distinct and vigorous characteristics of our own, our roots go deep into the rich soil of British tradition. The simplicity, the thoroughness, the devotion of the nurses in the Old Country are [sic] a continuing inspiration to us. This is the shining armour with which we may clothe ourselves in the day of battle."[172]

TABLE 1.16. SECOND WORLD WAR CANADIAN MILITARY NURSES, BY PARENTS' PLACE OF BIRTH, NSD (N = 494)

Father's Birthplace	Number Of Nurses	Mother's Birthplace	Number Of Nurses
Austria	4	Austria	3
Belgium	1	Belgium	1
British	6	British	7
Bulgaria	1	Canada	315
Canada	300	Czechoslovakia	3
Czechoslovakia	3	Denmark	1
Denmark	1	England	54
England	70	Finland	1
Finland	1	Germany	2
Germany	4	Holland	1
Iceland	3	Iceland	2
Ireland	18	Ireland	16
Italy	2	Italy	1
Lebanon	1	Lebanon	2
Martyniuk, S. America	1	New Zealand	1
Newfoundland	3	Newfoundland	3
Norway	3	Norway	2
Not indicated	558	Not indicated	558
Poland	4	Poland	4
Russia	7	Russia	6
Scotland	33	Scotland	40
Sweden	6	South America	1
Ukraine	2	Sweden	6
USA	18	Ukraine	2
Wales	2	USA	20

While not adequate alone to explain the strong Anglo-bias within the Nursing Sister population, familial connections to Britain partially explain the difference in volunteer rates compared to French Canadian nurses and to American nurses. Other factors must also be considered, such as the dominant language of operation within the medical units, and the question of professional reciprocity for nurses. The armed forces medical units operated predominantly in English at that time. Plans for completely francophone units did not materialize and as several nurses pointed out, francophone Nursing Sisters were typically posted to Kingston for language training quite soon after enlistment.[173] NS Gaëtane LaBonté was a French-Canadian Nursing Sister who stated that she enlisted "quickly while my parents were away for the summer. When they came back, it was 'fait accompli." LaBonté and her francophone nurse colleagues were sent immediately to Kingston for two months of military and English language training. "It was very hard for us who spoke English in a limited way . . . . The nurses would give the lectures and they would stop. And then one of us would translate to make sure."[174] Her unit was mobilized quickly for overseas because they wanted a French-speaking hospital to go to France. But France fell to Germany and the unit spent the next 2.5 years waiting in England where "We thought the worst was over, as we had been transplanted very suddenly from our cosy [sic] French milieu to a completely different world in English. . . . I was soon called 'All Wet' because [the Matron] would order me to sing that thing of a song that my generation never sang: *Allouette*." [175]

Initially, it was not clear whether Québec-trained nurses had registration reciprocity in Great Britain, since their professional association maintained a separate but associative relationship with the Canadian Nurses Association. Frances Upton reported in 1942 that "reciprocity has been established between our organization and the General Nursing Council for England and Wales, a fact we have hoped for many a long day."[176] Whether or not this delay actually deterred French Canadian nurses from enlisting is unclear, since the majority of military nurses from Québec were Anglophones who had trained in Montreal. French Canadians, in

general, were vehemently opposed to conscription during the First World War, and they accepted participation in this war only as necessary for home defense.[177]

Language may also serve as a potential indicator of ethnicity, as in the case of one nurse whose first language was Czechoslovakian. Only 0.3% of the nurses were unilingual Francophone while 85.5% were unilingual Anglophones; the rest were bilingual or trilingual with at least one of their languages as English (Table 1.17). Among the other languages spoken were: Danish, Dutch, Finnish, German, Icelandic, Italian, Norwegian, Polish, Russian, Slovak, Spanish, Swedish, Ukrainian, Arabic, Chinese, Flemish, and Czechoslovakian. I eliminated nurses that indicated 'some,' or 'a little' French, or 'reads French only' from this analysis because I was interested in language as a marker of ethnicity. It is also important to note that language ability was not tested, and that information on these forms was self-reported only. How nurses responded was likely contingent on what was at stake personally.

TABLE 1.17. SECOND WORLD WAR CANADIAN MILITARY NURSES BY LANGUAGE, NSD (N = 1052)

LANGUAGE(S)	NUMBER	PERCENT
English only	899	85.5%
English and another language (excluding French)	28	2.7%
Total non-French speaking	927	88.1%
French only	3	0.3%
English and French, or French and English	108	10.3%
English, French, and another language	14	1.3%
Total with bilingual capacity	122	11.5%

Religion is another variable with links to race and ethnicity (Table 1.18). Most military nurses were Protestant (77.9%) or Roman Catholic (20.8%). In spite of discriminatory training school admission practices, some Jewish women did acquire professional credentials and enlist in the armed forces (0.4%) as Nursing Sisters. NS Estelle Tritt had applied at the Montreal General Hospital School of Nursing, and was told that they didn't take Jewish nurses because "they get married too soon."[178] She re-applied successfully to the Women's General Hospital in

Westmount, and graduated in 1941. After working at the Jewish General Hospital to gain the required years of graduate experience, Tritt was accepted into the RCAMC. She mentioned several other Jewish friends who served with her, and made it clear that once they gained acceptance into nurses' training they perceived no further discrimination with the RCAMC.

TABLE 1.18. SECOND WORLD WAR CANADIAN MILITARY NURSES BY RELIGION, NSD (N = 1047)

RELIGION	NUMBER	PERCENT
Greek Orthodox	3	0.3%
Hebrew	4	0.4%
Not indicated	1	0.1%
Protestant	820	77.9%
Roman Catholic	219	20.8%
Total	1047	99.5%

Professional homogeneity needs to be understood, as well, in terms of the influence of class on the social construction of nursing. Although nurses came from both working-class and middle-class families, the nursing profession resembled other middle-class, female professions in relation to the educational requirements for admission and the length of training programs.[179] Nurse leaders pushed for professionalization from the beginning of the century by raising the minimum educational criteria for admission to training schools to Junior Matriculation by the early 1940s. At the same time, they fought for control over the accreditation of schools of nursing which enabled them to regulate both the length and content of training programs—assuring a measure of consistency and quality. These two strategies along with the rising social expectations of nurses necessarily limited the profession to women who could afford both the time and the expense of prolonged education since they typically could not fulfill the requirements until at least age twenty-three. These strategies also effectively structured class within the profession.

Like race and ethnicity, class is a socially constructed and historically-situated concept, making it especially challenging to determine what class was and what it meant in a particular

context. Recent scholarship typically considers class as one of several intersecting variables of difference. John Porter, Veronica Strong-Boag, and Kathryn McPherson have each problematized class as a category of analysis in ways that are relevant for this research. Porter's classic text on social class and power in Canada defines class as "a milieu within which one lives and from which one takes one's cues in almost all aspects of behaviour, but it is a milieu from which it is possible to escape and achieve some upward mobility."[180] He identified a lack of clear criteria and means to determine class as a major problem. Sociologists have used measurable indicators such as income, ownership of property, level of education, degree of occupational skill, and positions of responsibility or power. Subjective indicators have included occupational ranking by public opinion polls or ranking by prestige in lieu of wealth or power. The most commonly-used criteria, however, remain based on economics: income, property ownership, education, and occupational status involving levels of skill (professional, managerial, clerical, semi-skilled, unskilled, manual, or non-manual).[181]

A second major problem with class analysis is the lack of appropriate criteria that considers gender as a constituting variable. Porter suggested that women 'share' a family class position determined by the father's occupation.[182] Strong-Boag acknowledged this practice of shared class as sometimes useful but fundamentally imperfect—warning that "the terms 'working class' and 'middle class' should be regarded as a guide to the status and power of women's families rather than as a reliable measure of women's ability to command resources or to share in full the values of male capitalist society."[183] Nursing attracted women with both resources and the familial support necessary for an extended period of training—assets typically associated with middle class families.[184] McPherson argues that this gendered configuration of household resources was a more critical determinant of class than the position of the male head of household, demonstrating that nurses came from a range of class backgrounds: middle-class, working-class, and agricultural. They had a higher level of education on entering training (33% with 13 or more years of formal schooling) compared to other women workers (11%) and yet, working class women were still well represented, comprising 30% of the student population and

20% of the graduate nurses.[185] Regardless of myriad problems associated with using fathers' occupations as an indicator of class for women, I used this approach to examine the class origins of the Nursing Sisters. It is important to note, however, that these nurses were fully-qualified professionals. The majority had at least two years of experience prior to enlistment while at least 10.5% of them had either college or university education as well. Nurses were relatively privileged among other working women, and relatively well-paid in comparison to them, even though the Depression economy had left nurses barely able to live independently, as was the case also with teachers.

The Canadian *Census* provides one means to compare the class positions of Nursing Sisters with the general population of the same period. The background information for this census, however, acknowledged that occupational classification was problematic even in 1941.[186] Occupational data was grouped broadly into twelve main categories based on sectors of employment more than on social class indicators of relationship to the means of production. For example, seven of the twelve categories included owners, managers, and labourers within the same category: manufacturing, trade, construction, logging, mining and quarrying, personal service, and transportation and communication. Explanatory material also acknowledged that there was ambiguity in how work was reported, with a tendency for informants to overstate occupational status on the census schedules.

Personnel records asked if the soldier's father was living and if so, what his occupation was. This resulted in a data gap regarding occupation if the father was not living (as was the case for 23.7% of the nurses). A total of 43.2% of the records had data gaps regarding the father's occupation while another 6.8% stated the fathers were retired, incapacitated, in the military, or unemployed (with no other indication of previous employment)—leaving 526 files (50%) suitable for analysis. The form asked only if the 'soldier's mother' was living. Two of the 1052 nurses assertively wrote 'housewife' on the form although there was no follow-up question for mother's occupation—creating yet another data gap. This loss is regrettable in light of recent research which indicates that women's paid work and family economies were particularly

characteristic of working-class families.[187] Data from the oral history interviews reveal that at least 34.8% of these nurses' mothers worked prior to marriage while some also worked after marriage: one was a nurse, five were teachers, one was a grocery store clerk, and one was a supervisor in a crochet factory.

Acknowledging these limitations, I used the *Census* categories to examine and corroborate the occupations of NSD nurses' fathers (Table 1.19) with the occupation of parents as reported by the interviewed Nursing Sisters (Appendix 9). Weir had reported that approximately one-third of the nurses in the early 1930s had fathers who were farmers.[188] In spite of socio-economic disruptions of the 1930s, the class background of the Nursing Sisters remained remarkably stable, resembling both Weir's data and McPherson's analysis of the civilian nursing workforce during the 1930s.[189] Among the Nursing Sisters, 34.2% of fathers worked in farming, fishing, or ranching; 41.3% worked in professional, business, and clerical positions; 23.8% were in skilled, semi-skilled, and unskilled occupations; and 0.7% were men of independent means. Thus, almost one-quarter of the Nursing Sisters (23.8%) were from working-class families and three-quarters (75.5%) were from middle-class families. The oral history participants were less diverse, with almost 87% of them from middle-class families and 13% of them from working-class families (Appendix 9).

TABLE 1.19. SECOND WORLD WAR CANADIAN MILITARY NURSES: FATHERS' OCCUPATIONAL CLASSIFICATION, NSD (N = 526)

CATEGORY	NUMBER	PERCENT
Independent Means	4	0.7
Farming, Agriculture	180	34.2
Professional, Business, Clerical, Finance, Public Service, Managerial	217	41.3
Skilled, Semi-skilled, and Unskilled Labour	125	23.8
Total	526	100.0

The 1941 *Census* positioned nurses as professionals, in the same category with architects, authors, clergymen and priests, dentists, civil engineers, judges and magistrates,

lawyers, physicians and surgeons, professors, social workers, and teachers—regardless of their fathers' occupational status. Class in relation to nursing was, and still is, problematic because it intersected with gender, race, and ethnicity (among other variables) to privilege some nurses over others. But it did not always have predominance. 'Nurse' was not a universal category and nurses assumed a wide range of roles from hospital bedside care to administration offices, from independent practice in outposts to managing employee health programs in industries, from private duty and public health nursing to teaching courses in universities. As the NSD illustrates, Second World War Nursing Sisters came from both working- and middle-class backgrounds. They learned to use a variety of strategies to re-locate themselves as respectable, professional women—including education, expertise, and military officer status.

It is difficult to compare the Canadian military nurses with other military nursing services, since there is very little existing literature that has considered these nurses demographically. Reading the existing American, Australian, and British literature 'against the grain,' however, it is possible to glean some comparative insights. Approximately 52,000 American nurses served with the United States Army Nurse Corps during the Second World War, working in over 120 military hospitals in the United States and on more than 40 hospital ships.[190] Historian Mary Sarnecky described them as "young in years, and in the service."[191] Indeed, the Cadet Nurse Corps program reduced nurses' training from 36 to 30 months and students could spend the last six months of that training in federal hospitals—meeting a need for military nursing staff at home.[192] American nurses appear not only to have been younger than their Canadian counterparts, but they also do not appear to have had an equivalent level of post-graduate courses or graduate nursing experience. Sarnecky reports that there were no formal operating room courses until 1944, and that Army nurses became proficient primarily through 'on-the-job' training.[193] Elizabeth Norman wrote a popular account of ninety-nine nurses who became prisoners of war on the South Pacific island of Bataan. According to Norman, "most of the [nurses] had grown up on farms or in towns . . . . labored in the fields, made their own clothes, and read by lamplight, and they knew how to live lean, without amenities, and were accustomed

to hard work. The Army had given them luxuries and a new life, and now it was time to pay the Army back."[194]

Like the Canadian Nursing Sisters, American military nurses were all female and predominantly White, although Black nurses lobbied for, and finally gained, admittance to the Army on the verge of a conscription crisis when there were insufficient numbers of White nurses. According to Sarnecky, Black nurses were often assigned to less desirable cases, such as prisoners of war.[195] Enloe points out as well, that while Chinese-American women, Puerto Ricans, and Native Americans were assigned to racially integrated units, Japanese-Americans and Black nurses served in segregated units.[196] Black nurses were perceived to be less skilled and to be less tolerated by the general American public for the care of White soldiers until the bar was lifted in January 1945.

Australian military nurses appear to share some demographic resemblance to the Canadian Nursing Sisters, as described by historian Jan Bassett, who analyzed a small group of 122 Second World War Australian Army nurses.[197] There were a total of 3477 Australian Nursing Sisters, of whom 92.6% were Australian-born. They were predominantly Protestant (83.6%) with an average age of 28.5 years. Their ages ranged from 22-39, and was more narrow than the Canadian nurses' range. Approximately one-third of them were daughters of farmers while at least 22% were from working-class backgrounds. All were British subjects, and similar to the Canadian nurses, they had to be unmarried on enlistment and resign on marriage, until policy changes in 1942. Bassett did not address race, ethnicity, religion, education, or experience.

Juliet Piggott's classic history of the Queen Alexandra's Royal Army Nursing Corps provides a chronological narrative of British nursing history from Florence Nightingale and the Crimea to the 1970s, with a chapter on the Second World War.[198] Historian Penny Starns, used professionalization as her framework for a recent study of the British Second World War Nursing Sisters. And Nursing Sister Brenda McBryde's memoir is probably the best personal account of a British military nurse. While the McBryde account cannot be generalized to represent the whole of the QAIMNS, it does provide a remarkably detailed account of nurse training and military

nursing in terms of patient care. Each of these three accounts makes a contribution to knowledge of the larger international military nursing context which included the Canadian Nursing Sisters. But their lack of demographic analyses limits our ability to generalize from their specific accounts, to make comparisons between the nursing services of different nations, and to understand the perspectives of the thousands of rank-and-file nurses who made up the vast majority of the military nursing services.

Summary

Social, professional, technological, and military contexts of the 1930s positioned Canadian nurses as a readily-available, feminine workforce that volunteered in overwhelming numbers for the armed forces. Nurses had a great need for work. They were well-prepared with skills, education, and nursing experience which they used to enhance their applications for military service. With access to such a large pool of recruits, two main issues for the Canadian forces were: how to balance military needs with civilian needs for nursing, and which nurses to enlist.

In this chapter, I have examined a variety of influences which shaped military nursing and the Second World War as a strangely "happy" event for nurses—one that "saved" them from dire circumstances as women who needed to work, and provided them with the "strange privilege" of working midst pain, fear, and bloodshed. The NSD that I constructed for this thesis, allowed me to examine multiple variables that influenced who became Nursing Sisters. By relying on the civilian profession to train and deliver nurses to them, the military relieved itself of burdensome tasks and costs associated with credentialing women, especially when it was only for the duration of the war. Although well-prepared as civilian nurses, the Nursing Sisters had never encountered the type of casualties or the working conditions associated with war. In addition, as the war evolved, military nursing practice had to evolve and different decisions were made as to how to incorporate nurses into the armed forces, as the next chapter will examine.

Endnotes

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[1] As Beth Light and Ruth Pierson pointed out, women were even less protected against the effects of the Depression because the government focused on relief measures for jobless males. Yet most single women supported dependent relatives, in addition to themselves. See *No Easy Road: Women in Canada, 1920s to 1960s* (Toronto: New Hogtown Press, 1990): 16 and 149-150. Paul Axelrod also noted differential effects on men and women in *Making a Middle Class: Student Life in English Canada during the Thirties* (Montreal & Kingston: McGill-Queen's University Press, 1990): 156-157. Children and young adults had different experiences based on class, gender, and region but race and ethnicity altered this experience even further. See also: W. Peter Ward, *White Canada Forever: Popular Attitudes and Public Policy Toward Orientals in British Columbia* (Montreal: McGill-Queen's University Press, 1978; Donald Avery, *"Dangerous Foreigners": European Immigrant Workers and Labour Radicalism in Canada, 1896-1932* (Toronto: McClelland and Stewart, 1979); Irving Abella and Harold Troper, *None is too Many: Canada and the Jews of Europe, 1933-1948* (Toronto: Lester & Orpen Dennys, 1982); Howard Palmer, *Patterns of Prejudice: A History of Nativism in Alberta* (Toronto: McClelland and Stewart, 1982).

[2] Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996): 124.

[3] George M. Weir, *Survey of Nursing Education in Canada* (Toronto: University of Toronto Press, 1932).

[4] McPherson, "Science and Technique: Nurses' Work in a Canadian Hospital, 1920-1939," in *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, eds. Dianne Dodd and Deborah Gorham, pp. 71-101 (Ottawa: University of Ottawa Press, 1994).

[5] The term "post-graduate course" in this thesis is defined according to the way nurses and the contemporary professional literature used it, as courses which graduate nurses took after they had completed their basic training. They were of varying duration from three to twelve months, typically in a specialty area such as operating room technique, teaching, supervision, administration, obstetrics, or mental nursing.

[6] E. P. Scarlett, "Till the Barrage Lifts!" *Canadian Nurse* 36, no. 8 (August 1940): 479.

[7] *"Fisher's Folly": A History of the Ottawa Civic Hospital, 1924-1984* (Ottawa: Banfield-Seguin Ltd., nd), Ottawa Civic Hospital School of Nursing Archives (hereafter referred to OCHA).

[8]Data were extracted from the Ottawa Civic Hospital Annual Reports, 1924-1944, Ottawa Civic Hospital School of Nursing Alumnae Association Archives. The pattern of a declining proportion of student nurses to graduate nurses as hospital nursing staff, reflected a national trend.

[9] McPherson, *Bedside Matters*: 129-130. Commonly referred to as the Weir Report, this analysis may be found as Weir, *Survey of Nursing.* See also, Barbara A. Keddy, "Private Duty Nursing: Days of the 1920s and 1930s in Canada," *Canadian Woman's Studies/les cahiers de la femme* 7, no. 3 (Fall, 1986): 99-102.

[10] James Struthers, *No Fault of Their Own: Unemployment and the Canadian Welfare State, 1914-1941* (Toronto: University of Toronto Press, 1983): 81-83. Canadian social welfare programs were based on a constitutional division of power between federal and provincial governments, the British poor law tradition, and the principle of 'less eligibility'. Welfare initiatives were never intended to provide adequate support for families. They were structured to provide less support than what a minimum-wage working man could earn, in order to avoid pauperism. Eligibility was based on highly restrictive criteria that effectively eliminated many people who had the greatest needs: British citizenship, constraints on family size, establishment of residency in a locality (which was often impossible for transient labour in search of work), a prohibition on property ownership, and home inspection by social workers. See Struthers: 9-10.

[11] For good overviews of the principles and implementation of these various welfare programs,

see: James Struthers, *No Fault of Their Own* and *The Limits of Affluence: Welfare in Ontario, 1920-1970* (Toronto: University of Toronto, 1994); James G. Snell, *The Citizen's Wage: The State and the Elderly in Canada, 1900-1951* (Toronto: University of Toronto, 1996); and Dennis Guest, *The Emergence of Social Security in Canada*, 2nd ed., (Vancouver: University of British Columbia Press, 1985).

[12] Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939* (Toronto: Copp Clark Pitman, 1988): 48.

[13] Weir, *Survey of Nursing*: 498 and 15.

[14] McPherson, *Bedside Matters*: 137.

[15] Keddy, "Private Duty Nursing": 100.

[16] Doris Carter confirmed this process in her interview, describing her days of private duty nursing after graduation in 1935. Doris V. Carter, audio-taped interview with author at Ottawa, Ontario on 22 June 2001.

[17] Valerie Knowles, *Leaving with a Red Rose: A History of the Ottawa Civic Hospital School of Nursing* (Ottawa: Ottawa Civic Hospital School of Nursing Alumnae Association, 1981): 41; McPherson, *Bedside Matters*: 134; Natalie Riegler, *Jean I. Gunn: Nursing Leader* (Markham, Ontario: Fitzhenry & Whiteside, 1997): 186; H. E. MacDermot, *History of the School of Nursing of the Montreal General Hospital* (Montreal: Alumnae Association, 1940): 67.

[18] Dorothy M. (Grainger) Anderson, in *Military Nurses of Canada: Recollections of Canadian Military Nurses*, vol. I, ed. E. A. Landells (White Rock, B. C.: Co-Publishing, 1995): 411 [hereafter as *Military Nurses of Canada*].

[19] Weir, *Survey of Nursing*: 80.

[20] Gertrude LeRoy Miller, *Mustard Plasters and Handcars: Through the Eyes of a Red Cross Outpost Nurse* (Toronto: Natural Heritage Books, 2000).

[21] Eva Wannop, audio-taped interview with author at Toronto, Ontario on 25 April 2001.

[22] Many nurses referred to having 'alcoholic cases', as did the Weir Report. These cases involved patients who abused alcohol and were frequently experiencing symptoms of withdrawal. Their families hired a private duty nurse to stay with them during the withdrawal period. Due to potentially hazardous working conditions, nurses demanded higher wages for these cases. Many nurses refused to accept them. See Weir, *Survey of Nursing*: 88-89.

[23] Betty Riddell, audio-taped interview with author at Ottawa, Ontario on 26 November 2001.

[24] Muriel McArther, audio-taped interview with author at Barrie, Ontario on 14 May 2001.

[25] McPherson, *Bedside Matters*: 151-160.

[26] Frances Ferguson Sutherland, audio-taped interview with author at Edmonton, Alberta on 10 October 2001.

[27] Lois Bayly Tewsley, audio-taped interview with author at Ottawa, Ontario on 11 June 2001; and Riddell interview.

[28] Ethel Johns, "A Background of Experience," *Canadian Nurse* 36, no. 2 (February 1940): 75. See also, the *Eighth Census of Canada, 1941*, vol. VII: "Gainfully Occupied by Occupations, Industries, etc." (Ottawa: King's Printer, 1946): 96.

[29] McPherson, *Bedside Matters*: 74.

[30] For the emergence of medical technology related to the rise of hospitals in America, see Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, Inc., Publishers, 1987) and "Community and Communities: The Evolution of the American Hospital," in *The American General Hospital: Communities and Social Contexts*, eds. Diana Elizabeth Long and Janet Golden, pp. 3-17 (Ithaca: Cornell University Press, 1989); Joel D. Howell, "Machines and Medicine: Technology Transforms the American Hospital," in *The*

American General Hospital: Communities and Social Contexts, eds. Diana Elizabeth Long and Janet Golden, pp. 109-134 (Ithaca: Cornell University Press, 1989) and *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore: The Johns Hopkins University Press, 1995). For technology and nursing, a good source is Margarete Sandelowski, "'Making the Best of Things'": 7; *Devices & Desires: Gender, Technology, and American Nursing* (Chapel Hill, N. C. and London: The University of North Carolina Press, 2000): 72-78; "Thermometers & Telephones: A Century of Nursing and Technology," *American Journal of Nursing* 100, no. 10 (2000): 82-86; and "The Physicians' Eyes: American Nursing and the Diagnostic Revolution in Medicine," *Nursing History Review* 8 (2000): 3-38.

[31] Cynthia Toman, "Blood Work: Canadian Nursing and Blood Transfusion, 1942-1990," *Nursing History Review*, 9 (2001): 51-78. Further analysis of the shifting relationship to medical technology may be found in Cynthia Toman, "Crossing the Technological Line: Blood Transfusion and the Art and Science of Nursing, 1942-1990," Masters Thesis (Nursing), University of Ottawa, 1998.

[32] McPherson, "Science and Technique," 76-77 and 86-94.

[33] Further discussion of these issues can be found throughout the Weir Report. See Weir, *Survey of Nursing*: 104, 191.

[34] Articles in the *Canadian Nurse* encouraged nurses to take 'post-graduate courses' in specific areas as preparation for military nursing, as well as wartime service at home. See: "Annual Meeting in P.E.I.," *Canadian Nurse* 35, no. 8 (August 1939): 454-456 and "Nursing Service, RCAMC, CASF," *Canadian Nurse* 36, no. 2 (February 1940): 87-88.

[35] Bill Rawling, *Death Their Enemy: Canadian Medical Practitioners and War* (Ottawa: author, 2001): 117-119.

[36] See G. W. L. Nicholson, *Canada's Nursing Sisters* (Canada: Samuel Stevens Hakkert & Company, 1975): 102-103; Rawling, *Death Their Enemy*: 117-118; and Leslie Newell, "'Led by the Spirit of Humanity': Canadian Military Nursing, 1914-1929," unpublished Masters Thesis (Nursing), University of Ottawa, 1996: 4, 68-70. Nicholson based his statistics on W. R. Feasby, ed., *Official History of the Medical Services, 1939-1945*, vol. 1: *Organizations and Campaigns* (Ottawa: Queen's Printer, 1956): 12, 37, and appendix A.

[37] Newell, "'Led by the Spirit of Humanity'": 68.

[38] Newell, "Led by the Spirit of Humanity": 130; see also Rawling, *Death Their Enemy*: 126.

[39] For a political analysis of the Bennett years, refer to Larry A. Glassford, *Reaction and Reform: The Politics of the Conservative Party under R. B. Bennett, 1927-1938* (Toronto: University of Toronto Press, 1992) and John Herd Thompson with Allen Seager, *Canada, 1922-1939: Decades of Discord* (Toronto : McClelland and Stewart, 1985). See also: G. W. L. Nicholson, *Seventy Years of Service: A History of the R.C.A.M.C.* (Ottawa: Borealis Press, 1977): 121-122.; and Rawling, *Death Their Enemy*: 119 and 126.

[40] Elizabeth B. Pense Neil, interview with Norma Fieldhouse at Kingston, Ontario in March 1987, from the Oral History Collection, Margaret M. Allemang Centre for the History of Nursing.

[41] Rawling, *Death Their Enemy*: 116.

[42] Newell, "Led by the Spirit of Humanity": 42, 44, 124.

[43] According to Geneviève Allard, World War I Nursing Sisters comprised 37% of all active Canadian nurses. See Allard, "Des anges blanc sur le front: l'expérience de guerre des infirmières militaires Canadiennes pendant la première guerre mondiale," *Bulletin D'Histoire Politique* 8, nos. 2-3 (hiver-printemps 2000): 120.

[44] Rawling, *Death Their Enemy*: 117-118.

[45] "Nursing Sisters: Royal Canadian Army Medical Corps," Library and Archives, Canadian Forces Base Borden.

[46] See also, "Nursing Service, R.C.A.M.C., C.A.S.F.," *Canadian Nurse* 36, no. 2 (February 1940): 87-88.

[47] Margaret Dewart and Jessie Morrison, "Formation of the First Unit—Edmonton, 1920," *Nursing Sisters' Association of Canada: Commemorative Issue & National Directory*, (June 1994): 81.

[48] Susan Mann, "Where Have All the Bluebirds Gone? On the Trail of Canada's Military Nurses, 1914-1918," *Atlantis* 26, no. 1 (2001): 35-43.

[49] Cynthia Enloe, *Does Khaki Become You? The Militarisation of Women's Lives*, (Boston: South End Press, 1983): 77.

[50] Nicholson, *Canada's Nursing Sisters*: 98.

[51] Jean S. Wilson, "Notes from the National Office," *Canadian Nurse* 35, no. 8 (August 1939): 453.

[52] See Robert Craig Brown and Ramsay Cook, *Canada, 1896-1921: A Nation Transformed* (Toronto: McClelland & Stewart, 1994: 271-272; Desmond Morton, *A Peculiar Kind of Politics: Canada's Overseas Ministry in the First World War* (Toronto: University of Toronto Press, 1982): 136; and Cynthia Enloe, *Maneuvers*: *The International Politics of Militarizing Women's Lives* (Berkeley: University of California Press, 2000): 213. For an excellent analysis of the conscription issues in both wars that presents French Canadian perspectives as well, see Thompson with Seager, *Canada, 1922-1939:* 115-117 and 325-329.

[53] James Eayrs, *In Defense of Canada,* vol. I*: From the Great War to the Great Depression* (Toronto: University of Toronto Press, 1964) and vol. II: *Appeasement and Rearmament* (Toronto: University of Toronto Press, 1965); J. L. Granatstein, *Canada's War: The Politics of the Mackenzie King Government, 1939-1945* (Toronto: Oxford University Press, 1975).

[54] J. L. Granatstein and J. M. Hitsman, *Broken Promises: A History of Conscription in Canada* (Toronto: Oxford University Press, 1977).

[55] Ann Graber Hershberger described extensive pressure on American nurses and nursing students to enlist in the military, in her research on Mennonite nurses who sought alternatives to enlistment as members of a 'non-resistant' peace church during the Second World War. Her sources indicated that some Mennonite nurses were threatened by state nurse examination boards, with the withholding of their certificates to practice nursing if they refused to enlist. See "Mennonite Nurses in World War II: Maintaining the Thread of Pacifism in Nursing," *Nursing History Review* 11 (2003): 153-154.

[56] Sarnecky argues that the need to conscript nurses was not real—but rather, a political ploy. She did not provide a strong argument or present clear evidence, however, making it difficult to understand her point on this matter. See Mary T. Sarnecky, *A History of the U. S. Army Nurse Corps* (Philadelphia: University of Pennsylvania Press, 1999): 269-270. The Kalischs' research is most interesting as they followed the movement through Congress: Phillip A. Kalisch and Beatrice J. Kalisch, "The Women's Draft: An Analysis of the Controversy over the Nurses' Selective Service Bill of 1945," *Nursing Research* 22, no. 5 (September-October 1973): 402-413.

[57] *King's Regulations and Orders for the Canadian Militia (1939),* (Ottawa: King's Printer, 1939).

[58] Most of the current historiography on the origins of Canada ignore the presence of a third founding nation, the peoples of the First Nations that had populated the northern part of the North American continent long before the British and French arrived.

[59] This is partially understandable given the controversy over conscription and prevailing French Canadian perspectives on the Second World War as a British war.

[60] Jean S. Wilson, "Military Service," *Canadian Nurse* 35, no. 10 (October 1939): 562.

[61] See McPherson, *Bedside Matters:* 17 and 118. Nursing Sister Harriet J.T. Sloan recalled one Oriental student at the Vancouver General Hospital School of Nursing while Sloan was a student after 1938. This is corroborated by articles on Asian students and a Canadian Nurses

Association resolution passed in 1944 on ending discrimination. See Alice Michiyo Uyede, "A Spotless Reputation," *Canadian Nurse* 35, no. 2 (February 1939): 93-94; Margaret Duffield, "Nursing Care for Racial Groups," *Canadian Nurse* 37, no. 5 (May 1941): 337-338; and Florence H. Walker, "Notes from the National Office," *Canadian Nurse* 40, no. 9 (September 1944): 702.

[62] Only female nurses were accepted in the Nursing Service prior to 1967, according to Dean Care, David Gregory, John English, and Peri Venkatesh, "A Struggle for Equality: Resistance to Commissioning of Male Nurses in the Canadian Military, 1952-1967," *Canadian Journal of Nursing Research* 28, no. 1 (1996): 103-117.

[63] These comments are taken from the military files of individual nurses who were discharged within the first six months after enlistment. Due to restrictions imposed by the National Archives of Canada, I am unable to provide identification for the specific files.

[64] Voluntary nurses pre-dated the First World War, as demonstrated in the excellent, classic work of Anne Summers, *Angels and Citizens: British Women as Military Nurses, 1854-1914* (London and New York: Routledge, 1988). For first person accounts of Voluntary Aid Detachment (VAD) nurse, see Vera Brittain, *Testament of Youth* (New York: Seaview Books, 1980 and 1978) and *Chronicle of Youth: War Diary, 1913-1917*, ed. Alan Bishop with Terry Smart (London: Gollancz, 1981). Julia Roberts describes volunteer nurses as de-skilling the profession and contributing to acrimonious relationships in "British Nurses at War, 1914-1918: Ancillary Personnel and the Battle for Registration, *Nursing Research* 45, no. 3 (1996): 167-172. Linda Quiney suggests that the World War I Canadian VADs posed no actual or intended threat to professional nurses in her research: "Assistant Angels: Canadian Voluntary Aid Detachment Nurses in the Great War," *Canadian Bulletin of Medical History* 15, no. 1(1998): 189-206 and "'Sharing the Halo': Social and Professional Tensions in the Work of World War I, Canadian Volunteer Nurses," *Journal of the Canadian Historical Association*, 8 (1998): 105-24. For further insights on the roles and controversies surrounding the use of VADs, refer to Morton, *A Peculiar Kind of Politics:* and Herbert A. Bruce, *Politics and the Canadian Army Medical Corps: A History of Intrigue, Containing Many Facts Omitted from the Official Records, Showing how Efforts at Rehabilitation were Baulked* (Toronto: William Briggs, 1919).

[65] Marjorie Barron Norris describes many incidences of nurses who tried repeatedly to enlist during the First World War in her book, *Sister Heroines: The Roseate Glow of Wartime Nursing, 1914-1918* (Calgary: Bunker to Bunker Publishing, 2002).

[66] Nicholson, *Seventy Years of Service:* 137; "V.A.D. Training," *Canadian Nurse* 36, no 2 (February 1940): 105.

[67] Jean S. Wilson, "National Enrolment," *Canadian Nurse* 35, no. 1 (January 1939): 31.

[68] Jean S. Wilson, "Emergency Nursing Service," *Canadian Nurse* 35, no. 8 (August 1930): 453.

[69] Ethel Johns, "Guarding the Flame," *Canadian Nurse* 35, no. 10 (October 1939): 563.

[70] Frances Oakes, audio-interview with author at Guelph, Ontario on 15 May 2001.

[71] F. I. McEwen, "Report of the National Joint Committee on Enrolment of Nurses," *Canadian Nurse* 36, no. 9 (September 1940): 584.

[72] E. Frances Upton, "Provincial Reports," *Canadian Nurse* 36, no. 9 (September 1940): 611.

[73] The Enrolment Committee report to the 1944 RNAO Annual Meeting resolved that, "whereas the original objective of the National Joint Enrolment Committee had been achieved (ie. basic standards for selection for the Armed Forces) and the lists compiled twice yearly were not being used by the Armed Forces as the source for personnel, and the labour and expense was not considered commensurate with the use made of the information, be it resolved not to re-appoint the joint committee." See the "RNAO Reports to Annual Meetings, 1944-49": 2-3, RNAO, 96F-2-04, Archives of Ontario. Rawling provides another explanation for the list's disuse in *Death Their Enemy*: 117 -118, arguing that the Depression required nurses to move around in search of work and they were seldom to be found at the registered addresses on the list.

[74] McEwen, "Report of the National Joint Committee": 584.

[75] Helen Morton Rendall, interview with Margaret M. Allemang at Toronto, Ontario on 14 and 21 March 1986, Oral History Collection, Margaret M. Allemang Centre for the History of Nursing.

[76] Constance Betty Nicolson Brown, audio-taped interview with author at Ottawa on 5 June 2001.

[77] Doris V. Carter, audio-taped interview with author at Ottawa on 22 June 2001.

[78] Dorothy Surgenor Maddock, audio-taped interview with author at Ottawa on 26 June 2001.

[79] Betty Young Ramage Hamilton, audio-taped interview with author at Edmonton, Alberta on 12 October 2001; Mary M. Bower White, audio-taped interview with author at Surrey, British Columbia on 20 October 2001.

[80] Beatrice Cole Hunter, audio-taped interview with author at Edmonton, Alberta on 13 October 2001.

[81] The Nursing Sisters Database (hereafter referred to as the NSD) is based on Department of National Defence records held by the National Archives of Canada [hereafter as NAC].

[82] Tewsley interview.

[83] White interview.

[84] Riddell interview.

[85] Isabel Morrison Fraser, audio-taped interview with author at Ottawa on 27 November 2001.

[86] Letter 17 February 1943 from Elizabeth Smellie to the Department of National Defence, "Correspondence and Instructions regarding Nursing Sisters for British South African Nursing Service," 324.009 (D204), Department of National Defence Directorate of History and Heritage.

[87] J. W. Tice, letters of 4 July 1941 and 24 April 1942, file 400-2-1, "Nursing Sisters, RCAF: Appointment of, Policy governing," RG 24, E-1-b, v. 3365, NAC.

[88] Letter 31 March 1942, file 400-2-1, "Nursing Sisters, RCAF: Appointment of, Policy governing," RG 24, E-1-b, v. 3365, NAC.

[89] Elizabeth Dean Doe, audio-taped interview with author at Nepean, Ontario on 30 June 2001.

[90] Margaret Roe Dewart, audio-taped interview with author at Edmonton, Alberta on 15 October 2001.

[91] Letter 5 October 1942 to C. G. Power, file 400-2-1, "Nursing Sisters, RCAF: Appointment of, Policy governing," RG 24, E-1-b, v. 3365, NAC.

[92] Ethel Johns, "The Home Front," *Canadian Nurse* 37, no. 9 (September 1941): 603-604.

[93] Marion Lindeburgh, "Our National Duty," *Canadian Nurse* 38, no. 10 (October 1942): 760.

[94] Public Health Nursing Section, New Brunswick Association of Registered Nurses, "A 'Practice' Raid," *Canadian Nurse* 37, no. 7 (July 1941): 478.

[95] "Report of the Committee on Nursing and Nurse Education in Canadian Hospitals," Bulletin #36 (1941), presented to the sixth biennial meeting of the Canadian Hospital Council, 96B-5-14, RNAO fonds, Archives of Ontario.

[96] Jean S. Wilson, "Report of the Executive Secretary," *Canadian Nurse* 36, no. 9 (September 1940): 546; "Notes from the National Office," *Canadian Nurse* 38, no. 5 (May 1942): 310; and "Notes from the National Office," *Canadian Nurse* 39, no. 4 (April 1943): 276.

[97] *Eighth Census of Canada, 1941*, vol. VII: 32.

[98] This table is based on data from "Appointment Statistics – Nursing Sisters, Physiotherapy Aides, Occupational Therapists, Dieticians and Home Sisters," 000.8(D93), Department of National Defence Directorate of History and Heritage, and RCAF memos dated 2 December 1940, 23 October 1944, 30 January 1945 and a 1943 nominal list in files 400-1-1 and 400-2-1, RG24, E-1-b, v. 3365, NAC.

[99] Kathleen W. Ellis, "The Report of the Emergency Nursing Adviser," *Canadian Nurse* 38, no. 9

(September 1942): 636-645.

[100] Marion Lindeburgh, "Important Emergency Measures," *Canadian Nurse* 38, no. 12 (December 1942): 925.

[101] Kathleen W. Ellis, "Some Pertinent Questions," *Canadian Nurse* 39, no. 4 (April 1943): 269-271. The National Selective Service was a compulsory registration of all females between twenty and twenty-four years old (single or married) except for members of religious orders, hospital patients, prison inmates, and women in insurable employment. See Ruth Roach Pierson, *"They're Still Women after All": The Second World War and Canadian Womanhood* (Toronto: McClelland and Stewart, 1986) and "Women's 'Emancipation and the Recruitment of Women into the Labour Force in The Second World War," in *The Neglected Majority: Essays in Canadian Women's History*, ed. Susan Mann Trofimenkoff and Alison Prentice, pp. 125-145 (Toronto: McClelland and Stewart, 1977).

[102] Jean S. Wilson, "Notes from the National Office: Registration of Nurses," *Canadian Nurse* 39, no. 6 (June 1943): 407. See also, *The Leaf and the Lamp: The Canadian Nurses' Association and the Influences which Shaped its Origins and Outlook during its First Sixty Years* (Ottawa: Canadian Nurses' Association, 1968): 88.

[103] Kathleen W. Ellis, "The Final Report," *Canadian Nurse* 39, no. 8 (August 1943): 531-533.

[104] This table is based on data from Table 109, p. 218 of the "National Health Survey, (1943)", RNAO files, 96C-2-08, Archives of Ontario.

[105] "Report of the Committee on Nursing and Nurse Education in Canadian Hospitals," presented at the seventh biennial meeting of the Canadian Hospital Council (1943) and based on the registration of nurses by National Selective Service on March 17-19, 1943, p. 7, RNAO fonds, 96B-5-14, Archives of Ontario.

[106] Allard, "Des anges blanc sur le front": 120.

[107] This table was re-constructed from information in Table 110, p. 219 of the *Report of the National Health Survey, part VIII—Nurses* (Ottawa: King's Printer, 1945), RNAO files, 96C-2-08, Archives of Ontario. The Survey was conducted 17-19 March 1943, and reflects the status of nursing as of those dates.

[108] This table is based on data from Table 108, p. 219 of the *Report of the National Health Survey, part VIII—Nurses*).

[109] Kathleen W. Ellis, "An Interim Report," *Canadian Nurse* 39, no. 6 (June 1943): 398-400.

[110] Ellis, "Final Report": 532-533.

[111] Jean S. Wilson, "Notes from the National Office: Labour Exit Permits," *Canadian Nurse* 39, no. 5 (May 1943): 345.

[112] Wilson, "Notes from the National Office," *Canadian Nurse* 39, no. 5 (May 1943): 345.

[113] A formidable body of Second World War Canadian military literature exists. I have not attempted to summarize the great variation and scope of perspectives available. I have focused instead on a synopsis from the perspective of the medical services—in particular, the Nursing Sisters and how events of the war influenced their practice. An introductory overview of major events can be found in Norman Hillmer, "World War II," *The Canadian Encyclopedia: Year 2000 Edition* (Toronto: McClelland & Stewart, 1999): 2551-2553. Major important sources include: Stacey, *Six Years of War*; Nicholson, *The Canadians in Italy*; Granatstein, *Canada's War*; and Morton, *A Military History of Canada*.

[114] Stacey, *Six Years of War*: 27-34; 43-45; and 60-61.

[115] Morton, *Military History of Canada*: 194.

[116] Conditions of the act are provided here, as cited in Stacey, *Six Years of War*: 82.

[117] Morton, *Military History of Canada*: 188.

[118] For an excellent source on the experiences of the Canadian troops in Hong Kong see Charles G. Roland, *Long Night's Journey into Day: Prisoners of War in Hong Kong and Japan, 1941-1945* (Waterloo, Ontario: Wilfrid Laurier University Press, 2001). Roland includes some references to the Nursing Sisters.

[119] Stacey, *Six Years of War*: 517.

[120] Stacey, *Six Years of War*: 517-519 and Hillmer, "The Second World War": 2553.

[121] Muriel McArthur, "52 RCAF Mobile Field Hospital," in *Military Nurses of Canada*, vol. III: 271.

[122] "List of Canadians who Served with South African Nursing Service – Second World War (1939-1945)," 000.8 (D91) and "Correspondence, reports, instructions, etc. re. Nursing Sisters enrolling in South African Forces, August 41-November 45," 325.009 (D575), Department of National Defence Directorate of History and Heritage.

[123] See Chapter 1 and the discussion in my research plan (Appendix 10).

[124] For example, three Nursing Sisters transferred from the RCAMC to the RCN, and twelve transferred from the RCAMC to the RCAF when they formed their respective nursing services. At least 69 Nursing Sisters served in both the SAMNS and RCAMC. Therefore, there were at least 83-84 fewer Nursing Sisters than commonly reported.

[125] More recent authors have cited John Murray Gibbon and Mary S. Mathewson, *Three Centuries of Canadian Nursing* (Toronto: Macmillan Company of Canada, 1947): 456-458 or Nicholson, *Canada's Nursing Sisters*: 208. Much of the variation in reported figures between sources can be explained by three factors: who was included in the calculations (nurses only or all Nursing Sisters), what date was used as the end point (since the services were not completely coordinated for reporting purposes), and whether the reported figure is an accumulated number or a nominal list number for a specific date. See also Feasby, *Official History of the Canadian Medical Services*, vol. I. To arrive at these figures, I used existing RCAMC and SAMNS statistics, adjusting for obvious duplications. Based on the proportion of nurses and non-nurses in both the RCAMC and NSD analyses (92%), I then extrapolated to the RCAF and RCN statistics to approximate the number of nurses in those totals.

[126] Physiotherapists were clearly designated as "Physiotherapy aides" in the Canadian armed forces during the Second World War, although the reason is not clear for this differentiation. See Nicholson, *Canada's Nursing Sisters*: 199-200. There is discussion among various minutes, that in order to meet the needs for a growing number of physiotherapy aides, new graduates would be permitted to do their six months of internship as part of their military service—serving primarily within Canada and under the direction of more experienced physiotherapy aides. This lack of full qualifications may have influenced their military rank title. See "Memo on Physiotherapy Aides and Occupational Therapists," 2 December 1943, 400-2-1, in "Women Medical Officers, Nursing Sisters, Physios, Orthopists, and Opthalmical Assistants," 181.003 (D1467), Department of National Defence Directorate of History and Heritage.

[127] Feasby, *Official History of the Canadian Medical Services*, vol. I: 329-331, 202-207, and 442; "Memo on Physiotherapy Aides and Occupational Therapists," 2 December 1943, 400-2-1, in "Women Medical Officers, Nursing Sisters, Physios, Orthopists, and Opthalmical Assistants," 181.003 (D1467), Department of National Defence Directorate of History and Heritage.

[128] I have not found additional primary sources for the RCN than those which appeared in the personnel records. Secondary sources include Nicholson, *Canada's Nursing Sisters*: 202-203 and Stanley T. Richards, *Operation Sick Bay* (West Vancouver, B. C.: Cantaur Publishing, 1994): 52.

[129] Feasby, *Official History of the Canadian Medical Services*, vol. 1: 323. Feasby provides a good overview on the Dieticians, Physiotherapists, Occupational Therapists, and Home Sisters, pp. 315-323.

[130] "The Royal Canadian Army Medical Corps," p. 39. Presented at the Victory Meeting of the

Canadian Medical Association, Banff Springs Hotel, Banff, Alberta in June 1946. MG 31, G19, v. 5, NAC.

[131] K. W. Ellis, letter to J. E. Porteous, 9 December 1943, file 400-2-1, v. 3365, E-1-b, RG 24, NAC.

[132] "Appointment Statistics," 000.8 (D93), Department of National Defence Directorate of History and Heritage.

[133] Dean Doe interview.

[134] "List of Canadians who Served with South African Nursing Service."

[135] Feasby, *Official History of the Canadian Medical Services*, vol. I: 325.

[136] Lamont Flynn interview.

[137] Ella Beardmore, audio-taped interview with Joan Williams, 26 November 1975, ISN 196092, NAC.

[138] Doris Taylor Rasberry, audio-taped interview with author at Pointe Claire, Québec on 19 June 2001.

[139] McPherson, *Bedside Matters*: 117.

[140] These percentages have been calculated based on the total number of nurses in the NSD, with only those reporting the death of at least one parent or the support of at least one dependent appearing in the table.

[141] Note that nurses most often had experience in more than one area of practice. Therefore the numbers and percentages in the table are not cumulative.

[142] McPherson, *Bedside Matters*: 117-118.

[143] Axelrod, *Making a Middle Class*: 139 and 149.

[144] Strong-Boag, *The New Day Recalled*: 20-21.

[145] It is surprising that so many nurses took one or more of these extra courses after graduation. Apparently, they did not feel completely prepared for independent practice solely on the basis of a three-year apprenticeship program—which calls to question the assumption that traditional three-year hospital training programs were sufficient preparation for nurses, even in the 1930s and 1940s.

[146] *What You Want to Know about Nursing*, (Montreal: Canadian Nurses Association, n.d.): 14. In "Background/Supplemental Material for CNA Nurse Recruitment, 1944-45," RNAO, 96B-5-20, Archives of Ontario.

[147] McPherson reported no male nurses at all in the 1931 census in *Bedside Matters*: 116.

[148] "District #4 Report for March 1940," Nursing Education Section, Minutes and Reports (1928-41) and the CNA annual report for 1940, RNAO, 96B-1-09, Archives of Ontario.

[149] *Eighth Census of Canada, 1941*, vol. VII: 328.

[150] Care, Gregory, English, and Venkatesh, "A Struggle for Equality": 103-117.

[151] Estelle Tritt Aspler, audio-taped interview with author at Westmount, Québec on 13 August 2001.

[152] Richards, *Operation Sick Bay*: 44, 52-53.

[153] McPherson, *Bedside Matters*: 39-40.

[154] Care, Gregory, English, and Venkatesh, "A Struggle for Equality": 104.

[155] Copies of these 'Undertaking' forms are found in every Nursing Sister's personnel record. Regulations regarding marriage were set out in paragraphs 136 and 263 of *King's Regulations*.

[156] "Appointment Statistics," 000.8 (D93), Department of National Defence Directorate of History and Heritage.

[157] The marriage bar for middle class working women was not limited to nurses but was part of the socially-constructed expectations for women in general. See Strong-Boag, *The New Day Recalled*: 42.

[158] Department of Defence letter regarding nursing sisters and marriage policy, 29 December 1942, confidential NSD file.

[159] Elizabeth Smellie, memo dated 6 January 1943, as found in several NSD files.

[160] RCAF Memo, DMS (Air), 16 November 1943, file HQ 400-1-1, RG24, series E-1b, v. 3365, NAC.

[161] Elizabeth Smellie, "Minutes of the Matron's Conference," Ottawa, 27-29 May 1943. In "Correspondence and Minutes of Meetings regarding Nursing Sisters—July 43/October 45," 147.73 C 132009 (D2), Directorate of History and Heritage, Ottawa.

[162] "Policy of NS marrying and requesting discharge," 28 July 1943 Department of Defence Memorandum, NSD files.

[163] For further discussion on the constraints imposed on nurses who married, see Chapter 3.

[164] Constance Backhouse, *Colour-coded: A Legal History of Racism in Canada, 1900-1950* (Toronto: University of Toronto Press, 1999): 1-6.

[165] Backhouse, *Colour-coded*: 6.

[166] Backhouse, *Colour-coded*: 8.

[167] Thompson, *Canada, 1922-1939:* 6.

[168] *Eighth Canadian Census*, 1941, vol. VII: 334-335.

[169] R. Scott Sheffield, "'Of Pure European Descent and of the White Race': Recruitment Policy and Aboriginal Canadians, 1939-1945," *Canadian Military History* 5, no. 1 (Spring 1996): 8-11.

[170] Sheffield, "'Of Pure European Descent": 12.

[171] Sheffield, "'Of Pure European Descent": 11.

[172] Ethel Johns, "This Heritage of Freedom," *Canadian Nurse* 36, no. 7 (July 1940): 401.

[173] Lisa Bannister corroborates the use of language schools for francophone military personnel in all three service branches. She refers to the Canadian Women's Auxiliary Air Force (CWAAF) that became the RCAF (Women's Division), the Canadian Women's Army Corps (CWAC), and the Women's Royal Canadian Naval Service (WRCNS) that organized between 1941 and 1942. See Lisa Bannister, producer, *Equal to the Challenge: An Anthology of Women's Experiences during World War II* (Ottawa: Department of National Defence, 2001): xiii-xv.

[174] Gaëtane LaBonté Kerr, audio-taped interview with Lisa Weintraub at Montreal, Québec on 11 April 1985, Concordia Oral History Project, ISN 167796, NAC.

[175] Gaëtane LaBonté Kerr, in *Military Nurses of Canada:* 338.

[176] E. Frances Upton, "The A.R.N.P.Q. Meets in the City of Quebec," *Canadian Nurse* 38, no. 4 (April 1942): 266.

[177] John Herd Thompson, *Canada, 1922-1939*: 325-329.

[178] Tritt Aspler interview.

[179] Neil Sutherland points out that until the Second World War, working class families considered secondary school entrance as the minimum necessary formal education. During the 1940s and 1950s, this changed to completion of grade 9 and 10. The costs of allowing a child more education included the loss of that child's income, and the family had to calculate the value of that education in relation to the immediate loss. For middle-class families, junior matriculation was considered to be the minimum education necessary. See Sutherland, *Growing Up:* 74-77. Refer also to: Strong-Boag, *The New Day Recalled*: 53, McPherson, *Bedside Matters*: 125, and Axelrod, *Making a Middle Class*: 159. Axelrod argues that education did not necessarily lead to

a rise in class but did prove to be critical for occupational mobility within the middle class.

[180] John Porter, *The Vertical Mosaic: An Analysis of Social Class and Power in Canada* (Toronto: University of Toronto Press, 1965): 9.

[181] Andrew C. Holman, *A Sense of their Duty: Middle-Class Formation in Victorian Ontario Towns* (Montreal and Kingston: McGill-Queen's University Press, 2000): 11-16 and 98.

[182] Porter, *The Vertical Mosaic*: 9-10.

[183] Strong-Boag, *The New Day Recalled*: 3.

[184] Strong-Boag, *The New Day Recalled*: 53. McPherson's research also supports this argument in *Bedside Matters*: 125. She states that it was critical for a family to be able to do without a daughter's income for the required years of preparation, and that this ability outweighed the occupational class of the male head of household as a determining factor for who became nurses.

[185] McPherson, *Bedside Matters*: 117, 121, and 125.

[186] *Eighth Census of Canada, 1941* vol. VI: "Earnings, Employment and Unemployment of Wage-Earners" (Ottawa: King's Printer, 1946): xiii-xvii.

[187] One excellent example of research focused on working class women and on the family economy is Bettina Bradbury, *Working Families: Age, Gender, and Daily Survival in Industrializing Montreal* (Toronto: McClelland & Stewart, 1993).

[188] Weir, *Survey of Nursing*: 70, 98, 119, and 168. Weir evaluated nurses roughly as three groups: private duty, institutional, and public health as well as educators, supervisors, and administrators. Thus his statistics vary slightly between groups.

[189] Refer to Table 4.1 in McPherson, *Bedside Matters*: 121.

[190] Kathi Jackson, *They Called Them Angels: American Military Nurses of World War II* (Westport, Connecticut: Praeger, 2000): xviii.

[191] Sarnecky, *A History of the U.S. Army Nurse Corps*: 177 and 231.

[192] Sarnecky, *History of the U.S. Army Nurse Corps*: 270.

[193] Sarnecky, *History of the U.S. Army Nurse Corps*: 277.

[194] Elizabeth M. Norman, *We Band of Angels: The Untold Story of American Nurses Trapped on Bataan by the Japanese* (New York: Random House, 1999): 47.

[195] Sarnecky, *History of the U.S. Army Nurse Corps*: 233-234.

[196] Enloe, *Maneuvers:* 215-217.

[197] Jan Bassett, *Guns and Brooches: Australian Army Nursing from the Boer War to the Gulf War* (New York: Oxford University Press, 1992): 112-113 and 172.

[198] Juliet Piggott, *Queen Alexandra's Royal Army Nursing Corps* (London: Leo Cooper, 1975).

CHAPTER 2

INCORPORATING NURSES INTO THE MILITARY

The armed forces expressed little doubt regarding nurses' value as professionals. Medical officer T.S. Wilson quantified their value and objectified them when he wrote, "Of especial importance in a surgical centre are the attached nursing sisters, whose services like that of a Thomas Splint in compound fractures of the femur, are often worth five to ten bottles of blood or plasma in the eventual outcome of a case."[1] Military nurses constituted a feminine workforce that made a significant difference in the care of soldiers. They also released for combat non-commissioned men who had been seconded to the medical services.[2] The military did, however, express a great deal of ambivalence related to nurses' presence as women in theatres of war. Yet, nurses enthusiastically filled every nursing position, served throughout Canada and overseas, worked in unconventional practice settings, and developed expanded technological skills. Like the First World War Nursing Sisters, they enlisted as non-permanent members, serving "for the duration" only. A postwar military nursing quota of thirty Army, thirty Air Force, and twenty Navy nurses ensured their temporary status.

This chapter first compares Canadian military nursing during the First and Second World Wars, and then examines the incorporation of nurses into the military as professional soldiers. I argue that the military incorporated Nursing Sisters as an expandable and expendable feminine workforce, while nurses accepted dangers, risks, and military discipline as the price to be paid for the opportunities and benefits they sought. Nurses' expandability was based on underlying knowledge and skills that legitimated their presence in diverse medical units. Although their relationship to medical technology is more fully examined in the next chapter, it is important to understand here that their ability to function in expanded roles and responsibilities shaped where and how the military incorporated them into the system. It was their gender and not their abilities

that placed constraints on nurses--especially with respect to public discourses regarding women's roles and women's physical safety in the military.

Continuity and Change in Military Nursing

The Second World War Nursing Sisters comprised the second generation of Canadian military nurses to be fully-integrated members of the armed forces. They built on the leadership, traditions, and reputation of the First World War nurses, who provided continuity and guidance at the beginning of the second war. But the changing context of the Second World War soon began to shape this second generation's experience differently, in at least three areas: enlistment, training, and service.

The first generation had dealt with their loss of identity and professional opportunities after the war by forming local clubs and a national association for their mutual support and the promotion of military nursing.[3] Some of them re-enlisted in 1939, while others wrote about their experiences. One month prior to the declaration of war, the *Canadian Nurse* published a tribute to First World War NS, Mabel Clint, along with excerpts from her memoir entitled, *Our Bit: Memories of War Service by a Canadian Nurse.*[4] In 1974, NS Jessie Morrison referred to these First World War nurses when she wrote of her own experience: "We knew we had big shoes to fill."[5]

Matron Emma Pense (who served during the First World War and joined the permanent force in 1920) became the Royal Canadian Army Medical Corps (RCAMC) Matron-in-Chief for England in April 1940. She took the first contingent of Nursing Sisters overseas while Matron Elizabeth L. Smellie (who had also served during the First World War and was assistant Matron-in-Chief until her first retirement in 1920) became the RCAMC Matron-in-Chief for Canada.[6] When the Canadian Broadcasting Corporation (CBC) interviewed Matron-in-Chief Smellie on her appointment, she spoke of the special relationship between the two generations of Nursing Sisters:

> Most veteran nurses find it a little difficult to content themselves with knitting socks or making dressings. . . . But now a word to the new nursing sisters—your predecessors offer you greetings and good wishes. I suppose you will have your own distinctions, as we did. . . . And don't be resentful if, as we veterans pass you by, we reveal extraordinary interest in your uniform and tell you we wish we were going again, because we do so, scarcely realizing how much water has run under the bridge since 1918. . . .[7]

Among the 1052 nurses of the Nursing Sisters Database (NSD), there were at least five First World War military nurses who did re-enlist. They were between forty-one and fifty-four years of age on re-enlistment, and each of them served an additional four-and-a-half to six-and-a-half years. Only one of these re-enlisted nurses retired before the war ended while four of them served for another year after the Armistice.

Medical units initially organized in a similar manner to the Great War—that is, units mobilized from the staff of large hospitals associated with physician and nurse training programs.[8] But this policy had become problematic during the First World War when civilian hospitals lost a large number of their personnel to the armed forces, and enlistment was one of the first areas to change. No. 15 and No. 5 Canadian General Hospitals were the first medical units to organize in 1939. No. 15 Canadian General Hospital was comprised primarily of staff from the Toronto General Hospital and No. 5 Canadian General Hospital was comprised primarily of staff from the Winnipeg General Hospital (WGH). NS Ruth Littlejohn graduated from the WGH in 1936 and worked there until told she would have to "take over the teaching of classes for the student nurses on maternity" in 1939 because the mobilization of No. 5 Canadian General Hospital had "stripped the hospital of nurses and physicians" and "there were no experienced nurses on the wards."[9] The Canadian Nurses Association (CNA) and the *Canadian Nurse* journal expressed extreme concern for a balance between military and civilian needs soon after Parliament declared war. By February 1941, *Canadian Nurse* Editor Ethel Johns wrote that hospitals were already feeling the effects of the withdrawal of 'key' nurses entering the military while Matron-in-Chief Smellie (a former vice-president of CNA) reiterated the need for good relationships with the civilian profession, and altered the recruitment policy to include nurses from all regions in each unit.[10]

Defence Scheme No. 3 (1938) had formed the basis of Canadian prewar preparations and one of its guidelines called for proportional representation by population in the military[11] as the Mackenzie King government sought to avoid a variety of sociopolitical issues related to the recent high level of unemployment, the national manpower requirements of 'total war,' and the implementation of conscription. The unemployed wanted equal access to military jobs while the distribution of labour at home also had to be considered in relation to recruitment to avoid the alienation of regions such as the Prairies and Québec.[12]

Proportional representation, combined with the nursing profession's concern for civilian hospital staffing, began to change the way that medical units were mobilized. At the end of 1942, No. 10 and No. 12 Canadian General Hospital became the first groups of Nursing Sisters recruited from all parts of Canada.[13] Matron-in-Chief Smellie reported to the Matrons' Conference in Ottawa (May 1943) that "from now on all units are representative of different sections of Canada, not of individual localities."[14] The *Lady Nelson* was an excellent example of change in the recruitment policy. It was Canada's first hospital ship and had space for 500 bed patients. Twelve Nursing Sisters, selected to represent all regions of Canada, formed the nursing component of the *Lady Nelson*.[15] In addition to the mobilization of specific units for overseas, other nurses enlisted as 'reinforcements' or a pool of nurses who served as replacements and/or supernumerary staff during periods of heavy casualties. They moved between units as needed and as Col. G. A. Winfield commented, "[T]heir body does not necessarily have to be where their home [base unit] is."[16]

As a second area that required change, military training for Second World War nurses varied but it gradually became more formal than the lectures described by one First World War nurse as primarily to "fill the sisters' time at sea".[17] Some RCAMC nurses reported that they had little orientation, and what training there was focused primarily on military aspects such as recognizing rank, using titles, and understanding military organizational structure. They enlisted as Second Lieutenants and after six months automatically became First Lieutenants.[18] Other nurses described at least two weeks of classes with drills, a trip through the gas chamber, and a

period of work in a military hospital within Canada that served as a 'qualification period' prior to promotion and potentially, the coveted overseas posting.[19] These nurses wrote a qualifying exam that covered components of the *King's Regulations and Orders for the Canadian Militia (KR)* as well as questions such as: "What is your duty with regard to the admission of a patient to your ward, death of a patient, and patient's kit?" and "Discuss the responsibility of a matron in charge of a general hospital with regard to Nursing Sisters' quarters and domestic economy, confidential reports, Nursing Sisters on sick list, neglect of duty by N.C.O. in charge of ward."[20] Still other nurses underwent both an oral and a written examination as indicated in *KR* paragraph 787. NS Estelle Tritt explained that at Kingston Military Hospital, "[T]hey handed us the 'King's Rules and Regulations' to study—when we had time. . . . Then I had to write an exam with the KR camped right beside me. But I passed. . . . Learned how to order meals in the military hospitals . . . . We had to account for all the cutlery. This is what we were taught--to account for all the cutlery, the dishes, this and that.[21]

Several nurses described having additional field training, route marches, and field maneuvers lasting up to ten days at a time.[22] NS Evelyn Pepper described her training when she wrote: "Learning how to march, salute, read a map, pitch a tent, take it down, put it up again, live in it and like it, eat out of a billy-can, drive anything from a motorcycle to an ambulance, fire revolvers and 303's, practice Judo techniques on our fellow-officers, plus a general orientation to army terminology and procedure, bulged our training days and hardened our muscles."[23] By 1943 the RCAMC established an official "Qualifying Course for the Nursing Service," described as a four-week course that was necessary before promotion.[24]

A few nurses received no military training. NS Frances Oakes was one of the first four nurses in the Royal Canadian Air Force (RCAF) in November 1940. She was posted overseas before the RCAF developed their three-week training program known as the "School of Aviation Medicine Course in Aviation Nursing" at Havergal College, in Toronto. But most RCAF nurses enlisting after December 1942 attended one of twelve such courses.[25] Royal Canadian Navy

(RCN) NS Dorothy Surgenor articulated the tenuous position of military nurses who were considered 'support' and not 'combat' personnel. She said,

> I didn't even have a basic training. I just went from nursing to nursing. And this stood up very sharply because one day, [six] of us were supposed . . . to be a colour party for launching of the corvette. And we didn't know anything about marching much less saluting or anything else. So for two days, the patients on the floors instructed us on how to do this because nobody really knew. . . . We weren't really part of the Navy. . . . We were not given any pre-instructions so we had to learn all about 'galley' (and most of that was learned from the patients on the floor) because they *loved* teaching the Nursing Sisters. . . . We were in the Navy but not part of it.[26]

NS Kay Christie also had a similar awareness that nurses were not fully-accepted members of the military. She explained that in any references to the total number of the Canadian troops in Hong Kong, the official terminology was: "We were always 'plus two.' You know, there were 96 men officers plus two [nurse officers]."[27] And SAMNS NS Jean Keays explained that she did not have any 'Army training' because she was "just going to nurse after all."[28] Betty Riddell served with the United States Army Nurse Corps (USANC) and found the situation similar there because "we knew how to nurse." No special military training was included as part of her postings, either in the United States or in Papua, New Guinea.[29]

Nursing service was a third area that exhibited both continuity and change. Whereas all of the First World War military nurses served in the Canadian Army Medical Corps (CAMC), Second World War Nursing Sisters served officially in three branches of the Canadian armed forces, as well as with the South African force. The RCAMC was the only nursing service at the beginning of the war and for more than a year, all nurses enlisted through the Army. Even when the RCAF and RCN formed separate nursing services, Matron-in-Chief Smellie provided important initial leadership that facilitated continuity in policies, uniforms, pay, and benefits between the branches.

Like their foremothers, the second generation Canadian Nursing Sisters formed an expendable workforce that was expected to return to civilian life at the war's end—with civilian life defined primarily, as hospital or hearth.[30] Department of Veterans Affairs counselors generally perceived nurses either as well-qualified professionals who did not need assistance to find

employment, especially during the wartime and postwar nursing shortages, or as women destined for matrimony. As one counselor wrote, with respect to a nurse's eligibility for educational benefits: "Eventually marriage must be given a place in this winsome lady's figuring."[31] Overall, these nurses were eligible for more and better veterans' benefits than their predecessors—even though their options were stereotypically limited to traditional women's roles.

Matron-in-Chief Smellie epitomized continuity and change through her leadership of the RCAMC nursing service and indirectly, the other military nursing services. She brought previous experience from the First World War, tempered by her interwar roles with the Victorian Order of Nurses and the Canadian Nurses Association, into the varied contexts of the Second World War. In her first official Canadian Broadcasting Corporation interview, she established the ideal public image of the military nurse: "A nursing sister, no matter where she is, still represents the spirit of nursing and Canadian womanhood. Beyond rules and regulations, there is an individual code to abide by on or off duty. One thing we know—the Canadian nurse will be well taken care of—the Army sees to that."[32]

Nursing Sisters as an Expandable Workforce

Changes in the technologies of destruction, transportation, and communication during the Second World War influenced the type of medical care available and where it was provided. There were more invasive surgical interventions for burns, facial reconstruction, head and chest trauma, and extensive wound debridement to avoid limb loss where possible although there were still a large number of amputations. There were the first large-scale uses of blood, blood products, and intravenous fluids as well as the introduction of penicillin. Psychiatric and stress-induced syndromes came to be treated significantly different than they had been during World War I. Each of these changes called for expanded nursing expertise associated with diagnosis, surgical procedures, treatments, and the follow-up recovery. Moreover, large-scale campaigns involving the rapid movement of troops over vast distance required that this care take place ever

closer to the front lines in active theatres of war. For example, blood and plasma transfusions in the forward areas made a huge difference in the number of casualties that survived initial stages of shock to require subsequent emergency surgery in the field prior to evacuation to a base hospital. As the war progressed, military and medical policies shifted to position nurses forward in small mobile field units that followed the troops closely—sometimes under enemy observation and weapons.[33] Their geographical locations varied, as did the type and size of these medical units, and the nursing skills required to work in them (Chapters 2 and 4).

In Canada, the Nursing Sisters worked in military hospitals that functioned as sick bays, as screening and immunization units, and as trauma centers for casualties resulting from training accidents, especially at the air training centers of the Commonwealth Air Training Program. They were posted at the experimental station for chemical and biological warfare in Suffield (Alberta),[34] on hospital trains, in prisoner of war and internment camps, and in convalescent and rehabilitation hospitals. Overseas, they served on hospital ships that crossed the North Atlantic, transporting casualties between North America, England, and the Mediterranean, in addition to a variety of stationary and mobile medical units. Only 4.8% of the sampled nurses served one year or less, while 51.7% of them served 1-3 years, and at least 10% served more than 5 years (Table 2.1).

TABLE 2.1. SECOND WORLD WAR MILITARY NURSES BY LENGTH OF SERVICE, NSD (N = 1052)

Nurses	1-12 months	12.5 - 24 months	24.5 – 36 months	36.5 – 48 months	48.5 – 60 months	60.5 – 72 months	72.5 – 84 months
Number	50	285	259	197	155	70	36
Percent	4.8	27.1	24.6	18.7	14.7	6.6	3.4

RCAMC Nursing Sisters comprised the largest group of military nurses, serving in more than 100 medical units in Canada, three RCAMC hospitals in Newfoundland (considered to be an overseas posting), and at least 33 medical units in England. They moved with their units into the Mediterranean, to Northwest Europe after D-Day, and to occupied Germany after V-E Day.[35]

Initially, the RCAMC also provided medical and nursing services for the relatively small Navy and Air Force branches. As the senior service, they staffed Canada's first hospital ships (the *Lady Nelson* and *Letitia*) beginning in 1943, and the sick bay quarters of the *Queen Elizabeth* and *Queen Mary* that transported soldiers, prisoners of war, and war brides between Canada, Great Britain, and the Mediterranean.[36] RCAMC nurses also staffed the hospital trains in Canada, consisting of specially designed and furnished cars attached to regular passenger trains, each with space for 16-28 bed patients and additional 'sitting' patients. Hospital trains also included living quarters for the accompanying nursing staff and by the end of the war there were approximately twenty cars in service. The first ones were donated by the Canadian National Railway in 1940 and the Canadian Pacific Railway in 1941.[37] In addition, RCAMC nurses were involved with the evacuation of patients on Dakota and Sparrow airplanes from the continent back to England after D-Day.[38]

Two RCAMC Nursing Sisters, May Waters and Kay Christie, served with the contingent of Canadian soldiers posted to Hong Kong at the end of 1941--although it was not in the manner they had anticipated serving on their enlistment. Christie had wanted to go overseas and she volunteered for a semi-tropical posting (thinking of Jamaica). She was asked to accept a 'secret' overseas posting with only five minutes in which to decide and without knowing the destination. She was put on a train for Vancouver, alone, and told not to reveal anything to anyone on the way: "[M]y heart just dropped when they said Vancouver. I thought you don't go to England (or Jamaica) by way of Vancouver. But I had said I would go and it was too late. . . ."[39] She and Waters, who joined her when the train passed through Winnipeg, only found out in the mid-Pacific that they were headed to Hong Kong to serve with the Canadian forces there. Exactly three weeks after their arrival, the Japanese attacked Hong Kong in parallel with the attack on Pearl Harbor. On Boxing Day, 26 December 1941, Waters and Christie began twenty-one months as Japanese prisoners of war, under privation and harsh conditions.[40]

A small number of RCAMC Nursing Sisters re-mustered with the establishment of separate nursing services for the RCAF and RCN. Twelve nurses re-mustered and, along with

newly-recruited nurses, formed a second distinct group of RCAF Nursing Sisters in November 1940.[41] For more than two years, they had no Principal Matron and the Director of Medical Services (Air) administered the nursing service with consultation and visits from RCAMC Matron-in-Chief Smellie. Flight Lieutenant Jessie E. C. Porteous was finally appointed to the RCAF Directorate Medical Services in April 1943 as the first Matron, and became Principal Matron (RCAF) with the rank of Squadron Leader, a year later.

By the end of 1944, there were at least 100 RCAF air training stations across Canada and Newfoundland that had hospital facilities or infirmaries. They varied in size from units that consisted of only a few beds to the largest facility in St. Thomas, Ontario (the 700-bed-hospital at St. Thomas Technical Training School). Nursing Sisters staffed units that had 25 beds or more as well as medical units of the Royal Air Force training schools operating in Canada under the British Commonwealth Air Training Program. They also served in RCAF hospitals at Gander, Newfoundland and Goose Bay, Labrador. There were no specially-designated, RCAF general hospitals in England, but RCAF nurses did serve at the station infirmaries for No. 6 Bomber Group (Northallerton), No. 3 RCAF Personnel Reception Centre (Bournemouth), RCAF Repatriation Depot (Warrington), and at the specialized plastic surgery hospital unit for Canadian burn patients at East Grinstead (in Sussex).[42] Infectious diseases and minor surgical procedures comprised most of the work in the infirmaries as relatively few men survived the air crashes of training programs and bombing missions. Those that did survive sustained extensive burns that usually required months (and years) of surgery and rehabilitation.[43]

Six RCAF nurses completed the American air evacuation course at Bowman Field near Louisville, Kentucky in 1943.[44] They were part of the RCAF No. 6 Casualty Air Evacuation Unit that flew casualties from Europe to base hospitals in England beginning in August 1944, and evacuated civilian emergency patients from Newfoundland and Labrador to larger medical facilities. An advance party of No. 52 RCAF Mobile Field Hospital landed in Normandy on 6 June 1944 and by 19 June, four RCAF nurses had joined that unit becoming the first Allied women in Europe.[45]

A third group of military nurses formed in November 1941 when three RCAMC Nursing Sisters re-mustered to the RCN nursing service.[46] Matron-in-Chief Smellie also provided interim consultation to the RCN nurses for almost two years until the appointment of Matron Marjorie Russell in September of 1943.[47] RCN Nursing Sisters served in at least nine land-based naval hospitals: the *HMCS Naden* (Esquimalt, British Columbia), the *HMCS Stadacona* and *RCNH Rockhead* (Halifax, Nova Scotia), the *RCNH Ste. Hyacinthe* (Ste. Hyacinthe, Québec), the *RCNH Cornwallis*, *Protector* (Sydney), and *Shelburne* in Nova Scotia, and overseas at the *RCNH Avalon* (St. John's, Newfoundland) and *RCNH Niobe* (Greenock, Scotland).[48] They were posted to several clinics and special units: the *Donnacona* at Montreal, a special treatment centre for tuberculosis at Ste. Agathe (Québec), the *Tecumsah* at Calgary, and the *HMCS Conestoga* in Galt, Ontario to train members of the Women's Royal Canadian Naval Service as medical assistants known in the RCN as sick berth attendants.

RCN nurses did not serve at sea because the Navy was primarily a fighting force and had no hospital ships of their own. As NS Surgenor explained, there were seldom survivors when ships sunk in battle and most of the medical care required on ships consisted of first aid given by the sick berth attendants.[49] Survivors from the Battle of the Atlantic and merchant seamen comprised the majority of patients in RCN hospitals on the east coast. The hospitals in Newfoundland and Labrador were strategically located related to German submarine and U-boat activity,[50] and they provided a much-needed resource for the local civilian populations. The only Nursing Sister to die as a result of direct enemy action was a RCN nurse who drowned off the coast of Labrador.[51]

South Africa was also a strategic geographic location on the evacuation routes between the Middle Eastern theatre and England (especially with the Mediterranean under enemy surveillance for most of the war) and between the Far Eastern theatre (China-Burma-India) and England. The South African government requested and received special permission in 1941 to recruit three-hundred Canadian Nursing Sisters for service in their military hospitals. NS Wheeler pointed out, however, that the South African shortage of nurses was related as much to racist

policies regarding Black women as professional nurses as to the government's reluctance to divert White nurses from civilian to military hospitals, while NS Florence Louise Jamieson also spoke of race relationships during her SAMNS postings in a 'Native" hospital of the Veldt where an all-White nursing staff cared for an all-Black patient population.[52]

This fourth major group of military nurses actually included 302 Canadians by the end of the war, and they served as non-commissioned South African Military Nursing Service (SAMNS) nurses.[53] The RCAMC was responsible for their initial recruitment and they wore the RCAMC uniform, but the SAMNS was responsible for their transportation, pay and postings.[54] They left Canada in three large groups (two groups of 80 nurses and one group of 125 nurses) plus a few smaller groups to complete the draft and to supply replacements for the original recruits.[55] With Matron Gladys J. Sharpe as the liaison officer between the Canadian, British, and South African governments, SAMNS nurses signed one-year renewable contracts to serve primarily in British military hospitals where their patients came from the war zones of the Middle East, North Africa, India, Burma, and China. One of the largest hospitals was the 1000-bed hospital at Baragwanath near Johannesburg, where Canadian Nursing Sisters comprised a major portion of the nursing staff. They were also posted to military hospitals at Durban, Pretoria, and Pietermaritzburg. At the end of their contracts, two-thirds of them signed on with the SAMNS 'for the duration' and many of those who extended were subsequently posted to Egypt, Northern Africa, and Italy.

SAMNS nurses protested the discrepancy in their pay compared to RCAMC nurses when it became clear to them that living accommodations in South Africa were not provided and that the cost of living was higher than in Canada. NS Marguerite McLimont wrote that "we shall have to cut our living to our pay" because £13 per month wouldn't go far and was only one-third the rate of RCAMC nurses.[56] But not all SAMNS nurses could afford to make do with the lower rate. NS Angela La Croix returned to Canada in February 1943 and enlisted with the RCAMC one month later because she had financial responsibilities for her mother who was a widow.[57] After the war, the Canadian government passed an Order-in-Council to 'top up' their war service

gratuities and extend the same veterans benefits to them in partial compensation for the lower rate of pay.[58]

The military increased the number of Nursing Sisters as the war continued, and expanded the geographical settings to which they were posted as medical units followed the troops (Table 2.2). Almost all of the Nursing Sisters, with the exception of 1.0% who served only with the SAMNS, began their service in district military hospitals and troop training camps across Canada, while another 25.1% of them remained entirely within Canada. At least 68% of the Nursing Sisters served in England, 31.4% in Europe, 18.2% in the Mediterranean, 7% in the North Atlantic theatre, 4.3% in South Africa, with two nurses at Hong Kong.

TABLE 2.2. SECOND WORLD WAR CANADIAN MILITARY NURSES, BY THEATRE POSTINGS (N= 1052)

	C	UK	E	M	NA	SA	HK	P
NUMBER	264	715	330	191	74	45	1	332
PERCENT	25.1	68.0	31.4	18.2	7.0	4.3	--	31.6

Legend: C = Canada only; UK = United Kingdom; E = Northwest Europe; M = North Africa, Sicily, and Italy; NA = Newfoundland, Labrador, and the North Atlantic; SA = South Africa; HK = Hong Kong; P = Pacific campaign volunteer.

Most of the Nursing Sisters who went overseas, worked in a variety of settings and moved wherever their skills were needed. There were at least twenty-one different combinations of posted theatres (Table 2.3). These combinations illustrate just how mobile the medical units were, as they followed the troops into battle.

Diverse geographical settings were accompanied by diverse organizational structures as medical services adapted to changing needs and contexts. The RCAMC organized units initially as field ambulances according to the same 'chain of evacuation' developed during the Great War. The 'field ambulance' was a system for collecting and evacuating casualties to different levels of treatment ever further to the rear based on their stability and treatment needs.[59] It evolved in function, and according to the medical services' reorganization (1941-1942), the field ambulance

was to be fully mobile--consisting of a headquarters and two stretcher bearer units per field ambulance unit without having field dressing stations attached.[60] The first level of assistance was typically established near the battle site at Regimental Aid Posts staffed by a medical officer and stretcher bearers. Regimental Aid Posts managed basic first aid and minor illnesses, and initiated the evacuation to the next level of treatment if necessary. They moved constantly, had little or no capacity to retain casualties beyond the time needed to obtain transport, and therefore, required no nurses.

TABLE 2.3. SECOND WORLD WAR CANADIAN MILITARY NURSES BY COMBINATION OF POSTED THEATRES (N = 1052)[61]

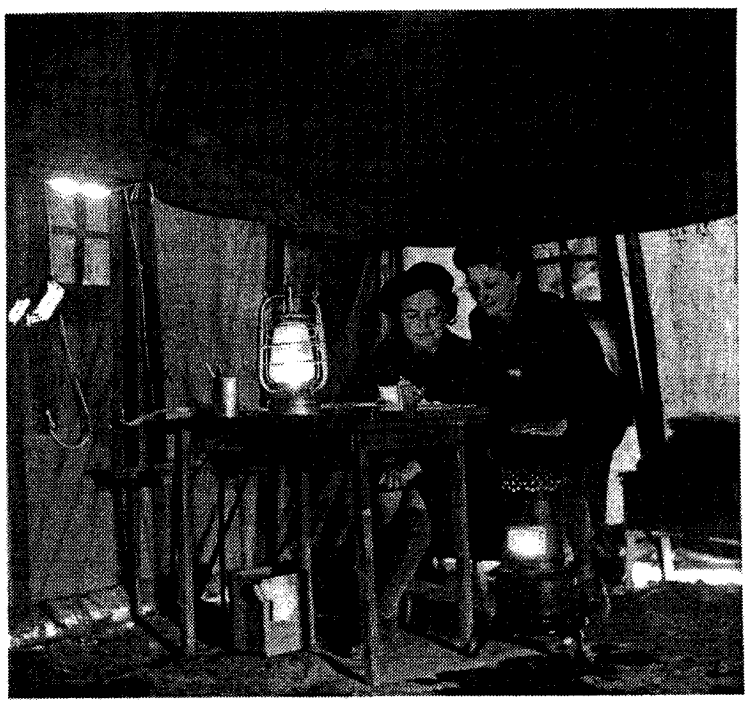
Number of NS	Canada	United Kingdom	Europe	Mediterranean	North Atlantic	South Africa	Hong Kong
1042	*						
715	*	*					
329	*	*	*				
57	*	*	*	*			
132	*	*		*			
1	*		*				
1	*			*			
20	*					*	
10						*	
1	*	*	*	*		*	
7	*	*	*			*	
4	*	*		*		*	
3	*	*				*	
2	*	*	*	*	*		
1	*	*	*		*	*	
6	*	*	*		*		
13	*	*		*	*		
10	*	*			*		
1	*			*	*		
2	*				*	*	
39	*				*		
1	*				*		*
264	Canada only						
332	Pacific volunteers						

The second level of evacuation now included the various field dressing stations and casualty clearing stations. Dressing stations provided several regiments with triage services: rapid diagnosis, essential emergency treatment, sorting and labeling of casualties in order of priority for further evacuation, and documentation.[62] They were sometimes differentiated into main dressing stations and advanced dressing stations with the term 'advanced' referring to their relative position to the front line more than to any 'specialized' level of treatment. As in the Great War, surgery and nursing care was initially unavailable to casualties prior to reaching casualty clearing stations and stationary hospitals. But that changed later with the formation of additional small, specialized units.

During the ten-month period between the Dieppe Raid (August 1942) and the Invasion of Sicily and Italy (June 1943), the RCAMC participated in numerous training 'schemes' in the United Kingdom (such as Exercise Spartan in the spring of 1943) that resulted in another re-organization of medical services. Instead of bringing the casualties over long distances to surgical care, the emphasis shifted to taking surgical care to the casualties.[63] Major changes involved the formation of even smaller specialty units that were more mobile than complete hospitals, the positioning of these field medical units further forward to reduce the delay in access to specialized care (such as emergency surgery, transfusion, and fluid resuscitation), and the addition of nurses to the staff to enhance the efficacy and efficiency of such units.[64] NS Patricia Moll was with No. 1 Field Dressing Station in Italy when they set up 2.5 miles behind the front lines--ahead of Canadian artillery and in sight of German patrols. Authorities pulled the unit back to 5 miles however, when they decided it was just too close.[65]

Two smaller specialty units evolved to meet these needs for increased mobility and earlier treatment: Field Surgical Units and Field Transfusion Units. They were attached to various Field Dressing Stations as needed and once attached the combined units were known as Advanced Surgical Centers. Once the unit ceased admitting casualties, the Field Surgical Unit and the Field Transfusion Unit moved to a different Field Dressing Station--leaving the regular

Field Dressing Station personnel to recover and evacuate the patients who by that point were post-operative.[66] Field Surgical Units have been described as self-contained, mobile units consisting of a generator and a water tank with enough linen, equipment, and personnel for 30-40 operations as well as vehicles to transport them. Based on the British Army's experiences in the Middle East campaigns and first used by Canadians in Sicily and Italy, field surgical units were staffed typically by two surgeons, two nurses, an anaesthetist, and two orderlies.[67] There were at least ten Field Surgical Units operating in Italy and Europe. Sources do not indicate that nurses were posted to Field Transfusion Units although they did indeed work in the resuscitation wards where transfusions were administered. NS Pepper and other nurses frequently described the tangle of infusion lines in these tented wards, where intravenous fluids and blood products hung from ropes along the top of tents.[68]



Photograph 1. "Nurses in a tent, night duty, North Africa." Photographer unknown. PA 213775, Department of National Defence, National Archives of Canada.

Medical services historian and physician, W. R. Feasby, assessed the effectiveness of nurses in these units this way: "It is emphasized that without the excellent post-operative care provided, the work of the surgeons would have been of little avail however far forward they might have been positioned."[69] One Field Surgical Unit in Italy attributed their mortality rate decline (from 15-16% to less than 10%) to 'better nursing.'[70] Another medical officer expressed ambivalence, however, regarding nurses' presence in the Field Surgical Units when he wrote to the *Journal of the Canadian Medical Services*:

> [I]n this particular set-up there have been 6 Nursing Sisters—four on the wards of the FDS, and one with each surgical team. It has been of value I think, but can well visualize situations where it would be impossible to have the nurses with us, and for that reason have not departed very far from our previous routine. Certainly the nursing on the wards has been excellent, and having our own girls has, if nothing else, improved the morale of the patients,--in fact we have been criticized for spoiling them![71]

But this medical officer's letter refused to see the addition of nurses to the Field Surgical Unit as anything but temporary and contingent, even to the point of denigrating their substantial contribution to patient outcomes to a level of morale building. The girls, who were mature professional women, were spoiled (a coded term for 'protected'), presumably by the men although the author does not indicate what concessions he felt they received. Nurses were often aware of their mixed reception in these advanced units, as NS Helen Bright wrote regarding her introduction into a field surgical unit at Dixmude, Belgium: "At first, we had only a few patients . . . . During this slack time, we had the opportunity of becoming acquainted with the orderlies with whom we were to work and to feel our way into the unit which had never had nursing sisters before."[72]

Partially to avoid the need for nurses in forward areas, the RCAMC began training 'other ranks' (men) as nursing orderlies who are also referred to as medical orderlies, medical assistants, or ward orderlies in the literature. Training began with a class of 80 men at Camp Borden in October 1943. The course lasted three months and after one year, 489 orderlies had qualified through the program. From this group, the 'most promising' orderlies were then given an additional sixteen weeks of instruction in Operating Room technique and posted to Field Surgical

Units and Casualty Clearing Stations s to supplement the nursing service.[73] These specially trained orderlies certainly played an important role and nurses developed a keen awareness of their strengths as well as limitations. But as military historian Bill Rawling pointed out, they could not substitute or replace fully trained professional nurses in terms of patient outcomes.[74] One war diary recorder described the introduction of nurses as members of a Field Surgical Unit attached to his Field Dressing Station in February 1944, noting there had been 'early doubts about this innovation':

> Most of the FDS commanders are a little leery about having nursing sisters around, believing that their personnel may resent their presence. In this case, however, the personnel of the FDS are very pleased to have them. Nursing orderlies have done considerable work and have considerable experience, but they have 1000 questions to ask that only a nurse can answer. Realizing this, the nursing sisters have been putting on lectures and demonstrations for them.[75]

The majority of RCAMC nurses served in large Canadian General Hospitals of 600-1200 bed capacities in England. Many of these base hospitals transformed into field hospitals that moved to the Mediterranean during 1943-1944 and into Northwestern Europe during 1944--although eleven of twenty-six medical units remained in England for the duration of the war.[76] When base medical units moved to an active theatre, they often doubled their size to accommodate casualties. Medical officers and nurses were added to the unit as required and as available, while regularly posted personnel worked extended hours to complete surgeries and evacuate patients in preparation for the next round of admissions. When bed capacity was reached, patients were treated on stretchers that lay just inches above the ground as NS Jean Dorgan wrote: "The fact that we had 200 beds meant nothing. When we ran out of beds we used stretchers."[77]

Nurses also served in smaller 200-600 bed Casualty Clearing Stations, whose chief mandate was to stabilize and evacuate critical patients. Prior to moving to an active theatre, Matron Agnes MacLeod described her Casualty Clearing Station in England during 1941 as consisting of an orderly room tent, an admission and discharge tent, a medical service tent, a surgical service tent, support services, and patient tents—in all "well over fifty" tents. She noted

the patient turnover was great because they were only to keep short term cases that did not need a general hospital.[78]

Casualty Clearing Stations evolved as the medical services sought increased mobility. The size of Casualty Clearing Stations had become cumbersome, and with the development of Field Surgical Units, the role of the Casualty Clearing Station shifted toward immediate post-operative care of patients in addition to stabilizing casualties for evacuation. By 1943, the RCAMC scaled down the essential components, and down-sized Casualty Clearing Stations to 100-200 beds. They also developed a pattern known popularly as 'leap frogging,' or alternating admissions between paired Casualty Clearing Stations that were positioned in close proximity to the front lines. These Casualty Clearing Stations were sited approximately five miles behind the front initially, and moved forward whenever the transportation distance approached fifteen miles. They were often associated with a small stationary general hospital of 200-bed capacity that handled priority III casualties and sick troops, while providing a pool of nurse reinforcements for the forward units.[79] These mobile units moved relatively soon behind the troops and adapted to whatever facilities they found: schools, convents, barns, bombed-out factories, chateaux or canvas tents. NS Pepper was one of eight nurses in No. 5 Casualty Clearing Station that leap frogged with No. 4 Casualty Clearing Station at least 18 times in Italy. She and another nurse were left for 4-5 days with only a driver, a cook, and 17 patients until the casualties could be evacuated to base (general) hospitals.[80]

From large field hospitals, casualties who required longer than two weeks of recovery were evacuated by hospital ships, trains, and increasingly by air ambulance back to England where Canadian General Hospitals and special medical units continued their treatment. Prior to the offensive campaigns, Canadian General Hospitals dealt primarily with casualties from the Battle for Britain and from the Dieppe Raid, as well as with medical needs and training accidents in the United Kingdom. Casualties returning from the Mediterranean and Europe had on-going needs for surgery as well as convalescent care and rehabilitation. Burn patients, for example, often required years of reconstructive surgery that was done in a series of meticulous,

intermediate steps to graft and rebuild eyelids, mouths, noses, ears, jaws and other essential body parts.[81] In addition, the number of patients with venereal diseases such as gonorrhea and syphilis increased tremendously during the first years of the war, and again during the Italian campaign.[82]

Not all patients were Canadian troop casualties. Medical units treated POWs in Canada and overseas and occasionally civilians as well. Nursing Sisters cared for more than 150 children during the bombing of Coventry, and 69 children from Birmingham at No. 1 Canadian General Hospital in Marston Green during 1940.[83] With No. 2 Casualty Clearing Station in Holland, NS Margaret Fletcher described two sisters, aged 7 and 11 who were brought to her unit, writing: "The little one had to have her arm off at the elbow, & the sister had two holes in her posterior chest, & a chest full of blood—more grenades. I had the job of making a pincushion out of the poor little souls, and couldn't speak a word to them. I never felt such a heel in my life."[84] And in Italy, NS Betty Nicolson described a local family who sought help from the only medical service available to them:

> We had a peasant (I remember) once in the OR when I was on duty. And we heard a lot of moaning and groaning coming up towards the hospital. And it was a group of Sicilians pulling a donkey, pulling a wagon. And obviously a family, all moaning and groaning. And their father had been out in the field tilling, and he had gone over a mine. And they were bringing him up to our hospital, of course. And we knew though when he came in, that there was nothing we could do for him. But they set up an intravenous anyway, and just waited. They mined a lot and booby-trapped a lot.[85]

Similarly, in Newfoundland and in isolated training camps across Canada, RCAF and RCN Nursing Sisters often served as health care resources for whole communities. Some of the first RCAF air evacuation flights involved nurses on 'mercy flights' to bring patients to larger medical centers while RCN nurses operated a well baby clinic.[86]

The armed forces based their projected nursing requirements on the First World War experience, exercising caution "to avoid a rush of volunteers such as occurred in the last war"[87] and to maintain good relations with civilian hospitals. Thus the medical units had a relatively small nursing staff compared to civilian hospitals of the same size but decisions regarding teamwork and the use of both 'other ranks' and recovering soldiers as nursing assistants made

these staffing patterns work.[88] For example, twenty-four hour coverage for a static 600-bed hospital was provided typically by eighteen medical officers, a Principal Matron and a Matron, 50 Nursing Sisters, two physiotherapist aides, one dietician, and 70 nursing orderlies.[89] A 1200-bed hospital required a minimum of 80 Nursing Sisters although the actual staffing varied according to the number of casualties and their level of acuity regardless of the planned size of the unit. When bed capacity and/or acuity increased, so did the number of nurses. In England, for example, small groups of nurses began working with specialty teams that grew into larger, specialized hospitals. Twenty nurses worked with Dr. Wilder Penfield (the well-known neurological surgeon from Montreal) at the Hackwood House site of No. 1 Neurological Hospital, while five nurses worked initially with the Canadian plastic surgery team at Park Prewett. These two units merged to become the Basingstoke Neurological and Plastic Surgery Hospital in 1943, increasing in size to 600-beds by 1944.[90]

There was a shift away from the deployment of medical units as static organizational structures to functional deployment where the type and size of a given unit was somewhat flexible—contingent on need as well as available resources. Field hospitals expanded by adding tents as additional wards and using the low-lying stretchers. A general hospital sometimes operated as a Casualty Clearing Station, while a Casualty Clearing Station sometimes downsized to operate as an advanced surgical centre or field dressing station. NS Kellough described her unit, No. 5 Casualty Clearing Station in Holland, as comprised of 'about fifteen Nursing Sisters' but 'up to twenty' whom they 'loaned out' when needed.[91] With the 1941-1942 reorganization, authorities deliberately planned to create a reinforcement pool of nurses to be located along with a 200-bed stationary hospital near the railhead on main evacuation routes of active theatres.[92] These nurses were to be 'above quota' and readily available wherever they were needed.

Adequacy of staffing is difficult to determine partially because it was contingent on individual settings, number of casualties, intensity of war activity, and even the transmission of contagious diseases. Adequacy also depended on whose perspective was solicited. Military authorities frequently claimed nurses enjoyed better working conditions than in civilian hospitals.[93]

Nurses also admitted that in some Canadian and overseas hospitals during times of relative inactivity, the staffing was generally better than in civilian hospitals. But they also described episodic situations with long hours of continuous work, dealing with horrendous crises, and the frustration of not being able to give the type of nursing care they had been taught.[94] NS Helen Mussallem compared war nursing to civilian nursing as being much more fragmented: "In the Army, it was just a question of (I don't like to use the word), but sort of 'patching' them up and get them ready for more war or patching them up and sending them back to Canada."[95] Posted to No. 6 Casualty Clearing Station in France, NS Frances Ferguson explained:

> The highest number of nurses I think I remember in the CCS, was eight. We were supposed to be a 20-bed-unit and we got patients in, all during the day. We got some at night, too . . . . [W]e had patients in the bed, under the bed, head-first if they had something wrong with their feet, and feet-first if there was something wrong with their head . . . . I think we were—at one time we had about 56 patients in a 20 bed unit. So what do you do with them? You know. And they were all in need of a lot of help. So that means with eight nurses on (to cover for 24 hours), they've got to go pretty hard. So we went as long as we could walk and it was daylight. We were on the go.[96]

NS Margaret Roe also recalled: "You worked pretty hard. I remember being so tired coming off night duty, you'd walk past the dining room going upstairs to your room . . . . We'd just plod upstairs, and we were just so tired, we didn't want to eat. You felt nauseous."[97]

Two ways in which nurses coped with the workload was by teaching and supervising, first medical orderlies and second recovering patients to assist with nursing care. In the RCAMC, nurses trained the 'other ranks' or non-commissioned troops as medical orderlies. In the RCN, they trained ratings and Women's Division personnel to be sick berth attendants. And in the RCAF, they trained Women's Division personnel and other ranks.[98] The training began informally, but as the number of enlisted men increased, so did the bed capacity and the need for trained medical assistants. By 1943, there was a formal training program for RCAMC medical orderlies consisting of a one-month course with 80, half-hour periods of lecture and scheduled demonstration periods. There followed a period of supervised practice with both written and practical examinations at the end. In June 1943, 56 medical orderlies also received training as operating room assistants for work in the new Field Surgical Units. As Major J. L. Patterson

reported, these trained assistants would "go where Nursing Sisters cannot go."[99] There were significant differences in background preparation between the medical orderlies and the professional nurses. However, as Rawling points out:

> Doctors (and Nursing Sisters, one might add) were basically civilians—or more specifically, professionals—in uniform, who had undergone all their essential medical training before volunteering for service. Other ranks followed a different career path, not beginning their medical education until after joining up and completing a course of basic military indoctrination. . . . [Other ranks] were essentially soldiers first and medical practitioners second . . . .[100]

NS Pepper wrote: "Our 'boys' . . . had come from farms, businesses, shops, school rooms, construction work, and numerous other occupations far removed from the teachings and routine of a health institution . . . . Most of the instruction was accomplished on the job." She noted however, that they were "alert, watchful learners"—many of whom became "expert and highly reliable" as they dealt with "dust, heat, stench, and the scarcity of water."[101]

Medical orderlies extended the eyes, hands, and feet of nurses. As NS Ferguson said, "When we worked in the CCS, we had some wonderful male orderlies that we trained to help us. That was their job. They weren't also cooks or cleaning men or anything else. They were on duty with us, and they helped us watch the intravenous and anything else we needed done. They were excellent."[102] But in other settings, orderlies could be problematic and less enthusiastic regarding work assigned in the medical units. NS Louise Jamieson found it necessary sometimes to have the ward sergeant enforce the 'work list'. She also had to 'watch the back rub bottles' (containing alcohol) to prevent the boys from taking them.[103] NS Tritt found medical orderlies required careful supervision because of their limited preparation. She needed some sterile supplies for a surgical procedure, and asked the orderly for them: "[T]he orderly said, 'Oh, Sister McClellan taught me how to sterilize things'. . . . So he brought out this big pillowcase, and we said, 'What's that?' 'Oh, I sterilized them and then I opened them, and put them in the pillowcase.'"[104] This orderly did not realize that he had re-contaminated the sterilized equipment by his actions.

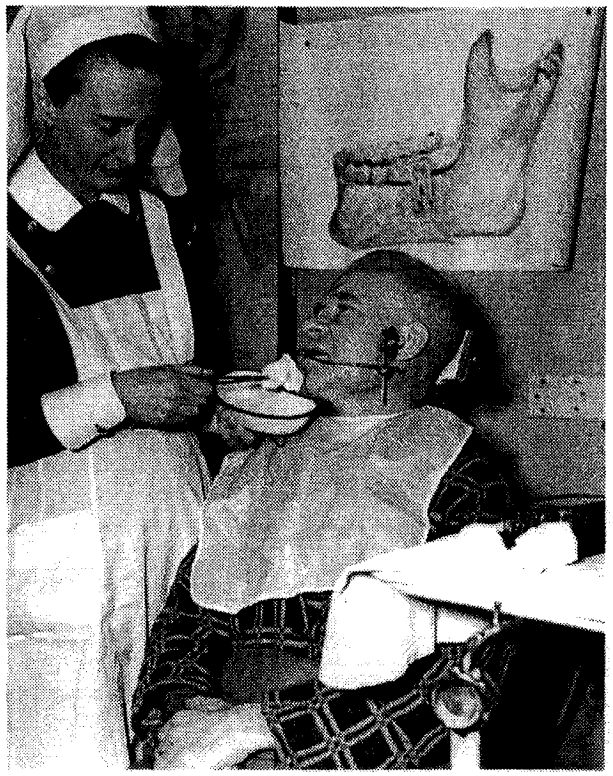
In the military, even the patients were expected to work—not only at getting well but also at ward duties. Indeed, medical services depended on patients' work to offset the minimal quota of nurses and medical orderlies per unit. NS Littlejohn posted patients to the ward 'duty roster' while NS Bayly explained that as soon as patients could move around, they were expected to make their own beds and help on the ward, unlike patients in civilian hospitals.[105] NS Margaret Mills called the work that patients did, "'Joe Jobs'—they cleaned the sinks, they swept the floors, they did whatever they could do. . . .They all had jobs. The Nursing Sister had to make out a fatigue list every morning."[106] NS Ferguson noted that patients wanted to help nurses and one another, even in the frontline areas: "The fellows that were up and around were always [asking] 'can I help you?' [and] 'What can I do?' They'd see you carrying something and they'd be right there. They were a grand bunch."[107] But dependence on patient work was not always appropriate. NS Joan Doree said there were never enough nurses at Basingstoke because the quota was based on having the assistance of "up-patients," but her area didn't have many recovering patients capable of providing assistance due to the number of serious burns cases treated. As the war continued and Canada experienced manpower shortages, the military not only conscripted men but also reshaped the workforce of medical units. As Doree stated, "We had fewer orderlies because they were taken away to carry a gun . . . they were so desperate for soldiers."[108]

These strategies partially alleviated military concerns regarding a shortage of civilian nurses at home. The use of medical orderlies and recovering patients did reduce the total number of nurses required although a need for Women's Division personnel as medical orderlies emerged toward the end of the war during the conscription crisis as the armed forces sought to re-classify men for combat duty. Success in the substitution of less-prepared workers for fully trained nurses in the forward units varied considerably. Once again, nurses parlayed their technological skills and flexibility into roles in the forward units and on specialized care teams.

By 1943, yet another layer of 'triage' was added to the system as medical units began to sort patients according to specialized care needs and evacuate to specific hospitals with staff

skilled in those areas (such as No. 1 Neurological and Plastic Surgery and the RCAF Plastic Surgery wing at East Grinstead in England, or No. 15 Canadian General Hospital for VD and No. 14 Canadian General Hospital for psychiatric care in Italy). Military medical units treated a relatively larger number of patients with head injuries, chest trauma, extensive burns, and more severe psychiatric symptoms than ordinarily encountered in civilian practice settings. As a result, they learned ways to modify and/or develop new treatment techniques to deal with these problems. One such specialized group was the Maxillo-Facial surgical team that dealt with reconstruction of the jaw and face. The team typically included a surgeon, a medical specialist, an anesthetist, and several nurses who were trained in specific techniques.[109] Other small mobile medical teams with expertise in chest surgery or head surgery operated in Europe after D-Day.

As we shall see, within these newly-formed field surgical units, field dressing stations, and reorganized casualty clearing stations, the Nursing Sisters encountered a variety of new technologies and modified others while assuming expanded practice roles.[110] NS Elsie Barr wrote, "[M]uch of our expertise (savoir faire) was acquired by encountering a problem and rising to the occasion."[111]



Photograph 2. "Nurse with a patient, North Africa," photographer unknown. PA 213778, Department of National Defence, National Archives of Canada.

As staff worked together daily within these small units, they came to know and value each other's roles and expertise. NS Sloan called it "a true appreciation of each others' skills--that we knew what the surgeons and physicians did, was absolutely vital. And what we did was absolutely vital in carrying out those orders. Because everybody wanted everybody to get better, or to at least be comfortable before they died."[112] They developed standard practices so that when there were a large number of casualties, all team members could proceed without waiting for individual medical orders. NS Wannop never received a desired posting to the continent because of her expertise in the care of burns. She remained at Basingstoke where, she explained:

> [W]hen the big push would come on and patients would be brought in, you were pretty well much on your own. But by this time, you pretty well knew what to do . . . . The doctors were so busy that I guess we were trained ahead of time . . . . [T]hey used to come around once a day and check everything, and if there were any questions or that. And then you carried on and if you were concerned about something, you know you could always call them but they gave you a lot of responsibility . . . . I was told that

because it was such a unique hospital and the work was specialized--that you couldn't do it on the field and that's why they kept us there, and the patients were flown back to us.[113]

Nursing Sisters as an Expendable Workforce

The Second World War lasted somewhat longer for the Nursing Sisters than for the fighting forces. They continued to care for recovering casualties, ill military personnel, and through most of 1946, they increasingly cared for civilians released from concentration camps. At first, they continued as members of the active service and then as the Army of Occupation while medical units gradually downsized and closed throughout Europe and England (Table 3.4). The last overseas medical unit closed on 15 May 1946—six years and nine months after the declaration of war.[114] Then military hospitals across Canada also gradually closed down as soldiers with long-term needs for medical care transferred to the Department of Veterans Affairs (DVA) hospitals where several hundred nurses (including at least 126 nurses or 12% of the NSD) worked as civilians and civil servants.[115] From the end of 1946 to the end of 1947, RCAMC medical units were part of the Interim Force while the military considered the size and shape of a permanent postwar establishment. The Canadian Army Active Force (Interim) had 79 Nursing Sisters in 1947.[116]

TABLE 2.4. SECOND WORLD WAR MILITARY NURSES BY YEAR OF DISCHARGE, ACCORDING TO THE NSD (N = 1052)

	1940	1941	1942	1943	1944	1945	1946	1947
Number	4	21	18	18	44	426	505	16
Percent	3.8	2.0	1.7	1.7	4.2	40.1	48.0	1.5

As previously noted, the postwar quota for military nurses was set at 30 for the RCAMC, 30 for the RCAF, and 20 for the RCN. Nurses could apply for short service commissions (from three to seven years) that ensured a steady flow of nurses, but they offered little long-term

stability.[117] Only 2.9% of nurses in the NSD were accepted into the Permanent Forces, although many of them expressed the desire to remain in the military as indicated in their discharge interviews.[118] NS Sloan described an effort to have regional representation in the postwar Nursing Service. Since there were fewer applicants from the western Canadian provinces, she was invited to apply for the Permanent Force RCAMC. She was accepted and spent the rest of her nursing career there, until retirement as Matron-in-Chief of the Canadian Forces Medical Service in 1968.[119] Other nurses, however, had less positive experiences with discharge. When NS MacLean returned from overseas to Montreal, she was told by her superior that: "The war is over. You will leave the service." She then recalls: "And we were about twenty-five of us, sitting there. And I said, 'I'm waiting for my boyfriend. I'm going to work!' And he said, 'All right, you can go up to the Military Hospital.' There were ten of us went up to the military hospital. The rest of them quit."[120]

The Second World War had offered Nursing Sisters a reprieve from the working conditions of the 1930s, with a variety of opportunities to further their experiences professionally and socially. When the war ended, nurses were eligible for a package of veterans' benefits that many described as 'opening new possibilities' for them.[121] Like American military nurses, they viewed inclusion for veterans' benefits primarily as a progressive step for women rather than perceiving increased militarization as a loss of autonomy for professional nursing.[122] "The Post-Discharge Re-establishment Order," PC 7633, provided a legislative basis for postwar financial support, while veterans "were unemployed, pursuing vocational training or higher education, temporarily incapacitated, or awaiting returns from farming or other private enterprise."[123] The program of benefits became known as "The Veterans Charter" (from the publication that outlined the regulations and policies) and a brochure titled *Back to Civil Life* explained the process to veterans.[124] The plan was complex and designed to ostensibly treat men and women equally, allow veterans to make choices, and participate in the program's administration.

But as Peter Neary and Shaun Brown point out, "It is easy to . . . to confuse the equality of opportunity proclaimed in *Back to Civil Life* with what actually happened under the charter's

provisions" because it was designed primarily with men in mind.[125] Few women qualified for the Veterans' Land Act, women's benefits were modified by marital status, and DVA counselors reinforced gendered occupational choices through their power of recommendation. Veterans who experienced war wounds were eligible for further compensation consisting of medical care, living allowance supplements, and pensions for long-term disability.

Nurses typically benefited from three main components of the package: the War Service Gratuity, re-establishment credits, and education allowances. The length of service and where they served determined the amount of War Service Gratuity to which nurses were entitled. It accumulated at a rate contingent on rank and postings—with extra allowances for overseas postings. The basic rate was $7.50 per thirty-day period of service in Canada and $15.00 per thirty-day period of service overseas, with an additional supplement for each period of six months spent overseas. The gratuity for nurses who served in the armed forces four or more years with overseas postings could constitute a substantial amount for the postwar period (approximately $2000 or more).[126]

The re-establishment credit was equal in amount to the basic gratuity but it was considered as an alternative to training and land settlement grants. It consisted of credit that could be claimed for housing and furnishings, tools, establishing a business, purchasing insurance, or purchasing a government annuity—up to the total eligible amount.[127] Education allowances consisted of tuition and a monthly living stipend for the duration of the course but the veteran had to meet admission requirements of the program desired—often placing further education beyond reach for many of the Depression generation, who left school without grade twelve matriculation, which was necessary for university courses.[128] This constraint was noticeable in the data from this research as nurses most frequently chose postgraduate certificate nursing courses offered by universities rather than degree programs of study. Close to one-third of the nurses had enlisted during the last 1.5 years of the war and therefore qualified for relatively smaller gratuity and pro-rated benefits. They were eligible for less educational allowance, and since the discharge principle was on a "first in--first out" basis, these nurses were also among the

last discharged. They found classes filled to overflowing at the universities offering post-graduate nursing courses, and frequently had to wait a year or longer to apply.

Nurses shaped their compensation benefits in different ways. NS Lamont illustrated how she and her veteran husband combined disability, re-establishment, and education allowances—making gendered choices. She received a small veteran's pension for her "war wound" acquired when she had to "hit the ditch" while biking at night and a convoy of military trucks forced her off the road. She injured her shoulder but the extent of the damage was not recognized until she was working in a DVA hospital postwar and required surgery on the shoulder. The injury was attributed to her fall and she received a small pension of $40.00 a month until 1950 when the Army paid her out with an additional $98.00. In addition, she used her re-establishment credits to purchase a bedroom suite while her husband used his benefits to go to university.[129] In a similar manner, NS MacLean bought a washing machine and furniture with her credits.[130]

The War Service Gratuity and education benefits were the two most significant programs for nurses, but access to them was conditional on the circumstances of discharge and the DVA counselor's recommendation.[131] First, the official statement of discharge carried great import as language worked to control military women's eligibility for benefits, medals and awards, gratuities, re-establishment benefits, and self- esteem.[132] I found no "dishonourable discharges" among the NSD sample of nurses, but I did find cases where nurses were "asked to resign" for a variety of reasons such as "psychoneurosis" or "unsuitability for the military". As discussed previously, nurses who married prior to 1943 had to resign their commissions and therefore, they forfeited all rights to benefits—unlike male officers who married. But official discharge records stated the reason for discharge in a variety of ways that allowed a measure of ambiguity, such as "permitted to retire", "permitted to retire on compassionate grounds", permitted to marry, resigned, or simply demobilized (without a reason). Pregnancy was another situation in which language was occasionally used to obscure a diagnosis that would result in the loss of benefits, through the substitution of vague terms such as "physiological tumour", "absence of menses", or simply "unable to meet medical requirements". It was very important to have a marriage qualified with

the phrase 'with permission,' as noted previously. Nurses had to go through official channels for discharge that included medical examinations, requests for permission from the commanding officers, and filing innumerable forms. And at each level, those in power made decisions about the contents of personnel records that had consequences for a lifetime.

Second, counseling (and DVA counselors) shaped nurses' options and decisions. While many nurses indicated satisfaction with the process, there were those who felt they had not received adequate support and advice. NS Wheeler said poor counseling required her to live on previous savings at the University of British Columbia while waiting on veterans' credits to start.[133] NS MacGregor was not impressed with her discharge process: "I went for a physical examination and a lot of interviews. The officers doing the discharge procedure seemed much more interested in the amount of benefits I would receive than in what I would do with the rest of my life after over five years in the Army. I was given a pin to wear to show I was a veteran, and a ribbon to show that I had served overseas, defending the Empire."[134]

A severe civilian nursing shortage had begun to emerge during the war and there were a great many more vacant positions than nurses who wanted to fill them following the war. One result was that DVA counselors (and indeed, the nursing profession) viewed returning Nursing Sisters as a "solution" to the civilian problem rather than being concerned about their employment issues. Almost all of the NSD discharge summaries contained comments that veterans who were nurses would have no problem finding employment. With few exceptions, nurses who indicated they wanted to change careers did not receive support to do so. Even in cases where nurses indicated they would not be seeking employment either because they had married in the military or were getting married on discharge, counselors frequently noted these women could always "fall back on nursing if need arises in the future." Married nurses were encouraged to use their re-establishment credits for furniture or appliances rather than education—as another example of gendered expectations. One record simply stated that the nurse should "use her benefits to improve her home conditions."

Nursing was clearly perceived to be the ideal feminine profession in the postwar world. Nurses read in the *Canadian Nurse*, for example: "When we survey, specifically, the position of women in his postwar world, we recognize again that you are in a fortunate field—free from male competition. You contemplate a world in which no man wishes your job or thinks that your earnings cut him off from legitimate employment."[135] Society urged other women to return to the home, vacating full-time employment for returning male veterans and resuming traditional feminine roles as wives and mothers. But nurses were needed at civilian bedsides and the military released them without excessive concern for their futures as an expendable work force.

Gender, Danger, and Public Discourse

Military nursing was not without its dangers, although nurses were expected to work only in traditional roles, in safe settings, and well-protected by the armed forces. Existing literature often perpetuates a silence around military nurses and danger, through the questions that are asked, as well as those questions that not asked. For example, NS Mary Bray contributed to one anthology, and donated a copy to the Canadian Forces Base Borden library almost a decade later. In the accompanying letter, she wrote: "We were asked to recall the fun times but indeed there were more sadness and horror of what the war was all about."[136] During the war, the military constrained nurses from speaking or writing about their experiences, when all troops were warned not to divulge any military information verbally or in writing to prevent information leaks to the "enemy". All mail was censored to ensure their conformity.[137] NS Pepper wrote:

> It was certainly a man's war. Many situations were quite unnatural for women. For example, obeying security rules when writing home was difficult: You mentioned only the mundane happenings, when you were just *dying* [emphasis in original] to tell your family all about the last combined operations field exercise of the whole Corps . . . . Imagine not being allowed to mention, either by name or unit, the boys from home whom you were caring for! Also, the fact that at sun-down every nursing sister in the Italian theatre of war had to don long trousers and cream herself with anti-malarial ointment rather than an exotic perfumed product would have made interesting reading in letters sent home. As a result of these security regulations, we padded our letters and made it all sound like real fun.[138]

Nurses were already used to a form of self-censorship regarding patients, from their earliest student days. Many of them also internalized military censorship, to the extent that they still hadn't talked about their experiences, even fifty and sixty years later. Some had personal reasons to impose silence or declare topics "off-limits", like NS Fletcher, who wrote to her brother: "Mind you—there will be lots that I won't talk about, because things that happen in Eng & the continent just wouldn't be accepted in Victoria—just as the odd drink wouldn't be accepted by some of our relatives."[139] Some Nursing Sisters made it clear in my interviews that there were topics which we could not discuss further. Regarding personal relationships within the medical units, for example, NS Van Scoyoc replied: "Some of them [the nurses], I guess, it was a little bit beyond family! We'll leave it there."[140] Several nurses were very uncomfortable with any criticism of the military or of physicians, and at least two of them requested material to be deleted from their own accounts.

For the most part, Nursing Sisters made "excellent soldiers" in that they maintained their official silence during and after the war. Wartime journalist, Lotta Dempsey, described them as "a silent service among women . . . who tell nothing. That reticence has become a part of their work and their life in the Army."[141] NS Carter wrote of several remarkable experiences during the bombing of England. The impact of a nearby bomb during an air raid knocked her off her bicycle one night on the way to work at the hospital: "[A] Home Guard, also on a bicycle going to his point of duty . . . brushed me off, found my bike and got me started on my way again . . . . I never told anybody at the hospital about it, as too much was happening."[142] Another nurse endured the effects of war in silence when she returned from Italy, with severe psychiatric problems, and in a catatonic state.[143]

The reticence to associate combat and risk with women (especially with nurses) may be partially explained in terms of shaping public support for the war. But there was also a deep denial that nurses were an essential part of the military machine—indeed, they made the military machine more efficient (by returning men to combat), more acceptable (by assuring competent care was quickly available for casualties), and more 'normalized' if women could serve there

safely.[144] This denial has kept nurses invisible and silent regarding their own history, even sixty years later. For some nurses, it has also meant that they never received needed counseling and support, either during or after the war. Nursing Sisters spoke of feeling restless, unsettled, or unable to make decisions following the war. Some of them struggled through years of unhappy relationships and/or dysfunctional family situations. Still others continue to cope with painful memories and losses experienced. NS Ruth Littlejohn McIlrath frequently referred to feeling "scattered", at a "crossroads", and at "loose ends" while NS Mary White wrote and spoke about her unhappiness in the military and the counseling that she felt she needed.[145]

According to the existing literature, forty-six Nursing Sisters died during the First World War, twenty-one of them from enemy action and twenty-five of them from disease—but only one Nursing Sister is acknowledged, generally, as dying from 'enemy action' during the Second World War.[146] RCN NS Agnes Wilkie was returning from Sydney, Nova Scotia to St. John's on the Newfoundland ferry *SS Caribou* when a German submarine torpedoed and sunk it. Wilkie and her companion, NS Dietician Margaret Brooke, hung onto a capsized lifeboat for over two hours in the cold and rough waters of the Atlantic before Wilkie lost consciousness. Brooke was later rescued, and Wilkie's body was recovered for burial with full Naval honours.[147] According to Brooke,

> There was [sic] about a dozen of us. We clung to ropes. The waves kept washing us off, one by one, and eventually Agnes said she was getting cramped. She let go, but I managed to catch hold of her with one hand. I held to her as best I could until daybreak. Finally, a wave took her. When I called to her, she didn't answer. She must have been unconscious. The men left tried to reach her, but she floated away.[148]

A four-page, anonymously-published article with photographs of RCAMC nurses in Sicily (October 1943), repeatedly made the point that there was little distinction between military and civilian medical services—that nurses were in familiar, safe environments and that the most advanced in medical care was always available to the Canadian troops.[149] The photographs showed a nurse relaxing in front of her tent with washing on the clothesline (much like a domestic scene or a camping holiday), a room of hospital beds neatly lined up in a row (much as they would be in any civilian hospital of the period), and a group of nurses sitting in front of a "beautiful

piece of tapestry" with the tea service on the table in front of them—all reinforcing images of safety and normalcy. Matron Edith Dick wrote a letter to the *Canadian Nurse*, concluding that: "We live surprisingly normal lives over here."[150] Matron-in-Chief Smellie's assertion that the Army always protected its nurses reinforced the dominant discourse, but promised more than it was possible to deliver. Indeed, I found there were more deaths, injuries, exposures to danger, and hardships than are generally acknowledged.

There are at least twelve other nurses and an occupational therapist that died while on active duty, including accidents and diseases, as reported by various sources.[151] There are discrepancies as to the number of deaths and the names of the nurses, partially based on which causes of death and which dates were used to determine inclusion as a Second World War death (Table 3.5). The RCAMC statistical record appears complete when corroborated with additional sources, but it only included RCAMC Nursing Sisters: nine nurses and one Occupational Therapist. There were at least two RCAF Nursing Sister deaths, one caused by a training accident during a familiarization flight, and the other from disease. Three deaths were the result of motor vehicle or bicycle accidents. Seven nurses died from disease processes, such as a coma of unknown origin, a brain tumour, septicemia, uremia, bacterial myocarditis, cerebral hemorrhage related to hypertension, and cerebral meningitis. The "Books of Remembrance," in the Memorial Chamber of the Peace Tower on Parliament Hill, list seventeen names as Nursing Sisters who died "during or after" the war. Of the additional four names that this source lists, one death was the result of a disease process, two years after the war ended, and the remaining three deaths are not corroborated in any other source.[152]

TABLE 2.5. SECOND WORLD WAR CANADIAN MILITARY NURSES: DEATHS FROM ACCIDENTS AND DISEASES, 1939-1945[153]

Name	Service	Date of Death	Age	Place	Cause
Marion Bell	RCAMC	26 Sept. 1940	29	England	Biking accident
Frances Spafford	RCAMC	8 Mar. 1941	28	England	Coma of unknown origin
Frances Polgreen	RCAMC	11 May 1943	32	England	Septicemia

Ruth Ashley	RCAMC	6 June 1943	28	England	Brain tumour
Nora Peters	RCAMC	12 Aug. 1944	34	Italy	Motor Vehicle Accident
Vera MacDonald	RCAMC	22 June 1945	26	England	Motor Vehicle Accident
Frances Cooper	RCAMC	26 Oct. 1945	35	Vancouver	Uremia
Gladys Fitzgerald	RCAMC	30 Dec. 1945	35	Ottawa	Bacterial myocarditis
Frances Gannon	RCAMC	15 Mar. 1946	43	Calgary	Cerebral hemorrhage, hypertension
Agnes Wilkie	RCN	11 Oct. 1942		Newfoundland	Drowning (as result of enemy action)
Jessie Margaret McLeod	RCAF	29 Apr. 1941	39	Dartmouth, Nova Scotia	Cerebral meningitis
Marion M. Westgate	RCAF	27 Oct. 1943	26	Regina	Flying accident

Motor vehicle accidents were quite common, especially in England under blackout conditions with many roads heavily damaged from bombing. Motorcycles were particularly notorious as a cause of injury and death among men—sometimes referred to as "Hitler's secret weapon" against the Allied forces.[154] In addition, alcohol use and abuse along with frequent party invitations from various messes compounded the risky driving conditions. Bicycles were a popular form of transportation and recreation (given the extent of gasoline rationing) but they were also relatively unfamiliar to many nurses who described buying and riding their first bicycle in England. Nurses who had ridden them previously in Canada were not familiar with British bicycles with hand brakes. Numerous accounts exist of their biking adventures and accidents.[155] NS Helen Rendall required head and facial stitches after her accident: "It was at night you know—I didn't have any lights and I shouldn't have been riding the bicycle at night. I ran into this thing [a truck]. A man drove us back to the hospital and then they sent an ambulance to get the bicycle."[156]

Perhaps the most poignant death involved a nurse who developed septicemia from an infected thumb at No. 8 Canadian General Hospital. She was treated with sulfathiazole and blood transfusions while unsuccessful attempts were made to secure doses of a new drug for

her.[157] Penicillin was still in the early days of testing and only very small amounts were produced at the time she needed it. It would emerge from the war as a "miracle drug", but it was too late for this nurse.

In addition to the risk of potential death, there was danger associated with travel to and from postings, on- and off-duty activities, training demonstrations, and combat.[158] Ninety nurses (plus five other Nursing Sisters and four Red Cross workers) of No. 14 Canadian General Hospital were rescued when their ship, the *Santa Elena,* was torpedoed in the Mediterranean en route to Sicily in 1943.[159] NS Cox was on the *Santa Elena* as the attack happened, around 6:00 PM, just at the end of the evening meal when an aerial torpedo hit the stern of the ship:

> Right away the ship sank in the stern part. And went down quite a bit, but we were still alright. So then, they had us get to our [lifeboat] stations. We had practiced that before. We had a Philipino crew who . . . had never even tried to use them. So they hadn't any idea how to get these boats out and how to do it. So it was quite a mess. . . . Finally, mine landed on the water and we had to row over to the *Monterey* which stood by . . . . The rest of the convoy went and they put up a smoke screen . . . . What you had to do was bring the boat along side the ship. And as the waves took your boat to the ship, one person would grab the net. They had a tremendous net on the whole length of the ship, and you had to climb it. And so, that was not easy. Anyway, we managed. All of us got out. There was just one of the girls who just couldn't make it. So they sent down one of these (sort of like a sling) and were able to put her into that. And then they got her up. Anyway, we got up and managed to get over, and then climbing over the top--we just got to the top and some of the boys there would heave us over. And our faces were black. All you could see were black faces from the smoke screen. Nobody recognized anybody . . . . It was funny though, how the girls that were picked up by the destroyer . . . said they were grabbed out of the boat. They didn't touch the ground at all. They were passed from one soul to another into the destroyer, and down until they landed to wherever they were going to go. Two of our girls—one fell off this—unless you were very athletic, it was not an easy thing to do. And she was injured (fortunately not in any severe way). She had no fracture and they managed to get her back up.[160]

One group of nurses was picked up by the *SS Monterey* and taken to Naples, while the rest went by a Canadian destroyer to Philippeville in North Africa. They lost all their personal belongings as well as all of the hospital's equipment. Both Cox and NS Marjorie MacLean recalled the strafing during the attack. Cox said, "It was like July the 1st standing on that deck and watching all this stuff going up. That's what it reminded me of. Fireworks, tremendous amount of stuff went up." NS Marjorie MacLean also remembered that "when you got out and away from the liner, you could still hear some of the shooting going on. It was a beautiful night, warm and everything. I

don't think it was more that a couple of hours before the other one picked us up."[161] NS Nicolson was a "reinforcement", on her way to Sicily with No. 5 Canadian General Hospital, in the same convoy. She noted that whenever aircraft attacked the convoy, the nurses were ordered below deck—yet another case where the predominant discourse was protection of women. Nicolson questioned the wisdom of this order saying, "I wondered if that was a good thing or not, in case we had been hit. I mean there were lots of us, but anyway, we were below."[162]

Nurses experienced bombing, strafing, and accidents both on and off duty. NS Rendall spent three years with No. 15 Canadian General Hospital at Bramshott, England where as she said, "That first September we were there, [we were] bombed several times every day. And we could set our clocks by the time the Germans would come over. We got so [familiar with the bombing missions, that] we could recognize their machines—the sound of their machines—and they'd come at exactly the same hour every night, to bomb London."[163] NS Sloan went to Europe with No. 8 Canadian General Hospital where,

> At night, the firing in our area was heavy, and although the tracers and flares were beautiful to behold, the rattle of shrapnel through the trees was frightening. Our Colonel issued hospital beds for all sisters, and instructions to hop under the bed with bedroll once the firing started. Since moles, field mice and lizards inhabited the area under the beds, we had to make a choice between the shrapnel and the livestock. Usually we ended up in bed with tin hats covering our faces and enamel wash basins over our stomachs.[164]

At least fourteen RCAMC nurses were wounded in training accidents, as well as, by enemy and 'friendly' fire (two in England and twelve in Sicily).[165] Three Nursing Sisters were injured during a grenade demonstration in England. Two suffered phosphorus burns and one nurse required plastic surgery to 17 areas of her body. Another NS spent two months in the hospital with a fractured skull and shoulder sustained in a jeep accident that killed her companion.[166] NS Jean Scrimgeour was the only survivor among five pedestrians hit when a passing jeep ran over a land mine in Italy.[167] And although NS Sloan suffered a fractured spine in three places (C2, T5 and T6) when she fell off of a railway handcar in Canada, she healed in time to serve in England and Europe during the Normandy Invasion.[168] At Catania (Sicily), the Nursing Sisters of No. 5 Canadian General Hospital lived on the top floor of a sanitarium that had been

converted for temporary hospital facilities. The building was located just below Allied batteries, and the nurses' mess was on the balcony of the top floor.[169] During an air raid (2 September 1943), Allied 'friendly fire' fell on the balcony at supper time—injuring twelve nurses and three orderlies with shrapnel. Two nurses required evacuation to North Africa and one to England.

Nurses worked in dangerous situations although official records and discourse denied it. NS Kellough was with No. 5 Casualty Clearing Station near Nijmegan in Holland where the nurses were billeted in homes. Around 0300 or 0400, the Officer Commanding collected all of the nurses, and transported them back to the hospital because German troops were entering the town.[170] My sources revealed many more injuries (fractured arms, legs, spines, and heads along with wounds that required surgery, stitches, hospitalization, and rehabilitation), that never made it onto the official 'wounded' lists of the armed forces, even though the injured spent days or months recovering in hospitals. The invisibility of this wastage was partially related to the discourse around women, safety, and male protection. Women were to be protected—especially, military women who were to remain far from frontlines. For nurses, however, invisibility was also consistent with their training and discipline. They were expected to be the sacrificing 'mothers' and angels who gave their lives willingly on behalf of patients with infectious diseases such as tuberculosis, diphtheria, and influenza.

The *Lady Nelson* made several trips to the Mediterranean during 1943, to pick up patients from Sicily, Italy, and North Africa and return them to England and Canada. Nurses from the ship (except for a skeleton staff) were on shore leave at Philippeville prior to the return trip when the harbour was bombed—sinking a British ship and killing 400 troops near the *Lady Nelson* that sustained extensive damage as well.[171] According to NS Littlejohn, the nurses felt compelled to return immediately to the ship for duty but on returning dockside, they found the *Lady Nelson* had been moved out into the harbour for safety. They argued with security and finally persuaded an American captain to take them out to ship where they climbed a rope ladder in skirts, gloves, and carrying purses. Littlejohn said, "When we walked into what had been the

dining room, I wish you could have seen the look of astonishment on the doctor's face. 'What are you doing here, how did you ever get here?' 'We haven't climbed up ladders on the farms for nothing,' I said. 'We've been up lots of ladders before.'"[172] In spite of feminine accoutrements, these nurses could be 'masculine' when necessary.

Nurses frequently dealt with adverse weather events: a North African 'sirocco' that blew hospital tents down and dispersed patient documents across the desert; extremes of heat and cold while working in tented hospital units; makeshift buildings without windows or doors; periods of heavy rain that called for rubber boots instead of nursing duty shoes; and both rough seas and submarine threats on hospital ship crossings. NS Eleanor MacGregor described the North African heat as so intense, that the nurses slept under wet towels to cool down as much as possible.[173] For her part, NS Cox recalled the poor sanitation and cold conditions of Italy:

> I was running into this dysentery sort of thing. It was nasty, nasty business. And I would take this sulfa, you know, and it would control it eventually . . . . [S]anitation was terrible especially in Italy and in that barracks. They didn't have any seats on the toilets to start with. They had just urinals, and you can imagine what that was like for the women! 'Till they managed to put some holes in. It was an awful situation! And we got so cold. Ethel and I went on night duty when the first unit opened up, with 140 patients. And it was so cold, that's where I put the hot water bottle on one side and put a string onto a hot water bottle on the back, in order to keep warm. We were freezing to death! It was awful. We worked all night with hot water bottles hanging around [our necks]. We were not very handsome, I tell you! [174]

Other occupational hazards included malaria, tuberculosis, infected wounds, lice, fleas, poisonous scorpions, electrical equipment,[175] occasional belligerent patients and POW, exposure to toxic substances, and more. Malaria was endemic in the Mediterranean region, and the armed forces ordered all personnel to take preventative measures including anti-malarial drugs—beginning en route to the area. NS Cox said, "We were on Mepacrine from the time we hit Italy till we left. And we were all as yellow as ducks' feet . . . Everybody was supposed to be on it, but of course, the boys probably up the line never bothered to take it half the time. They would come down with [malaria]."[176] NS Rendall recalled they had to take the drug in front of the Officer Commanding and have their names checked off while NS MacGregor explained that malaria prevention was taken so seriously that "If we got it, it was considered a 'self-inflicted wound.'" NS

Kellough described a sign on their mess table that asked, "Have you had your mefloquine today?"[177] NS Carter claimed Mepacrine was responsible for her hair falling out and losing its curl while Kellough attributed their blackened teeth to the heavily chlorinated water used for tea, admitting that new staff thought the nurses extremely strange-looking with yellow skin and black teeth.[178] Nurses, like all Canadian soldiers during the Second World War, had a chest x-ray prior to enlistment. It is likely, therefore, that those nurses, who were discharged with tuberculosis (0.8%) as medically unfit, acquired it from their patients. To control lice and fleas, DDT (dichloro-diphenyl-trichloroethane) was impregnated into their clothing, especially the seams, as a preventative measure while DDT powder was also issued for personal and patient use.[179] NS Cox recalled using DDT liberally:

> Well, we were using a lot of that. I remember always shaking some in to my bedroll. We had these little bedrolls--that was our bedding in Italy. And we used to open the thing up and shake this stuff in. I mean, when you think of the amount of DDT that went in to those bedrolls! We must have been completely saturated in the stuff! Anything was better that those fleas that you'd get![180]

Possibly the most difficult and uncertain conditions, however, were those NS Kay Christie and May Waters encountered as POWs. They were working with a British medical unit staffed by members of the Queen Alexandra's Imperial Military Nursing Service (QAIMNS) and volunteers at the Bowen Road Hospital in Hong Kong when Japanese forces attacked 8 December 1941 (on the other side of the dateline). The hospital itself was bombed and shelled for eighteen days—taking 111 direct hits that damaged two of the three floors. Nursing staff from Bowen Road also served in small auxiliary hospitals on the island such as St. Stephen's Boys School where horrendous atrocities were committed against patients and personnel. (Both medical officers and patients were shot and bayoneted). At St. Stephen's School, QAIMNS NS Molly Gordon and six Volunteer Aid Detachments (VADs) were raped, with three of the VADs beheaded afterwards. As Gordon told Christie her story, Christie said:

> I will never, never forget the look in her eyes! . . . . Molly wasn't young, she must have been in her late 40's, just a little woman . . . . The Japs [Japanese soldiers] took a lot of the men's bodies, the ones they had killed, and dragged them across the corridor and into a small room, and put the bodies in there. Then they dragged mattresses in and put them on top of the bodies. And then they went at the nurses . . . . They took [their Red

> Cross arm bands] off and wiped their faces with them and then they stripped them and they went after the nurse. And Molly said it wasn't just one Jap per person, she said it was just a series of Japs on you. And what they were really afraid of was that these women would be infected, [with] something like venereal disease but not the two old favorites that we knew of over here . . . Eventually, in a day or so, they got them back. I think they were put on some kind of a vehicle and covered up with stuff and told not to utter a sound. . . .[181]

Christie and Waters knew about the atrocities in the auxiliary hospitals and wondered what would happen to them when the Bowen Road hospital would be taken. On duty Christmas night, they thought: "[E]ach time footsteps approached the darkened ward, we'd wonder 'Is this it?'"[182] The Japanese arrived on Boxing Day, ordered the surrender, put up barbed wire, and declared the hospital "Prisoner of War Camp A." Japanese soldiers maintained constant surveillance in the hospital wards and dormitories, day and night, carrying their guns and bayonets while running their fingers up and down the blade. Christie recalled frequent unnerving experiences of being watched during procedures with patients, waking up at night with one of the guards standing in the doorway, and observing "every method of torture" used as punishment.[183]

According to the Geneva Convention, nurses were not supposed to be taken as POWs but Japan did not sign nor recognize the agreement. For the first eight months, the Nursing Sisters remained at Bowen Road and cared for casualties as well as they could with dwindling supplies. In August 1942, all female nursing personnel were loaded onto trucks and taken to a civilian internment camp (Stanley Camp) on the other side of the island, where they remained behind barbed wire with 2400 others and in no better circumstances than at Bowen Road. There, three nurses (Christie, Waters, and a civilian nurse[184]) slept, ate, and lived in a nine by twelve foot room for another fourteen months, sleeping on the cement floor initially. They eventually acquired the barest of furnishings, sharing one enamel basin for washing purposes and 'scrounging' an assortment of parts to create a makeshift 'hot plate' for preparing their meager rations. The Japanese refused to recognize women as officers or grant them officer rights that would have provided a minimal pay for use on the black market to supplement their rations: 8 ounces of cooked rice, 3 ounces of flour, ¾ ounce of 'flesh' (meat or fish), and some indigestible 'greens' per day. In March 1942, the Japanese announced their intention to pay the Canadian

Officers at a rate corresponding to Japanese Officers, including "the two nurses that had the two stars on their shoulders" but not the British Nursing Sisters. According to Christie,

> [The QAIMNS] Matron got mad and said that if they wouldn't pay her Sisters, well they weren't going to pay us either, which was very foolish because we could have bought some things we could have shared. But, no, she wasn't going to have anyone paid if her Sisters weren't paid—they finally slapped her face, she'd argued with them too much . . . . Our Canadian officers established a fund and they gave three Padres and May and myself 25 military yen a month. And a military yen has no real value, but we used to be able to get a bit of stuff with it. That's why May and I had money . . . and that's the only way we managed, because it would have just been dreadful.[185]

Christie wrote and spoke further of the physical hardships (the poor diet and weight loss, vitamin deficiencies, visual deterioration, lack of clothing, difficulty with cleanliness), the lack of privacy, the many restrictions, and the uncertainty that accompanied their daily existence.[186] They received only one Red Cross food parcel (November 1942) and Christie received only three letters during the entire period (written over a year earlier and delivered June 1943). Her family was misinformed regarding her situation—there was an official report as 'missing, presumed dead' and information from an escaped prisoner who reported that she had been killed. She described the enforced idleness that compounded hunger, as two of the most difficult aspects. While a group of civilian nurses operated a small hospital within the internment camp, they did not want the military nurses to work with them after their transfer to Stanley Camp, until after eight months had passed and they needed some relief help for night duty. By the fall of 1943, the Canadian government arranged to have the two nurses included as part of an American prisoner exchange. The Japanese did not release the British Nursing Sisters or the volunteer nurses, for another two years.[187] According to Christie, "We were told that the Japanese were out to humiliate the British, and they did." She clearly differentiated, however, between the behaviour of Japanese soldiers and Japanese civilians, who were not involved in these activities.[188]

The suddenness and violence of the Hong Kong defeat reinforced the potential cost of including women in active theatres of war to military authorities, while expectations regarding women's safety in the military increased. At the same time, public discourse on women's safety in the military down-played the dangers, and failed to address the very real possibilities nurses

might encounter. Increasingly, the armed forces implemented policies that were ostensibly for women's protection: restriction of their off-duty activities; the use of physical barriers, such as fencing, mandatory escorts, and guards; and "confined to barracks orders".[189] NS Jean MacBain called fencing "the greatest drawback for all of us . . . we (nursing sisters) were not allowed out unless accompanied by an armed escort. 'Don't fence me in' was our theme song."[190] As NS Rendall recalled:

> We weren't allowed to go out alone, while we were there [North Africa]. We had to go out in groups or with officers. But one night when we were all sleeping the Arabs came into our compound. And some of our girls had their clothes hanging out on the line (they'd washed them). The Arabs came and just took everything. They even went through a couple of the tents and grabbed the things off the poles where the girls had their clothes. They took a shirt; maybe another one got a skirt. So our outfits were kind of incomplete for a little while . . . . Our compound had the barbed wire around and we had the guards all the time.[191]

Near Caen (France), NS Rita Murphy wrote that nurses were ordered to sleep in 'slit trenches' that she described as areas dug in the earth about twenty inches blow ground level. This was another precautionary measure against anti-personnel bombs taken "so we would be available in case of disaster."[192] Nurses were valuable resources, not unlike scarce medical equipment that was divided up for transport so that if part of it was lost or damaged, the rest might survive. NS Van Scoyoc recalled that, with No. 6 Casualty Clearing Station in Europe, "We were set up so that when we moved, there was one nurse in each truck. And in case we would be shelled, we wouldn't lose all our supplies, or all our staff."[193]

There were other areas of danger about which military nurses remained relatively silent. NS Sloan spoke of an embarrassing nervous tic she developed in Belgium related to psychological stress when the bombing intensified there:

> [I]t was a horrible time. I developed a tic--it was very embarrassing. It happened so often. My arm shot out: jerk, jerk, jerk. That was in Antwerp where the Germans were trying to get the harbour (the use of the harbour) because it was the best harbour on that North coast. . . . [A]lthough they said that these things [the V-2 bombs] crashed in Antwerp every 20 minutes, they did never hit the port facilities. They were difficult to control, their projectory [sic] I guess you call it. But they were frightening because they were devastating. They made no noise and made these terrible, terrible concussions. It destroyed a tremendous amount of Antwerp—that beautiful, beautiful city. And well in the last hours in Antwerp, they hit a theatre and we got 1200 casualties from the

> theatre—civilians. And it was very bad. But that's where I got the tic. It was terribly embarrassing.[194]

The nurses of No. 5 Canadian General Hospital landed four miles from the front in Sicily (at Augusta) in landing crafts on the ninth day of the Invasion—apparently to the surprise of those who were in charge, and who were not expecting women during an assault. Their supply ship (carrying both medical supplies and personal belongings) was blown up in the harbour as they landed. NS Nicolson recalled:

> I must tell you that it was interesting because the British officer in charge of movements. . . . They were horrified because there were Nursing Sisters there. And it was the first time ever in any allied British or Allied war that Nursing Sisters had been landed on an assault area. And he didn't know what to do with us! It was kind of exciting . . . . They got us into trucks and moved us a little farther up, to Syracuse. We went in at Augusta. So they got us away from that harbour where the other ships were coming in and landing . . . . They didn't know what to do with Nursing Sisters. We weren't supposed to be there at the beginning![195]

NS Elizabeth Burnham wrote about the stress within her unit: "We were put up in one large ward, fifty-five of us, the beds having just been vacated by the Germans. . . . Heavy shelling kept on all night which didn't make us feel very relaxed. . . . I think we were a bit overwhelmed by the constant shelling." Later she added, "Alone on the roof on night duty with many shell-shocked and mental patients, I often wondered about our safety in this wartime nursing."[196] Medical units frequently set up in vacated facilities where nurses had the job of preparing spaces for patient care—another potentially dangerous (as well as distasteful) job. In Rome, they found toilets "filled to the brim", plumbing and electricity destroyed, and live grenades in drawers as well as "an arm under a mattress and a leg up on a shelf."[197]

During the Hong Kong invasion, NS Christie struggled between her own fears and obedience to orders that required her to lie under patients' beds during bombing attacks—to be available to the most helpless patients who could not be moved to safety:

> The nursing sisters had orders, from the DMO [District Medical Officer] that we must--each of us must get under the bed of the sickest patients . . . . To look after them. We were to look after the patients but, you know, I couldn't see much sense in that because we all might get a couple of floors of the hospital come down on top of you. But then to get a big iron bed, and a patient and a double mattress come down on you! . . . . I had been lying in the space between the two [beds]. I could look after two patients and not get the whole thing down on top of me. But somebody must have told the DGM and so

> next day there was a notice posted: ALL NURSING SISTERS (and ALL was underlined about ten times) WILL GET UNDER THE BEDS OF THE SERIOUSLY ILL OR DAMAGED PATIENTS . . . . You know as I was under the bed [with] all this crashing, I thought, "And Kay, you used to be afraid of thunder storms!"[198]

Nurses were integrated into the military more and more, while their position as non-combatants became less and less clear, and medical units became strategic components of battle plans. In Italy, prior to a major offensive around Cassino during November 1943, medical units were concentrated under camouflage instead of displaying the Geneva Red Cross symbol prominently. Nurses became suspicious this was not really a rest period when according to NS Pepper, they watched and listened to battle plan discussions and the "traffic" increased daily. In a similar manner, when No. 3 Canadian General Hospital, No. 1 Canadian General Hospital, and No. 4 Casualty Clearing Station moved from Italy to join the European invasion (March 1945), medical units moved to Marseilles and from there to Holland in secret, stripped of any identifying insignia. This was particularly problematic for nurses who had to be kept out of sight, and confined to barracks, to avoid disclosure in Marseilles because they were a large group of women, moving as a unit, and in uniform.[199] As nurses became increasingly militarized, their neutrality status and rights to protection under the Geneva Convention became increasingly questionable.

In addition to physical and psychological dangers, there were personal and professional dissonances for nurses. Nurses spoke of their ambivalence about sending patients back into the fighting units, or seeing the same soldier two or three times on re-admissions (especially in Italy). NS Mussallem said, "In the Army, it was just a question of . . . patch them up and get them ready for more war, or patching them up and sending them back to Canada." At the Casualty Clearing Station near Nijmegan where NS Bayly worked,

> [T]here were quite a few Scottish regiments around us that had casualties and they started a cemetery beside the hospital. There were perhaps two or three there, when we came. And then, the whole area was filled. And they'd play the bagpipes and the 'Last Post.' Well it went just right through you, you know. You listened to it. So after the war, I really would burst in to tears if I heard it--for quite a while. That was one thing I couldn't stand for a long time . . . . And we had a chap attached to us from the Graves Commission, for a short time. And the poor fellow--I never knew his name--we called him "Graves" all the time.[200]

NS Betty Herringer explained, "You expected but hoped against hope you would not find your friends among the badly wounded and severe casualties."[201] Yet, when a Nursing Sister was killed in a jeep accident in Italy, her friends "had to dress her in her uniform, fix her hair, get a casket and arrange for burial" in addition to forming the Honour Guard.[202] NS Lettie Turner found that she was unprepared for the civilian suffering and starvation, or for the nursing care of POWs, who carried photographs of their families and children—putting a different face on war.[203] For NS Van Scoyoc, the most haunting memories were associated with her Casualty Clearing Station posting just after V-E Day, when her unit received patients from nearby concentration camps:

> [A] lot of the time, we had to give them morphine. Because they were so ill-nourished, it was so painful for them. And a lot of them never made it back to their country. It was very sad . . . . [W]hen I was in Holland, I remember that at night, often we would hear screaming. And we thought it was a psychiatric hospital, a Dutch psychiatric hospital—that it was the patients that were screaming. But afterwards, we realized we were quite near Belsen and it was probably the people from Belsen we were hearing. But we didn't know it. We didn't know it until we got home, really. [204]

Not all nurses could take care of POWs readily—nor were all POWs willing to be taken care of by Allied military nurses. Penicillin was, initially, a scarce resource to be used as a last resort, and to be reserved only for the worst cases. When a Major Surgeon ordered NS Fletcher to give penicillin to a POW, as she wrote: "I just looked at him; we had had hate drilled into us for so long—that anything German was evil. I said, 'Do you mean to say you're going to take that penicillin away from our boys who need it and give it to that man?' He looked at me and said, 'Sister, you damn well do what you are told and don't try to play God.'"[205] Other nurses described experiences where German POWs refused care, spat in their faces, or unnerved them with looks of hatred during treatments.[206] NS Bray was a member of No. 3 Casualty Clearing Station when it took over an enemy casualty clearing station in France; she admitted that professional bonds did not transcend enemy relationships in this situation, as the "German nurses glared at us and we glared back."[207]

These nurses were among the small number who spoke of fear, stress, revulsion, grief, pain, and horror. In most existing accounts, including my own interviews with Nursing Sisters,

they have preferred to relate anecdotes about their off-duty social activities, their novel living conditions, or memories of soldiers' bravery when wounded and/or dying. As student nurses, they had been socialized to consider patients needs before their own needs and war was no exception. One Nursing Sister went so far as to call the military 'permissive' compared to her school of nursing.[208] Wartime journalist, Lotta Dempsey, wrote of the Canadian Nursing Sisters: "Trained not only in hospital routine, first aid and care of the sick but also in discipline and service, they take to the rigors and strict routine of military life without qualms."[209]

Summary

Nursing Sisters enlisted in great numbers, knowing very well that they had "big shoes to fill" in view of the reputation of their foremothers involvement in the First World War. They experienced both continuity and change as the Canadian military medical units expanded into three armed forces branches, seven theatres, a variety of practice settings, and expanded practice roles. They also moved progressively forward to the frontlines, as it became clear that professional nursing was significant to the outcome of medical and surgical care. The process of incorporating nurses into the military was constrained more by gender than by their abilities.

The dominant gendered public discourse assured military nurses that they would "always be well taken care of" by the Army, and that they would serve in safety. But nurses' experiences did not always correspond to this discourse; their acceptance of a variety of dangers and risks became part of the price for enhanced status and opportunities as Nursing Sisters. There was, however, an official reticence to acknowledge nurses' association with risk and injury, or their career limitations. Regardless of how well they performed, military nursing was a temporary role with few positions available in the postwar armed forces.

The Nursing Sisters already knew how to nurse from their training schools, and they demonstrated their ability to adapt and expand these civilian skills to the military settings. But when they enlisted, nurses had to also learn how to be professional soldiers. Nurses' training

had socialized the right kind of nurse, but it was the military that shaped them as both "officers and ladies" according to a class, race, and gender specific set of expectations. Chapter 3 explores that transformation process.

Endnotes

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[1] T. S. Wilson, "Resuscitation in Battle Casualties," *Journal of the Canadian Medical Services* 2, no. 5 (1945): 520.

[2] Cynthia Enloe has also made this point in *Does Khaki Become You? The Militarisation of Women's Lives* (Boston: South End Press, 1983): 100.

[3] Beginning with the Overseas Nursing Sisters Club at Edmonton in 1920, Nursing Sisters formed local clubs at Montreal (1921), Calgary (1922), Winnipeg (1923), Brandon, Halifax, St. John, Toronto and Vancouver (1924), Victoria (1925), London (1926), and Hamilton (1927). During July 1929, these local groups united as the Overseas Nursing Sisters Association of Canada. They held their first biennial in 1932, with a membership of 667. "Nursing Sisters' Association of Canada, 1920-1966," Agnes MacLeod papers, Alberta Association of Registered Nurses Archives and Museum [hereafter cited as AARN]. Reports from various branches can be found typically in the *Canadian Nurse* such as "Overseas Nursing Sisters Association," *Canadian Nurse* 36, no. 1 (January 1940): 32. Cynthia Enloe suggested that British Nursing Sisters had also been "reluctant to return to civilian life in 1918. It appeared to them that their vistas were about to shrink." See Cynthia Enloe, *Maneuvers: The International Politics of Militarizing Women's Lives* (Berkeley: University of California Press, 2000): 214.

[4] Ethel Johns, "A Valiant Heart," *Canadian Nurse* 35, no. 8 (August 1939): 459-462. Clint's memoirs were published as M. B. Clint, *Our Bit: Memories of War Service by a Canadian Nurse* (Montreal: Barwick Limited, 1934).

[5] Jessie Morrison, "Address to Royal Alexandra Hospital Nurses Alumnae – Edmonton, 9 December 1974," Record numbers 87.4, 91.30, and 92.10 AARN.

[6] "Nursing Service, RCAMC, CASF," *Canadian Nurse* 36, no. 7 (July 1940): 425-426; "The Matron-in-Chief in Canada," *Canadian Nurse* 36, no. 8 (August 1940): 497-498; and Major McCabe, "Short History of the Nursing Service, RCAMC," 29 March 1952, 147.009 (D1), Department of National Defence Directorate of History and Heritage, Ottawa [hereafter cited as DHH].

[7] Elizabeth Smellie, "A Message from the Matron-in-Chief," *Canadian Nurse* 36, no. 9 (September 1940): 622-623.

[8] "Nursing Service, RCAMC, CASF," *Canadian Nurse* 36, no. 2 (February 1940): 87-88.

[9] Ruth Littlejohn McIlrath, audio-taped interview with Nina Rumen at Vancouver and Burnaby, British Columbia on 20 October 1987 and 23 November 1988, Oral History Collection, Registered Nurses Association of British Columbia, Vancouver, B.C. [hereafter cited as RNABC].

[10] Ethel Johns, "The Shape of Things to Come," *Canadian Nurse* 37, no. 2 (February 1941): 84.

[11] C.P. Stacey, *Official History of the Canadian Army in the Second World War*, vol. 1 *Six Years of War: The Army in Canada, Britain and the Pacific* (Ottawa: Queen's Printer, 1955): 30-31, 43.

[12] Stacey, *Official History of the Canadian Army*: 110-122.

[13] G. W. L. Nicholson, *Canada's Nursing Sisters* (Canada: Samuel Stevens Hakkert & Company, 1975): 131; Doris Taylor Rasberry, audio-taped interview with author at Pointe Claire, Québec on 19 June 2001.

[14] E. L. Smellie, "Recommendations from Minutes of Matrons' Conference," in "Correspondence and Minutes of Meetings re. Nursing Sisters—July '43/Oct '45," 147.73-C-132009 (D2), DHH.

[15] A reprinted article from the *Winnipeg Free Press* by Frederick Griffin provides a good description of the Lady Nelson hospital ship: "On Duty with the Fighting Forces," *Canadian Nurse* 39, no. 9 (September 1943): 577-580. See also the Marion C. (Story) McLeod Scrapbook of the *Lady Nelson*, dated April 1943, AARN archives and news clippings such as: "Edmonton Service

Personnel aboard New Hospital Ship, *Edmonton Journal*, 15 April 1943; and "Canada's First Hospital Ship Prepares for Maiden Voyage," *Halifax Mail*, 15 April 1943.

[16] Col. G. A. Winfield, "Recommendations from Minutes of Matrons' Conference," in "Correspondence and Minutes of Meetings re. Nursing Sisters—July '43/Oct '45," 147.73-C-132009 (D2), DHH.

[17] Nicholson, *Canada's Nursing Sisters*: 53.

[18] Doris V. Carter, audio-taped interview with author at Ottawa, Ontario, 22 June 2001.

[19] Lois Bayly Tewsley, audio-taped interview with author at Ottawa, Ontario, 11 June 2001; Pauline Cox Walker, audio-taped interview with author at Kingston, Ontario, 13 June 2001; Dorothy Surgenor Maddock, audio-taped interview with author at Ottawa, Ontario, 26 June 2001; Beatrice Cole Hunter, audio-taped interview with author at Edmonton, Alberta, 13 October 2001.

[20] "Non-Permanent Active Militia Qualification: Nursing Sister (December 1939)," Henny Greenwood Fonds, Record 91.40, AARN.

[21] Estelle Tritt Aspler, audio-taped interview with author at Westmount, Québec on 13 August 2001. In respect to this emphasis on ward administration, military nursing was not that different from civilian hospital nursing with its emphasis on ward administration and ward maintenance. See Kathryn McPherson, "Science and Technique: Nurses' Work in a Canadian Hospital, 1920-1939," in *Caring and Curing: Historical Perspectives on Women and Healing in Canada,* eds. Dianne Dodd and Deborah Gorham, (Ottawa: University of Ottawa Press, 1994): 76 and 80-81.

[22] Evelyn Pepper, in *The Military Nurses of Canada: Recollections of Canadian Military Nurses*, vol. I, ed. E. A. Landells (White Rock, B.C.: Co-Publishing, 1995): 45-46 [hereafter cited as *Military Nurses of Canada*]. See also, Mary (Benwick) Baldwin in *Military Nurses of Canada,* vol. II: 131-132 and Nicholson, *Canada's Nursing Sisters*: 125-126.

[23] Evelyn A. Pepper, Gaëtan (LaBonté) Kerr, Harriet J.T. Sloan, and Margaret D. McLean, "'Over There' In World War II," *Canadian Nurse* 62, no. 11 (November 1966): 32.

[24] A. M. MacPherson, "Camp Borden Military Hospital," *Journal of the Canadian Medical Services* 3, no. 5 (July 1946): 481.

[25] Frances Oakes, audio-taped interview with author at Guelph, Ontario on 15 May 2001. Mary Priscilla Chisholm, "RCAF Nursing Sisters, Second World War," unpublished notes of Fred Brailey, Orangeville, Ontario (March 2001), used with permission; and W. R. Feasby, ed., *Official History of the Canadian Medical Services, 1939-1945: Organization and Campaigns*, vol. I (Ottawa: Queen's Printer, 1956): 439.

[26] Surgenor Maddock interview.

[27] Kay Christie, audio-taped interview with Joan Williams, 20 November 1975, ISN 196090, National Archives of Canada [hereafter cited as NAC].

[28] Jean Ellen (Wheeler) Keays, audio-taped interview with Sheila Zerr on 16 August 1994 at White Rock, British Columbia, RNABC.

[29] Betty Riddell, audio-taped interview with author at Ottawa, Ontario on 26 November 2001.

[30] Enloe argued that First World War British Nursing Sisters were "paid off at the end of the war with little long-term cost or commitment from the military for postwar re-establishment in civilian life." See *Maneuvers:* 212.

[31] Comment taken from confidential files of the Nursing Sisters Database created for this research.

[32] Smellie, "A Message from the Matron-in-Chief": 623.

[33] Enloe makes a similar point that, "Nurses, in practice, have served in combat regardless of official prohibitions banning their presence there. They have served in combat not because of

unusual individual bravery—the stuff of nursing romances—but because they have been part of a military structure that has needed their skills near combat." See *Maneuvers:* 223.

[34] Anne A. (Gair) Evans, in *Military Nurses of Canada*, vol. I: 345-346 wrote that the patient care was different at this experimental station as young volunteers suffered severe, extensive burns especially when the wind changed and the chemicals burned their eyes severely. Dorothy M. (Grainger) Anderson, in *Military Nurses of Canada*, vol. I: 412 mentioned biological warfare. See also Rossalea O. (Hughes) Crowe in *Military Nurses of Canada*, vol. I: 250.

[35] "Victory Meeting," Report to the 77th annual meeting of the Canadian Medical Association, Banff Springs Hotel, Alberta, 10-14 June 1946, pp. 39 and 42, G.W.L. Nicholson fonds, MG 31, G19, v.5, NAC; Nicholson, *Canada's Nursing Sisters*: 234-235.

[36] The RCAMC prerogative to staff hospital ships was based on a precedent from the First World War when there were no Navy nurses. But it exacerbated rivalries between the services and made the RCAMC nurses unpopular with RCN nurses, according to NS Littlejohn, RNABC. NS Reta Moffat made 42 Atlantic crossings—no small achievement given the activity of German submarines and ships. See *Military Nurses of Canada*, vol. III: 21.

[37] Nicholson, *Canada's Nursing Sisters*: 195-198; "Hospital Car for Canadian Casualties," *Canadian Nurse* 37, no. 10 (October 1941): 716; and "Hospital on Wheels," Frances Ferguson Sutherland scrapbooks, book 2, 91.34, AARN.

[38] Helen (Bright) Armstrong in *Military Nurses of Canada*, vol. I: 184-185.

[39] Kathleen G. Christie, ""Experiences as a Prisoner-of-War, World War 2," interview HCM 28-82, with Charles G. Roland on 8 December 1982, Oral History Archives of the Hannah Chair for the History of Medicine, McMaster University [hereafter as HCM 28-82].

[40] Christie, HCM 28-82; Kay Christie interview, NAC; Kay Christie, "Behind Japanese Barbed Wire—a Canadian Nursing Sister in Hong Kong," *Royal Canadian Military Institute Year Book* (Toronto: RCMI, 1979): 11-13; Kathleen G. Christie, "M. & V. for Christmas Dinner," *Canadian Nurse* 63, no. 12 (December 1967): 28-30; Kay Christie, audio-taped interview with Bill McNeil for "Voice of the Pioneer," January 1992, Kay Christie fonds, 94.41, AARN; Jessie G. Morrison, "Kathleen Georgina Christie, 1911-1994: In Memoriam," 91.31, AARN; Bill McNeil, *Voices of a War Remembered: An Oral History of Canadians in The Second World War* (Toronto: Doubleday Canada, 1991): 96-104; Charles G. Roland, "Massacre and Rape in Hong Kong: Two Case Studies Involving Medical Personnel and Patients," *Journal of Contemporary History* 32, no. 1 (1997): 43-61 and *Long Night's Journey into Day: Prisoners of War in Hong Kong and Japan, 1941-1945* (Waterloo, Ontario: Wilfrid Laurier University Press, 2001): 10, 45, and 54.

[41] G. W. L. Nicholson, *Seventy Years of Service: A History of the R.C.A.M.C.* (Ottawa: Borealis Press, 1977): 146; Feasby, Official History of the Canadian Medical Services: 331, 438.

[42] Nicholson, *Canada's Nursing Sisters*: 192-194. Nicholson's account is incomplete with some inaccuracy regarding the RCAF unit that went to Normandy after D-Day. Both Frances Oakes and Muriel McArthur were RCAF nurses who served during The Second World War in England and both later became Principal Matrons and Matrons-in-Chief after the war. Their interviews and correspondence with the author provide corrective information regarding the RCAF nurses in England and especially with the No. 52 Mobile Field Hospital in Normandy. McArthur's account can be found in *Military Nurses of Canada*: 271-276 and Muriel McArthur, audio-taped interview with author at Barrie, Ontario, 14 May 2001. All subsequent references attributed to NS McArthur are from this interview unless indicated otherwise. See also, "The RCAF Nursing Service," *Canadian Nurse* 40, no. 3 (March 1944): 164-166. A good article on the RCAF hospital at East Grinstead was published anonymously as "History of the RCAF Plastic Surgery and Jaw Injury Unit," *Journal of the Canadian Medical Services* 4, no. 1 (November 1946): 90-94.

[43] A recent account of the East Grinstead hospital, its personnel, and rehabilitation program is Rita Donovan, *As for the Canadians: The Remarkable Story of the RCAF's 'Guinea Pigs' of The Second World War* (Ottawa: Buschek Books, 2000).

[44] "The RCAF Nursing Service," *Canadian Nurse* 40, no. 3 (March 1944): 166.

[45] Harriet J. T. Sloan, audio-taped interview with author at Ottawa, Ontario, 14 March 2001. Also see: Nicholson, *Canada's Nursing Sisters*: 213 and Feasby, *Official History of the Canadian Medical Services*: 373-377.

[46] G. W. L. Nicholson, *Seventy Years of Service: A History of the R.C.A.M.C.* (Ottawa: Borealis Press, 1977): 146; Feasby, *Official History of the Canadian Medical Services*, vol. I: 331, 438.

[47] Matron-in-Chief Smellie was the highest ranking woman in the armed forces during the war. In addition to providing initial leadership for the RCAF and RCN, she also supervised organization of the Canadian Women's Army Corps (CWAC) when the first women's division was formed in 1941. "The Organization of the CWAC," *Canadian Nurse* 37, no. 8 (August 1941): 545.

[48] Nicholson, *Canada's Nursing Sisters*: 182-185; Marjorie G. Russell, "The Royal Canadian Naval Nursing Service," in *Military Nurses of Canada* vol. III: 230-235; "Royal Canadian Navy Nursing Service," *Canadian Nurse* 37, no. 12 (December 1941): 830; and "Royal Canadian Naval Nursing Service," *Canadian Nurse* 40, no. 2 (February 1944): 96-98; Norman K. Harrison, "The Hospital Ship that Never Puts to Sea," *Nursing Mirror* (15 January 1944): ii-iii.

[49] Surgenor Maddock interview.

[50] Stacey, *Six Years of War*: 145 and 166.

[51] "Last Post," *Canadian Nurse* 38, no. 12 (December 1942): 938-939; Marjorie (Cowan) Horton, in *Military Nurses of Canada*, vol. I: 554-555.

[52] Wheeler Keays interview, RNABC; and Florence Louise Jamieson, interview with Margaret M. Allemang at Toronto, Ontario on 24 April and 3 May 1987, MMA. Both nurses' observations support Shula Marks' research findings regarding racism and South African nursing in "The Legacy of the History of Nursing for Post-apartheid South Africa," in *Nursing History and the Politics of Welfare*, eds. Anne Marie Rafferty, Jane Robinson, and Ruth Elkan, pp. 28-44 (London and New York: Routledge, 1997): 31-33.

[53] "List of Canadians who Served with South African Nursing Service – Second World War (1939-1945)," 000.8 (D91) and "Correspondence, reports, instructions, etc. re. Nursing Sisters enrolling in South African Forces, August 41-November 45," 325.009 (D575), DHH.

[54] Isabel Morrison Fraser, audio-taped interview with author at Ottawa, Ontario, 27 November 2001. Elizabeth L. Clement, in *Nursing Sisters' Association of Canada: Commemorative Issue and Membership Directory*, June 1994: 19; Keays interview, RNABC; Florence Louise Jamieson, audio-taped interview with Margaret Allemang on 24 April and 3 May 1987, MMA; Gladys Sharpe, "Our Canadian Nurses in South Africa," *Canadian Hospital* 20, no. 8 (August 1943): 20-22; and Nicholson, *Canada's Nursing Sisters*: 174-178.

[55] For an account of their recruitment, their contracts, and areas of service see the following articles: "Canadian Nurses for South Africa," *Canadian Nurse* 37, no. 9 (September 1941): 623; "Canadian Nurses for South Africa," *Canadian Nurse* 37, no. 10 (October 1941): 698; "Canadian Nurses for South Africa," *Canadian Nurse* 37, no. 12 (December 1941): 830; and "On Active Service at Home and Abroad," *Canadian Nurse* 38, no. 2 (February 1942): 95.

[56] Marguerite McLimont, "Canada Goes to South Africa," *Canadian Nurse* 38, no. 12 (December 1942): 914-920. See also the Jamieson interview and Nicholson, *Canada's Nursing Sisters*: 174-178.

[57] Angela M. (La Croix) Smith in *Military Nurses Of Canada*, vol. I: 354.

[58] Elizabeth Louise Clement in *Military Nurses Of Canada*, vol. I: 434.

[59] Two good sources for details on medical organization during the Second World War, are: Feasby, *Official History of the Canadian Medical Services*: 17-20, 27-29, 56-58, 62-7, 83-87 and Bill Rawling, *Death Their Enemy: Canadian Medical Practitioners and War* (Ottawa: author, 2001): 129-236 and 275-278.

[60] Feasby, *Official History of the Canadian Medical Services*, vol. I: 84.

[61] Note that 10 of the nurses in the NSD served only with the SAMNS, and that the North Atlantic theatre included service in Newfoundland, Labrador, and on hospitals ships that crossed the Atlantic. See Nicholson, *Canada's Nursing Sisters*: 197.

[62] Feasby, *Official History of the Canadian Medical Services*: 85. Triage grouped casualties into three groups according to the need for evacuation. Group I included cases of severe shock requiring immediate resuscitation that could be treated in advanced dressing stations or divisional FDSs with a FTU attached. Group II cases required immediate surgery and were evacuated to a corps Field Dressing Station with a Field Surgical Unit attached. Group III cases were stable enough for evacuation to a Casualty Clearing Station for surgery or treatment. Also refer to the chart on "Plan of Casualty Evacuation in the Field," p. 86.

[63] "Advances in Military Medicine," *Journal of the Canadian Medical Services* 2, no. 1 (November 1944): 78.

[64] Nicholson, *Seventy Years*: 156.

[65] Patricia Moll audio-taped interview with Lisa Weintraub on 5 July 1985, ISN 167813, NAC.

[66] Wilson, "Resuscitation in Battle Casualties:" 520; Feasby, *Official History of the Canadian Medical Services*: 187-188, 200.

[67] "Front Line Surgery," *Canadian Nurse* 39, no. 2 (February 1943): 130; Wallace Reyburn, "Medicine Goes to War," *Maclean's Magazine* (1 September 1943): 32; Rawling, *Death Their Enemy*: 157-159; and Feasby, *Official History of the Canadian Medical Services*, vol. I: 188-189.

[68] Pepper, Kerr, Sloan, and McLean, "'Over There' In World War II: 32; Wilson, "Resuscitation in Battle Casualties;" W. A. Scott, "Letter on Transfusion Service in Sicily and Italy," *Journal of the Canadian Medical Services* 1, no. 2 (January 1944): 108-109; "A Canadian F.T.U.—C.A. Overseas," *Journal of the Canadian Medical Services* 2, no. 2 (January 1945): 113-115; and J. C. McC. Brown, "A Simple Method of Serum Transfusion in the Field," *Journal of the Canadian Medical Services* 3, no. 2 (January 1946): 144-146.

[69] Feasby, *Official History of the Canadian Medical Services*, vol. I: 189.

[70] F. Mills, "A Letter from a Field Surgical Unit C.M.F. (Overseas)," *Journal of the Canadian Medical Services* 1, no. 3 (March 1944): 187.

[71] "A Canadian F.S.U.—C.A. Overseas," *Journal of the Canadian Medical Services* 2, no. 2 (January 1945): 115.

[72] Helen (Bright) Armstrong in *Military Nurses Of Canada,* vol. I: 181-183.

[73] A. M. MacPherson, "Camp Borden Military Hospital," *Journal of the Canadian Medical Services* 3, no. 5 (July 1946): 481.

[74] See further discussion of nurses' value in Rawling, *Death Their Enemy*: 196-198.

[75] 22 February 1944, No. 5 Casualty Clearing Station war diary, RG 24, series C-3, volume 15941.

[76] Nicholson, *Seventy Years*: 156.

[77] Jean Dorgan in *Military Nurses of Canada*, vol. I: 128.

[78] For a good description of a Casualty Clearing Station in England (1941), see Agnes J. Macleod, "With a RCAMC Casualty Clearing Station," *Canadian Nurse* 37, no. 2 (February 1941): 95-96.

[79] Feasby, *Official History of the Canadian Medical Services,* vol. I: 188; Rawling, Death Their Enemy: 195.

[80] Evelyn Pepper, in *Nursing Sisters' Association of Canada: Commemorative Issue and Membership Directory* (Edmonton: Nursing Sisters' Association of Canada, 1994): 34-35.

[81] Eva Wannop, audio-taped interview with author at Toronto, Ontario, 25 April 2001. See also: Rita Donovan, *As for the Canadians: The Remarkable Story of the RCAF's 'Guinea Pigs' of The*

Second World War (Ottawa: Buschek Books, 2000).

[82] Margaret Roe Dewart, audio-taped interview with author, Edmonton, Alberta on 15 October 2001. See also, Feasby, *Official History of the Canadian Medical Services*, vol. II: 109-114.

[83] Entry for 15-16 November 1940, No. 1 Canadian General Hospital War Diary, RG 24, Series C-3, vol. 15666, serial 282 and "RCAMC Sisters to the Rescue," *Canadian Nurse* 37, no. 2 (February 1941): 115.

[84] Letter from Margaret Fletcher to her family, 30 October 1944, Margaret Fletcher fonds: 1933-1945, SC042, University of Victoria Archives and Special Collections, British Columbia Archives [hereafter as the Fletcher letters].

[85] Constance Betty Nicolson Brown, audio-taped interview with author at Ottawa, Ontario on 3 June 2001.

[86] "The RCAF Nursing Service," *Canadian Nurse* 40, no. 3 (March 1944): 164-166; "Royal Canadian Naval Well Baby Health Service," *Canadian Nurse* 40, no. 7 (July 1944): 469-472.

[87] C.P. Stacey, *Six Years of War*: 59-60.

[88] Accordingly, military plans called for a medical service with bed capacity equal to 10% of the troop force or 7200 per Canadian Corps. As the Canadian Army increased in size, it also increased the medical capacity to 22,100 beds by May 1944. See Feasby, *Official History of the Canadian Medical Services*, vol. 1: 99 and 110.

[89] G.W.L. Nicholson, *Seventy Years*: 141.

[90] Nicholson, *Canada's Nursing Sisters*: 122; Wannop interview; Joan Doree, audio-taped interview with Nina Rumen, 11 February 1987, RNABC; and Jean Ciceri, audio-taped interview with Nina Rumen, 13 January 1987, RNABC.

[91] Margaret Helena Kellough, interview with Margaret M. Allemang at Toronto, Ontario during April and May 1987, MMA.

[92] Feasby, *Official History of the Canadian Medical Services*, vol. I: 85.

[93] For example, see the memo from R. W. Ryan to Air Commoodore, DMS (Air) for 4 January 1943, file 400-2-1, volume 3365, Series E-1-b, RG 24, NAC.

[94] Joan Doree, in *Military Nurses of Canada*, vol. II: 97-98. These issues are discussed further in chapter 4.

[95] Helen K. Mussallem, audio-taped interview with author at Ottawa, Ontario on 24 September 2001.

[96] Frances Ferguson Sutherland, audio-taped interview with author at Edmonton, Alberta on 10 October 2001.

[97] Roe Dewart interview.

[98] McArthur interview; Sloan interview; and Surgenor Maddock interview.

[99] J. L. Patterson, "Recommendations from Minutes of Matrons' Conference" from "Correspondence and Minutes of Meetings re. Nursing Sisters—July '43/Oct '45," 147.73-C-132009 (D2), DHH.

[100] Rawling, *Death Their Enemy*: 125-126.

[101] Pepper, Kerr, Sloan, and McLean, "'Over There' In World War II: 31.

[102] Ferguson Sutherland interview.

[103] Jamieson interview, MMA.

[104] Tritt Aspler interview.

[105] Bayly Tewsley interview.

[106] Margaret H. Mills, interview with Margaret M. Allemang, 5 April 1991, MMA.

[107] Ferguson Sutherland interview.

[108] Doree interview, RNABC.

[109] Sloan interview; Evelyn Pepper in *Military Nurses of Canada*, vol. I: 55. For a great description of some of the nursing care involved with the "Max Factors" patients (as they were nicknamed by the staff), refer to an account written by QAIMNS nurse Brenda McBryde, *A Nurse's War* (London: Chatto & Windus, 1979): 146-147 and 152.

[110] Margaret Van Scoyoc, audio-taped interview with author at Ottawa, Ontario on 13 June 2001; Cox Walker interview; Sloan interview; and Taylor Rasberry interview.

[111] Elsie M. Clay (Barr), in *Nursing Sisters' Association of Canada: Commemorative Issue and Membership Directory*, June 1994: 18.

[112] Sloan interview.

[113] Wannop interview.

[114] W. R. Feasby, "The Canadian Medical Services," in *Medical Services in War: The Principal Medical Lessons of the Second World War Based on the Official Medical Histories of the United Kingdom, Canada, Australia, New Zealand and India*, eds. Arthur Salusbury MacNalty and W. Franklin Mellor, pp. 469-559 (London: H.M.S.O., 1968): 500.

[115] Matron Edna Rossiter returned to Canada as Matron of a new DVA hospital in Victoria, and became the consultant for Western Canada. In her interview, she described the process of re-settling Nursing Sisters into civilian practice to staff DVA hospitals. Nurses were graded into classes and required to become civil servants but as she said, "Nurses accepted the demotion because they had lived with discrimination all their lives." Refer to her audio-taped interview with Nina Rumen at Vancouver, 27 October 1987, RNABC. "Postwar Planning Activities: Opportunities in DVA Hospitals," *Canadian Nurse* 41, no. 9 (September 1945): 720; "Opportunities for Nurses with the DVA," *Canadian Nurse* 42, no. 3 (March 1946): 236-237.

[116] "Appointment Statistics – Nursing Sisters, Physiotherapy Aides, Occupational Therapists, Dieticians, and Home Sisters," 000.8 (D93), DHH.

[117] Nicholson, *Canada's Nursing Sisters*: 212.

[118] One nurse from the NSD was described by the counselor as undecided about her future because "like many another she feels lost with the sudden cessation of her army career. She would rather have continued in the service."

[119] Sloan, personal communication with author at Ottawa, 8 January 2002.

[120] Margery MacLean Root, audio-taped interview with author at Ottawa, Ontario on 15 June 2001.

[121] As Margaret M. Allemang said, "It changed my life because that's where I got into the academic world. It became more exciting all the time." Margaret Allemang, audio-taped interview with author at Toronto, Ontario on 26 April 2001.

[122] Allemang, Mussallem, Wannop, Carter, and Ferguson Sutherland interviews. See the Riddell interview for a comparison with American nurses benefits. Riddell reported using her veteran's benefit for university. She was also granted U.S. dual citizenship in 1946 and has received a U.S. pension since her retirement from public health nursing. Cynthia Enloe suggested that American nurses' eligibility for the G.I. Bill (which she called "Congress's 'thank-you' package for returning veterans") was part of their increased militarization in Enloe, *Maneuvers*: 218.

[123] Peter Neary and Shaun Brown, "The Veterans Charter and Canadian Women of World War II," in *The Veteran's Charter and post-World War II Canada*, eds. Peter Neary and J. L. Granatstein (Montreal: McGill-Queen's University Press, 1998): 388. Neary and Brown provide an excellent explanation and analysis of this complex program in pp. 387-415. This account is based on data related to women who served in the Women's Divisions of the armed forces, however, and does not differentiate between them and the Nursing Sisters who were officers and who received equivalent pay and benefits during their service instead of the two-thirds to three-fourths pay

typical of the Women's Divisions. As well, they were already fully-trained professionals on enlistment and practicing in a female profession which requires further analysis than this account provided.

[124] Neary and Brown, "The Veterans Charter and Canadian Women": 389.

[125] Neary and Brown, "The Veterans Charter and Canadian Women": 410.

[126] Doris Carter reported a gratuity of $2052.50 for 57.5 months (almost 5 years) of service in her memoir, *Never Leave Your Head Uncovered: A Canadian Nursing Sister in World War Two* (Waterdown, Ontario: Potlatch Publications, 1999): 151.

[127] Neary and Brown, "The Veterans Charter and Canadian Women": 391 and "Postwar Planning Activities: Re-establishment Information," *Canadian Nurse* 41, no. 8 (August 1945): 636-638.

[128] Tritt Aspler interview; Gertrude M. Hall, "Notes from National Office: Of Interest to Nursing Sisters," *Canadian Nurse* 41, no. 1 (January 1945): 53-54.

[129] Pauline Lamont Flynn, personal communication with author, 16 September 2002.

[130] MacLean Root interview.

[131] Neary and Brown, "The Veterans Charter and Canadian Women": 411.

[132] The power inherent in language is a fundamental concept of post-structuralist theory and postmodernism analyses based on theorists such as Jacques Lacan, Jacques Derrida, and Michel Foucault. They and others have challenged the scientific progressivism of the modern period in their explorations of truth and how language (text) constructs people's experiences according to power differentials that favour dominant groups over less powerful groups. Post-structuralists argue language is not just reflective of historical events and human consciousness but constitutes them. Feminists have begun to explore the explanatory strengths and limitations of post-structuralism for women's history. See Joan W. Scott, "Rewriting History," in *Behind the Lines: Gender and the Two World Wars*, eds. Margaret Randolph Higonnet, Jane Jenson, Sonya Michel, and Margaret Collins Weitz, pp. 21-30 (New Haven: Yale University Press, 1987); Joan Wallach Scott, "Introduction," in *Feminism and History*, ed. Joan Wallach Scott, pp. 1-13 (New York: Oxford University Press, 1997); Michèle Barrett, "Words and Things: Materialism and Method in Contemporary Feminist Analysis," in *Destabilizing Theory: Contemporary Feminist Debates*, eds. Michèle Barrett and Anne Phillips, pp. 201-219 (Stanford, California: Stanford University Press, 1992); and Kathleen Canning, "Feminist History after the Linguistic Turn: Historicizing Discourse and Experience," *Signs*, 19 (2): 368-404.

[133] Wheeler Keays interview.

[134] Eleanor MacGregor, "Defending the Empire," unpublished paper given to the author by retired Nursing Sister Pauline Lamont Flynn, May 2001.

[135] M. Dorothy Mawdsley, "The Position of Women in the Postwar World," *Canadian Nurse* 40, no. 8 (August 1944): 548-552.

[136] Mary Bray Hutton, letter to Major Hayes at CFB Borden, 8 February 1994. Her letter was found in the back of a copy of the book that she donated to the CFMS library at the training school: Joyce Hibbert, *Fragments of War: Stories from Survivors of World War II* (Toronto: Dundurn Press, 1985).

[137] As Matron, Margaret Kellough did some of the censoring. See Kellough interview, MMA.

[138] Pepper, Kerr, Sloan, and McLean, "'Over There' in World War II": 32.

[139] Fletcher letters, 20 February 1945.

[140] Margaret Van Scoyoc, audio-taped interview with Cynthia Toman at Kingston, Ontario on 13 June 2001.

[141] Dempsey, "Canada's Blitz Sisters": 24.

[142] Carter, *Never Leave Your Head Uncovered*: 24.

[143] Helen K. Mussallem, audio-taped interview with Cynthia Toman at Ottawa, Ontario on 24 September 2001.

[144] Ann Graber Hershberger cited Mennonite church leader H. S. Bender who made it clear that nurses who enlisted became full and essential members of the military system, subordinating other identities. See "Mennonite Nurses in World War II: Maintaining the Thread of Pacifism in Nursing," *Nursing History Review* 11 (2003): 154.

[145] For several examples, see: Littlejohn McIlrath interview, RNABC; Mary M. White, *Hello War, Goodbye Sanity* (Canada: New Leaf Computer Publishing and Printing, 1992) and Carter, *Never Leave Your Head Uncovered.*

[146] Nicholson, *Canada's Nursing Sisters*: 98 and 187.

[147] "Last Post," *Canadian Nurse* 38, no. 12 (December 1942): 938-939; Marjorie (Cowan) Horton, *Military Nurses of Canada*, vol. I: 554-555.

[148] "Tells of Death of Winnipeg Nursing Sister," news clipping, Winnipeg General Hospital Nurses Alumnae Archives (hereafter WGHA).

[149] "On Active Service," *Canadian Nurse* 39, no. 10 (October 1943): 647-650.

[150] Edith Dick, "Overseas Mail," *Canadian Nurse* 40, no. 5 (May 1944): 343.

[151] Canadian Nurses Association, *The Leaf and the Lamp* (Ottawa: CNA, 1968): 81; "Appointment Statistics—Nursing Sisters, Physiotherapy Aides, Occupational Therapists, Dieticians and Home Sisters," 000.8 (D93), DHH; "In the Service of their Country," *Canadian Nurse* 39, no. 8 (August 1943): 511-512; *Journal of the Canadian Medical Services* 1, no. 1 (1943): 89; *Journal of the Canadian Medical Services* 2, no. 2 (1944): 203; *Journal of the Canadian Medical Services* 2, no. 6 (1945): 718; *Journal of the Canadian Medical Services* 3, no. 2 (1946): 169; Fred Brailey, "RCAF Nursing Sister, Second World War," unpublished paper in possession of author.

[152] The deaths of Margaret McCullough Stirling Parkinson, Margaret Agnes Briggs, and Marie Cecile Dussio do not appear in any corroborating source. See "Books of Remembrance," www.vac-acc.gc.ca/general/sub.cfm?source=collections/books

[153] One RCAMC Occupational Therapist died accidentally in England. This list contains the names that are generally agreed upon, in existing literature such as the *Canadian Nurse*, the *Journal of the Canadian Medical Services*, and the history of the Canadian Nurses Association.

[154] Pearl (Lundgren) Swift in *Military Nurses of Canada*, vol. II: 159; Tritt Aspler interview.

[155] Examples include Dorothy M. Dent, "Battles with Bicycles," *Canadian Nurse* 39, no. 6 (June 1943): 411-412; Carter, *Never Leave Your Head Uncovered*: 24; Tritt Aspler interview; Mussallem interview.

[156] Helen Morton Rendall, interview with Margaret M. Allemang at Toronto, 14 March 1986, MMA.

[157] From confidential files of the NSD.

[158] See the Nicolson Brown and Cox Walker interviews; "In the Service of their Country," *Canadian Nurse* 39, no. 8 (August 1943): 511-512; "Last Post," *Canadian Nurse* 38, no. 12 (December 1942): 938-939; "Courage and Discipline," *Canadian Nurse* 40, no. 1 (1944): 21; and the notifications in the *Journal of the Canadian Medical Services* 1, no. 1 (1943): 89; 2, no. 2 (1944): 203; and 2, no. 6 (1945): 718.

[159] Cox Walker interview. There are many accounts of the attack on the *SS Santa Elena.* See "A Salute to our Nursing Sisters," *Canadian Nurse* 39, no. 12 (December 1943): 795-799; "Courage and Discipline," *Canadian Nurse* 40, no. 1 (January 1944): 21; Nicholson, *Canada's Nursing Sisters*: 139-140; and Irene D. Courtenay, "Nursing Sisters' Association of Canada: Commemorative Issue and Membership Directory," June 1994: 19-22.

[160] Cox Walker interview.

[161] MacLean Root interview.

[162] Nicolson Brown interview.

[163] Three examples include the Rendall interview, MMA; Helen (Bright) Armstrong in *Military Nurses of Canada*, vol. I: 186; and Margaret Moss in *Military Nurses of Canada*, vol. I: 299.

[164] Pepper, Kerr, Sloan, and McLean, "'Over There' in the World War II": 27-28.

[165] RCAMC non-fatal battle casualties recorded in the statistical files included: one in 1941, twelve in 1943, and one in 1944. Two of these incidents occurred in England and twelve in Sicily. See "Appointment Statistics," 000.8 (D93), DHH.

[166] Within the confidential personnel records of the NSD, there were a surprising number of nurses who received severe injuries, or suffered occupationally-related diseases such as infections from working with contaminated wounds in the operating rooms or tuberculosis, for example. Due to restrictions imposed by the archives, I am unable to cite file numbers or identified these persons.

[167] Jean D. (Scrimgeour) Wilson in *Military Nurses of Canada*, vol. I: 248.

[168] Harriet J. T. Sloan, personal communication with author and in Jean E. Portugal, *We Were There: The Navy, the Army, and the RCAF: A Record for Canada*, vol. 5 (Shelburne, Ontario: The Battered Silicon Dispatch Box, 1998): 2276.

[169] Nicolson Brown interview. Also see accounts in Nicholson, *Seventy Years*: 165-166 and *Canada's Nursing Sisters*: 136-137. The NSD also corroborates these injuries as some of the sampled records described the injuries sustained during this attack.

[170] Kellough interview, MMA.

[171] Marion C. (Story) McLeod Scrapbook of the *Lady Nelson*, dated April 1943, held at the AARN archives. See also news clippings: "Edmonton Service Personnel aboard New Hospital Ship, *Edmonton Journal*, 15 April 1943; and "Canada's First Hospital Ship Prepares for Maiden Voyage," *Halifax Mail*, 15 April 1943.

[172] Littlejohn McIlrath interview, RNABC; and Ruth (Littlejohn) McIlrath in *Military Nurses of Canada,* vol. III: 18.

[173] MacGregor, "Defending the Empire."

[174] Cox Walker interview.

[175] At least one NS in the NSD received severe electrical shock injuries from an electric gauze cutter in operating room, requiring hospitalization.

[176] Cox Walker interview.

[177] Rendall interview, MMA; MacGregor, "Defending the Empire"; Kellough interview; and "Jungle Weapon," *Canadian Nurse* 41, no. 10 (October 1945): 803.

[178] Kellough interview, MMA; and Carter interview.

[179] Carter, *Never Leave Your Head Uncovered*: 79; Sloan interview; "DDT Studied for Outdoor Use," *Canadian Nurse* 41, no. 9 (September 1945): 702; Rendall interview, MMA. According to Helen Rendall, she was never free from fleas in Italy and she too, used DDT liberally in clothing and bedding.

[180] Cox Walker interview.

[181] Christie interview, McMaster University.

[182] Christie interview, NAC; and Christie, "Behind Japanese Barbed Wire".

[183] Christie interview, McMaster University.

[184] The civilian nurse was Pearl Needham, a Vancouver General Hospital graduate who went to Shanghai to do Public Health and married an Englishman, settling in Hong Kong. She was a volunteer at the Military hospital prior to the attack on Hong Kong. See the Christie interview, McMaster University.

[185] Christie interview, McMaster University.

[186] Christie interview, McMaster University; Christie interview, NAC; Christie, "Behind Japanese Barbed Wire"; Christie, "M. & V. for Christmas Dinner;" Christie interview, AARN; Morrison, "Kathleen Georgina Christie," AARN; McNeil, *Voices of a War Remembered:*; Roland, "Massacre and Rape in Hong Kong," and *Long Night's Journey into Day*: 10, 45, and 54.

[187] One British Nursing Sister wrote for the *Canadian Nurse* about her repatriation: Constance Murray, "A Repatriate from Hong Kong," *Canadian Nurse* 42, no. 3 (March 1946): 242-243.

[188] Christie interview, AARN.

[189] Surgenor Maddock and Cox Walker interviews. Also Pauline Lamont Flynn, audio-taped interview with author at Ottawa, Ontario on 3 April 2001.

[190] Jean (MacBain) MacAulay in *Military Nurses of Canada*, vol. II: 190.

[191] Rendall interview, MMA.

[192] Rita (Murphy) Morin, *Military Nurses of Canada*, vol. II: 176.

[193] Margaret Van Scoyoc, audio-taped interview with Lisa Weintraub at Montreal, P.Q. on 4 June 1984, ISN 167825, NAC.

[194] Sloan interview.

[195] Nicolson Brown interview.

[196] Elizabeth L. (Burnham) Lowe in *Military Nurses of Canada*, vol. I: 154-158.

[197] Barbara Ross in Jean E. Portugal, *We Were There: The Army, A Record for Canada*, vol. 5 (Canada: Royal Canadian Military Institute Heritage Society, 1998): 2250.

[198] Kathleen G. Christie, audio-taped interview with Margaret Allemang on 5 April 1992 and 3 June 1992, MMA.

[199] Pepper in *Military Nurses of Canada*, vol. I: 48-49 and 53-54; Elizabeth B. Pense, interview with Norma Fieldhouse at Kingston, Ontario during March 1987, MMA.

[200] Bayly Tewsley interview.

[201] Betty (Herringer) Campbell, in *Nursing Sisters' Association of Canada: Commemorative Issue and Membership Directory*, June 1994: 17.

[202] Ross in Portugal, *We Were There*, vol. 5: 2254.

[203] Lettie Turner, video-interview at the 1998 Charlottetown, PEI reunion of the NSAC for the television documentary "Nurses on the Battlefield," produced by Lori Kuffner and Barbara Campbell for Cooper Rock Pictures, 2001.

[204] Van Scoyoc interview.

[205] Margaret Fletcher in *Military Nurses of Canada*, vol. I: 87.

[206] Nicolson Brown, Van Scoyoc, Mussallem, and Ferguson Sutherland interviews; Evelyn Pepper in *Military Nurses of Canada* vol. I: 56-57; Constance Bond Young, interview with Ella Beardmore at Omeemee, Ontario on 4 July 1989, MMA.

[207] Mary Bray Hutton in Joyce Hibbert, *Fragments of War: Stories from Survivors of World War II* (Toronto: Dundurn Press, 1985): 127.

[208] Doree interview, RNABC.

[209] Lotta Dempsey, "Canada's Blitz Sisters," *Maclean's Magazine*, 1 September 1943: 24.

CHAPTER 3

SHAPING NURSING SISTERS AS "OFFICERS" AND "LADIES"

When Nursing Sister (NS) Kathleen Rowntree arrived in England with No. 23 Canadian General Hospital, she drilled and went for route marches, played softball, and spent the evenings in a "neat little pub" where there was a dance hall. "One morning I got called into the matron's office and told that 'jitterbugging' was not becoming to an officer. That was the first of a few trips to the matron's office, but I survived."[1] When NS Jean Wheeler arrived in South Africa to serve with the South African Military Nursing Service (SAMNS), Matron Gladys Sharpe warned her group that they were "not to disgrace themselves" regarding the use of alcohol—that one port or one sherry was the limit.[2] NS Margaret Van Scoyoc summarized nurses' perspectives this way: "We certainly didn't want to be sent home! Conduct was a very important factor. Maybe we were too conscientious!"[3]

Hospitals typically screened and socialized student nurses with an emphasis on femininity, discipline, obedience, hard work and endurance while providing them with necessary skills for diverse practice settings on graduation. Since the Canadian armed forces had no plans to establish their own nursing schools, they relied on the civilian profession to train and credential a pool of the 'right kind' of nurses from which they could draw. Military nursing became an attractive, highly-desirable option during the 1930s, with working conditions that far surpassed most civilian nursing jobs: full time employment, food, housing, medical and dental care, a rate of pay triple the average nurse's salary (and equal to men's pay), in addition to opportunities for patriotism, adventure, travel, and access to men. Clearly, there would be little difficulty recruiting sufficient nurses.

Nursing Sisters were the only women serving in the military at the beginning of the war, and this caused considerable anxiety for the armed forces. Some of the anxiety concerned

logistical issues that result when two sexes live and work together in close proximity twenty-four hours a day. During the Second World War, these issues included the sharing of space and privileges associated with the Officers' mess, provision for separate ablutions facilities, and assumptions regarding appropriate sexualities. Other anxieties, however, concerned the close supervision of women in the ultimate male domain of war--particularly in light of public support for the war effort and potential threats to femininity posed by new roles.[4] I argue in this chapter that the armed forces dealt with these anxieties by ensuring that Nursing Sisters were shaped as "officers"' and as "ladies" through gender, race, and class-based discourse that clearly distinguished them as "respectable" women, and maintained a measure of male military privilege.

Most nurses had experienced a militaristic style of training as students. On one hand, they were not particularly eager to return to regimentation with an additional layer of subordination as military women. There were plenty of replacements for those who could not, or would not, fit into military life. On the other hand, nurses also resisted these military constraints, aware that the armed forces would "turn a blind eye" whenever and wherever their skills were needed.[5]

I borrow and extend Kathryn McPherson's analysis of nursing as performance and her use of "nurse" as a learned, socially-created role,[6] to suggest that military nursing was more than the adaptation of nursing skills and responsibilities to military contexts. It included specific behaviours and attitudes with sanctions to enforce conformity to them, similar to the discipline experienced during nurses' training. Nurses frequently indicated that they knew and were comfortable in their nursing role, but that they had to learn to perform the military role. When NS Kathleen Dickey's unit arrived at Camp Borden for orientation to the RCAMC, nurses were admonished "that it was our responsibility to quickly learn, take this training seriously and not spoil the show for the sake of the men . . . . At this point most of us realized we were marching to war and often wondered just what part a nursing sister did play in the Army. As for nursing, we were learning nothing."[7]

I examine the process of becoming "one of the boys" through analysis of the Nursing Sister rank, with the privileges and restrictions that this relative officer rank imposed on women's activities and behaviours. Officer rank improved their benefits and challenged the boundaries of masculinity, while calling for them to demonstrate worthiness to become one of the boys. The behaviours and attitudes associated with being an officer were embedded within the hierarchy of military rank, and while rank gave nurses equivalent pay and benefits to male officers, gender and class shaped relative rank unequally. Initially, nurses held relative rank and when they began to receive commissions during 1942, the additional power of command was restricted to authority over women only. Both modifications gendered the Nursing Sister rank as a second-class status.

I examine the reinforcement of nurses' femininity as "ladies" through analysis of the Nursing Sisters' uniforms, with their embedded behavioural expectations. Nurses were accustomed to identification with a particular uniform (indeed as students, their uniforms and caps clearly distinguished them by schools of nursing). But for Canadian Nursing Sisters, there were several layers of identity—not only were they officers and ladies, they also "wore" a national identification that was clearly Canadian. Journalist Lotta Dempsey made this point when she used the Nursing Sisters' uniform to highlight performance of the military nurse role in *Maclean's Magazine*: "[T]he uniform they wear, designed for the job they do, is like the role they play. It is the King's Uniform."[8] Both rank and uniforms were highly visible, symbolic representations of the interplay of gender, race, and class in the shaping of women's roles, as well as the maintenance of male privilege.

Re-constituting Masculinity and Femininity

Canadian nurses had enlisted as an integral part of the militia with the "relative" rank and pay of a lieutenant from 1904 forward.[9] As previously discussed, they were the first nurses and, therefore, the first women to achieve officer rank. Relative rank did not, however, include officer

status since it excluded the power of command.[10] In 1942, military commissions were granted to Nursing Sisters, adding the power of command for those in authority within the nursing service, and giving nurses equivalent rank.[11] The military was careful to structure rank in ways that limited women's authority over men, marginalized them to the lowest officer levels with little opportunity for advancement, and created second-class officer status through the use of alternate titles such as Nursing Sisters and Matrons.[12]

Nursing Sisters were aware of the impact that rank could have on patient relationships. NS MacLean felt that rank had held an implicit power with their patients: "Because you had that rank, I think sometimes your patients were more conscious of the fact that you were a lieutenant instead of a private. . . . [Y]ou know that they can't talk back to an officer."[13] NS Fletcher described using her rank to arrest a soldier for drunkenness.[14] And NS Mussallem recalled an experience where she tried to avoid her responsibility when she had to place a corporal under arrest:

> If you were in charge as I was and the 'boys' were misbehaving, the sergeant major would say, "Corporal Mackintosh did this, this, and this and I want him put under arrest." You'd have to go with your clips on your shoulder and say, "Corporal Mackintosh, you have done so and so . . . . You are now under open arrest (or closed arrest)" . . . . I didn't like that part of it. . . . But you had to do it that way. You were on duty and that was one of your roles. . . . I remember saying to the Sergeant, "Try and talk him out of it." He would answer, "Sister, we've got to get on with this."[15]

NS Wannop used her discretion to 'bend the rules' in England: "[I]f a chap came in a little later than usual, we didn't report him. Because what difference did it make? He didn't do it on purpose if he was a little late getting in. He'd just get undressed and go to bed, and didn't say anything. Because otherwise you know the army was so rigid that they'd have him up on the carpet. Unless he did something wrong, and I don't think it was wrong to be a little late."[16] On at least one occasion, a soldier received punishment of seven days' loss of pay for leaving a ward without the permission of the Nursing Sister and lying about it.[17]

All RCAMC nurses enlisted as Second-Lieutenants and were promoted through the ranks to First-Lieutenant, Captain, Major, and Lieutenant Colonel. In February 1944, Matron-in-Chief Matron-in-Chief Smellie became the first Canadian woman to become a full Colonel. RCN nurses

followed a similar organization but with a flatter hierarchy and different rank titles such as Acting Sub-lieutenants and Sub-lieutenants; RCAF nurses enlisted as Pilot officers and could advance to Flying Officer, Flight-Lieutenant, Squadron Leader, and Wing Commander.[18] But gender intersected with rank to shape advancement differently for men and women. Historian G. W. L. Nicolson described the rapid advancement of one medical officer specialist from Lieutenant to Lt. Colonel in only nineteen days at No. 1 Neurological Hospital[19] while NS Sloan described her progress this way: "I went overseas as a Lieutenant Nursing Sister and came home as a Lieutenant Nursing Sister and it took 12 years to get my Captain's rank."[20]

Under the system of relative rank, nurses of all three branches were accountable to the Director of Medical Services through a parallel administration system of Matrons, Principal Matrons, and Matrons-in-Chief. The RCAMC was unique in having two Matrons-in-Chief due to the size of the nursing service--one primarily for Canada, and one for overseas. As the senior nursing service, Matron-in-Chief Smellie provided early leadership for both the RCAF[21] and RCN nursing service by means of consultations and letters with their respective Director of Medical Services (DMS).

Both the Air Force and the Navy delayed the appointments of Matrons-in-Chief as interesting debates eventually developed, regarding who would control Nursing Sisters and military nursing within these two branches. Matron-in-Chief Smellie quickly recognized the need for separate Matrons, as the size of each service increased, and as the units expanded geographically. She requested the appointments but Surgeon Commodore Archie A. McCallum, RCN Medical Director General, delayed Matron-in-Chief Russell's appointment almost 2 years until September 1943. Likewise, Air Commodore R. W. Ryan, DMS for the RCAF, delayed the appointment of Matron Jessie E. Porteous almost 2.5 years until April 1943.[22]

Rank became extremely contentious for the RCAF nurses after the formation of the Women's Division, with their alternative rank structure. There was a concerted effort to move Nursing Sisters (who enjoyed relative rank and equal pay to male officers) into the Women's Division. Nurses fought this effort on the basis that it would reduce their wages to two-thirds of

the equivalent male officers' pay, and it would position them outside of the medical services administratively. As one male officer pointed out, however, "[I]f full membership was granted to Nursing Sisters, they would be eligible to act on the Mess committee and vote on all matters raised at Mess meetings . . . and that would not be desirable."[23] So bitter was the controversy that a Brigadier and the Canadian Nurses Association became involved, before the Minister of Defence (Air) C.G. Powers confirmed nurses' RCAF rank and power of command within hospitals and medical settings. Non-nursing RCAF female medical personnel, such as dieticians and physiotherapists, however, continued to be enlisted as Women's Division personnel.[24]

Interestingly, Matron Porteous was not appointed until there was a change in command, and Air Commodore J. W. Tice became the DMS. A series of memos and letters reveal considerable tensions and contested power relations between the RCAF Nursing Service and its commanding hierarchy. There had been a recommendation made in the fall 1940 to appoint Ada Squires who was "known to be competent, a good organizer, and a disciplinarian" but she declined it related to family obligations. Frances Oakes was recommended in late 1940 but no action was taken on it—possibly because she went overseas around that time or possibly because she was involved in challenging the effort to move RCAF nurses to the WD. By May 1942 Matron-in-Chief Smellie asked officially for a Matron-in-Chief to be appointed and in July, she recommended five nurses for RCAF consideration. But the DMS rejected all five, stating he didn't want "to go to other services" and preferred his own RCAF nurses. Some of the stated objections allude to discord among nurses and reveal gendered discourse regarding women's behaviours. One nurse was considered strict but "only on matter of no importance . . . she leads to discontent among nursing staff and some nursing sisters prefer to stay in their bedrooms rather than face dinner knowing what was coming to them." Another letter described a potential candidate as forty-nine and stated that "she has passed that very difficult and uncertain period of a woman's physiological life [read as menopause], and therefore, has settled down to a matronly routine." The appointment was further delayed when Air Commodore E. E. Middleton declared that he would even prefer a civilian Matron to a non-RCAF nurse.[25]

Apparently, underlying tensions ran deeper than the appointment of a Matron-in-Chief, rank, titles, and whether Nursing Sisters belonged to the RCAF (WD). There were long-standing, contentious issues of saluting and drilling for RCAF nurses that were not resolved until 1944—and then only after the use of much paper and ink that involved the president of the Canadian Nurses Association as well. It seemed that RCAF nurses opposed the military practice of 'paying saluting compliments' and participation in drills and parades, arguing there was a shortage of nurses and the nature of their work kept them constantly on call to attend the sick. By March 1944, the Air Force and the nurses reached a compromise: Nursing Sisters would use an alternate form of paying compliments, described as "turning the head and eyes and bowing the head in the direction indicated."[26]

Saluting was contentious in the other branches, as well. RCN NS Marjorie Cowan wrote, "When we first became nursing sisters, we (at that time) did not return a salute; we were told to acknowledge a salute with 'a smile or a nod, but never a wink.' In due course, we had a class to teach us the correct naval salute."[27] RCAMC NS Pepper identified saluting as masculine behaviour and therefore a threat to nurses' femininity when she wrote:

> Saluting is very unfeminine. Saluting-on-the-march is even worse. When orders came that all nursing sisters were to salute their senior officers and return the salute of junior ranks, we were all upset. So much so that when three of the sisters saw a brigadier approaching, they exchanged a few heated words about who was to give the salute. Finally, the sister on the outside agreed to perform the honors. She did. Up came her arm. Off flew her hat. The brigadier retrieved it from Piccadilly Circus.[28]

The salute was an expected behaviour associated with masculinity, privilege, respect, and rank. As civilian nurses, the Nursing Sisters had been accustomed to 'paying compliments' in a hospital version of saluting: rising when a physician or senior nursing staff entered the ward or room.[29] But they were not always as comfortable with other aspects of rank, either the receiving of compliments or enacting the authority associated with rank. NS Ferguson said, "I don't think we ever thought about rank. Except that we had to salute other officers. We learned to salute in a hurry. But it felt rather strange to have people saluting--going down the street."[30] Some nurses sought to avoid situations that might require saluting such as when NS Betty Young and her

friend decided to change directions and go down a side lane. As she recalled, "You'd get used to it. But the first time, it really bothered me." [31]

Nurses trained as soldiers, and like soldiers.[32] RCAF Nursing Sisters may have been exempted from drill and parade, but the RCAMC nurses were not exempt. They could be the pride or the despair of drill sergeants during training and 'toughening up' exercises and sometimes they even made Sergeants nervous. NS Mills recalled that "a sergeant used to take us out on route marches which was [sic] pretty strenuous for us and the sergeant was very nervous because we were all commissioned officers. . . little did he know we were more scared of him (I think) than he was of us."[33] NS MacGregor wrote about drilling at the University of Toronto armories with World War I veteran and Regimental Sergeant Major Ed Miller: "He was a very kind and patient man. He despaired of us. When a soldier stands at attention, there is no day light showing between his arms and his body. There was no way we could accomplish this, so he finally considered 'Dames are built differently.'"[34]

Student nurses had been accustomed to strict discipline and supervision, but graduate nurses were used to relative independence and autonomy, acknowledging that while lines of authority still existed within hospital settings, most nursing practice was independent of hospitals prior to the 1940s. Given that the majority of Nursing Sisters had years of experience prior to enlisting, the return to close discipline and surveillance, such as existed over women in the military, was not an easy transition and one that nurses often resisted. At the beginning of the war, the Canadian military relied on a small number of Nursing Sisters who had served in the First World War, as well as older nurses with considerable experience in the administration and supervision of civilian hospitals, to become the Matrons of newly-mobilizing units. This practice was sufficient for the first years, when troops were training and waiting in England. But when the big 'pushes' came in 1943 and 1944, more units formed up and the existing units enlarged—thus requiring additional leadership in the form of Nursing Sisters who rose through the ranks.

When Canada received its own hospital ship in 1943, there were no Nursing Sisters with previous experience on hospital ships. World War I veteran Charlotte Nixon came out of

retirement at the age of fifty-four to serve as Matron of the *Lady Nelson*. NS Littlejohn served on the *Lady Nelson* with 'Ma Nixon' whom she described as "a bit out of touch" but well-respected and even fun-loving—producing laughter when she appeared on deck during an air raid with her tin helmet on top of her veil . . . ." [35] NS Jamieson served in Canada under Matron Gladys Sharpe who had been the Director of the Toronto Western Hospital School of Nursing. Jamieson spoke of problems between the nurses and the Matron:

> She was measuring the length of our skirts and all that sort of business and probably expecting nursing sisters to conduct themselves in the same way that you were expected as a student and that created some problems . . . . [I]t was brought to the attention of Miss Sharpe by a Western graduate who was older. I thought she deserved a great deal of respect for being able to talk to the group and realize that she was not performing the way they thought she should . . . [S]he gained a lot of respect for doing just that . . . . Well you see that didn't bother me because I was such a recent graduate. But for some of the nursing sisters who had been out earning a living . . . it was very irritating to them.[36]

Jamieson volunteered for the SAMNS when that opportunity arose, and went to South Africa where Sharpe was the Matron and liaison officer for the Canadians serving there. Jamieson was placed in charge of thirty-one nurses for the trip from England to South Africa, and she spoke of the difficulty she had as the one expected to control the rest of her peers. Part of Jamieson's problem stemmed from differences in nurses' class backgrounds, as she herself points out:

> Of the thirty-one, I found out that there were about five of them that were sneaking out at night, and going down and sleeping with whomever in the male category. . . . [F]rom the background that I was from, I just couldn't understand how anybody in a Canadian uniform on a British ship during wartime could do that. My education was being enlarged. . . . I tried different things and then I realized I was being very unrealistic. . . I just gave up, because I thought it was like Miss Sharpe. . . . [I] was to proceed to Baragwanath Military Hospital in the state of Transvaal. So I had to choose twenty people from the thirty to go with me. So I left behind the five that were a problem.[37]

NS Kellough served with No. 15 CGH as a Nursing Sister, until her promotion to assistant Matron at No. 15 CGH, and then to Matron at No. 5 CCS. Her promotions placed her in an uncomfortable position of holding rank and authority over her peers, and as she said, "You knew their best and not their best, and their work, and everything else. You had to be very impartial and I often knew what the girls were doing . . . . I often knew where they were going but I didn't say anything to anybody." When asked about disciplinary problems, Kellough replied she had

some but that she didn't talk about them.[38] On another occasion, Kellough argued with her Colonel over an order for her nurses to march in an Easter Parade at Oss, Holland:

> I argued and argued with him because we were on duty and Number 4 CCS was at rest. Their Colonel hadn't asked them to march. I said to the Colonel, "Well, there will only be a few of us, because the girls that are on duty can't go, the girls that are on night duty are sleeping." So actually there were only nine of us and myself that could go in this march. And we had taken some marching drill and stuff, but we weren't that proficient at it . . . . So our girls were practically ready to revolt and I said, "Look I've done as much as I can with the Colonel, we've got to do it, let's do it to the best of our ability."[39]

Gender, class, and rank intersected to constrain nurses' public behaviour, social activities, and personal appearance. Rank segregated nurses socially from enlisted men, while reserving them socially, for officers. Paradoxically, nurses' officer rank positioned them in closer social contact to physicians than had existed typically in civilian practice, but they also held enhanced social status (as a scarce resource) with all officers. As NS Van Scoyoc explained,

> We were a minority and these were our first experiences of relationships with friends who were engineers, signals . . . people outside the medical profession. . . . It did change our ideas of our relationships with doctors in that we had always looked up to them as 'gods' but they didn't spoil us. . . . These other people did—the officers from the other units really spoiled us . . . . [The doctors] were left without female company. . . . We benefited by having other male officers around and the doctors were sort of left out socially.[40]

NS Allemang found military rank relaxed some of the traditional barriers between medicine and nursing: "In some ways, the Air Force was a more relaxed situation for me (and more informal), and much more socializing with the medical people. We'd always have coffee in the morning." NS Cole felt there were differences in the way older and younger nurses experienced this change in relationships: "I think regarding the more experienced nurses, that there was a good comradeship between them and the medical officers. I wasn't exactly like a probie but I . . . must have been probably ten years younger that any of the medical officers." The nurses with less professional experience and less military experience tended to maintain more traditional lines of deference to medical officers.

Rank carried both responsibilities and privileges that permeated all spheres regardless of gender: the hospital, the military unit, and civilian settings. As NS Nicolson said, "When you are in the Army (and especially overseas), you were in the Army *all* the time." When NS Carter

explained that her posting was incorrect, she learned "there were 'no mistakes' as such made in the Army"[41] and when reprimanded for having liquor, Carter also learned that "all my thinking would be done for me."[42] NS Kitty Murphy's commanding officer issued a memo that "no authority was given to this Nursing Sister to state her views to the Press" when her picture and posting to Newfoundland appeared in the local newspaper.[43] NS Pepper didn't want to leave her CCS unit in Italy and wrote, "I was sad to leave but quietly moved on. One always did as one was told. Unless you were of senior rank . . . you were never a participant in the decision-making."[44] And NS Bower struggled with rank all through her Army career: "There was the military protocol, you know. . . . I didn't really fit into that ever, I think, which was a probably a problem to everybody." At one point, Bower was paraded by her Matron for "inciting the soldiers to riot." Bower spoke of her earlier upbringing and associations with labour and socialist movements of western Canada that she felt had raised suspicions about her activities related to soldiers' living conditions. Involvement with socialist movements was an indicator of working-class status, and as such, inconsistent with officer rank that bestowed professional status. As Bower explained:

> I think they would have loved to cut my pips off. And I walked into this... the sergeant major came for me and he paraded me down to this room. I had no idea that I was going to be chastised or anything else. And I went in this room and the matron was there and my equals were sitting around in a circle. And the [commanding officer] of the hospital was sitting behind a desk. And the guy marches me up and salutes, you know, and stands there. "Prisoner at the bar." Me. And it was so stupid. He said I was . . . inciting the soldiers to riot.[45]

Rank for the Nursing Sisters was a complex and contested aspect of the military. As the first women in the armed forces, it was not always clear to the nurses or their male superiors just how the embedded behaviours and attitudes of rank were to be enacted when gender intersected with performance of their role.

Remaining Feminine

While some aspects of rank could be negotiated, however, the Nursing Sisters' position as "girls" and "ladies" was non-negotiable. The military needed nurses for more than their professional skills. The Nursing Sisters were members of predominantly male units that lived and

socialized together, in addition to working together. NS Mills referred to nurses' chief contribution to the war as, "being female."[46] They were to serve as models of femininity, as companions and dance partners, as morale-boosters, and as a touch of home—all within the limits of respectability. RCAF nurses selected for posting to the special plastic surgery unit at East Grinstead became part of the treatment (the technology), valued for their femaleness and beauty. Author Rita Donovan described the nurses selected to work at this specialized unit, emphasizing their physical attributes that "validated his [the patient's] ego and assisted his recovery. . . . [These nurses] were chosen not only for their abilities but also for their empathy, their sense of humour, and, in this case, their looks. Their role was clearly larger than that of medical support for they were also to assist in rebuilding the confidence of these damaged men."[47] NS Lamont related an incident that occurred on the way to England in which nurses' femininity was placed on display:

> One day we heard the intercom saying, 'All Nursing Sisters report immediately to the port deck.' And so we thought, 'Oh boy, this is it. You know, we're needed.' And tore up and got on the deck. And the Captain was there smiling. And what happened was, the Canadian frigate was right--very near us and they had heard that there were Canadian girls on board. And they just wanted to have a look at us. So we all waved and yelled.

McPherson points out that the key element of ladylike behaviour was 'restraint' and that much of the student nurses' training had involved the inculcation of restraint into their practice and into their lives.[48] Learning to be a military nurse involved "getting used to four-letter words, men, and Army life," as NS Jamieson pointed out.[49] But it also involved learning how to behave during off-duty activities where there were opportunities for drinking and engaging in sexual behaviour. Male officers frequently hosted parties for which they requested a certain number of nurses to attend, and Nursing Sisters often reciprocated.[50] NS Mary Bray said that in her unit, "we were well watched over by everyone. Our behaviour had to be the best. . . . We could never go out unless there were six of us to any Officers Mess or party in the camp. . . . [O]ne day one of the officers came in to our Major and said, 'I would like to have six of your assortment!'"[51] For social occasions, nurses could be chosen like chocolates in a box. NS Tritt recalled that her Matron even assigned nurses to attend parties as part of their duties such as when she posted a

notice that read: "There will be a dance at headquarters. 'X' Nursing Sisters required. You were supposed to sign up." NS Kellough described these 'emotional times,' as nurses sought to fulfill this dual roles of nurse and companion to the troops, especially when some of them had a brief 'rest period' from frontline action. She described the physical and mental stress of staying up most or all of the night and then going on duty with minimal or no sleep: "They would want parties and we felt that we were obligated to go to the parties because they would soon be going back into the line again. . . . [W]e had to be up and at it in the morning . . . . [T]hey knew and we knew that some of them would come back as patients; some of them wouldn't come back. So it was an emotional time, but they had to talk to somebody."[52]

In the same way that nurses knew 'how to nurse' before becoming military nurses, orientation lectures reminded nurses that they already understood what was expected regarding professional deportment with physicians and patients. The same lectures warned them, however, that they had a 'twenty-four-hour' responsibility to represent the medical services branch in the military unit and in civilian settings. They were to conduct themselves as ladies, particularly in the Mess. As NS Taylor recalled: "You had to follow the rules or you weren't going to be there." Nurses were admonished not to abuse their privileged access to the Mess because it was "primarily man's domain," and not to wear out their welcome by "aimless sitting around . . . drinking and chatting . . . ." They were to avoid fraternizing too much with the 'other ranks;' they were not to criticize the armed forces or complain in public places; and "no lady ever drinks too much." There were regulations about carrying parcels and purses, smoking, make-up, nail polish, jewelry, gum chewing, hair style, loud talking, cleanliness, travel, uniforms and shoes, and more—but overall, "Our actions should be dictated by the laws governing the conduct of a lady."[53]



Photograph 3. RCAMC Major/Principal Matron Edna E. Rossiter and Major Pierce at No. 12 Canadian General Hospital near Bruge, Belgium sometime after April 1945. Matron Rossiter wrote on the back of the photograph, "The dignified Matron and Major Pierce (E. N. T.) coming home from the Officers Mess at Knocke. (We didn't start till it got dark for obvious reasons.)" Photographer unknown, photograph donated by Nursing Sister Eleanor Smith to the Hamilton Military Museum (Ontario). Used with permission.

Drinking alcoholic beverages was typically a major part of dances and parties, but drinking was not without pitfalls, especially within military hierarchies. NS Van Scoyoc described the consequence for a colleague who transgressed the boundaries on drinking at Petawawa: "[O]ne of the girls got drinking too much. It was a brigadier and of course, they are very rank conscious (particularly in Canada). And she was talking about all his stars on his shoulder. And they said she had too much to drink. So she didn't get overseas."[54] In England, there were places to go off-duty as well as organized social activities; but when nurses were in active theatres of war, their world was very small and off-duty opportunities were far fewer. Sometimes drinking became sufficiently problematic at the unit level that measures were taken, such as when NS Amy White wrote home from the *HMCS Niobe* that, "We have had the bar removed from our

ward room by mutual consent and serve coffee instead, every night at ten. The liquor was becoming too much of a problem."[55]

In the *Canadian Nurse*, a variety of ads used the imagery of military nurses as busy and hard working, but at the same time, remaining "fresh" and "achieving victory over odours" when they used the product being advertised (Appendix 16). Deodorant ads reinforced the femininity of military nurses. A young nurse in battledress with her tin helmet in place cares for a bandaged but cheerfully smiling young man in a bed, with a jungle scene visible outside the window and a caption that reads: "Army nurses certainly have plenty to do these days, and still they must keep well groomed. That means attention to underarm freshness. MUM, the snow-white vanishing cream brings quick deodorizing victory over stale perspiration odor wherever it may arise."[56] Navy nurses were not overlooked in another ad: "'Full speed ahead' is the order of the day for Navy nurses and there's precious little time for personal fastidiousness. . . . [MUM] goes into action quickly and stays on duty for long hours. . . . Signal for MUM during sanitary napkin time. And try it for refreshing hot, tired feet, too."[57] TAMPAX advertised their product under the heading, "Unprecedented times? Unprecedented problems" referring to women's wartime work in the text: "Working steadily with men in near proximity—often wearing close-fitting slacks or coveralls—with less opportunity for private retirement than in more leisurely or more domestic times—it is little wonder that so many have found in Tampax the ideal means for improving their hygienic habits, as an aid to uninterrupted activity."[58] Nurses' feet even sold foot powder in an ad portraying columns of nurses on parade under the heading "War Effort Speeded by New Success over Athlete's Foot" and the lead-in sentence: "Every nurse must keep her feet in most perfect condition to keep working and marching to victory."[59]

The most visible symbol of gendered rank and femininity in the armed forces was the Nursing Sisters' uniform, which remained distinct from Women's Divisions' uniforms. The RCAMC uniform (patterned after the cherished World War I uniform) became the standard upon which RCN and RCAF Nursing Sisters' uniforms were based, so that Canadian military nurses of all three branches would be recognized as related services.[60] NS Carter described it this way:

> There were three types [versions] of uniforms, each with an Alice-blue two-piece suit with two rows of small brass Medical Corps buttons down the jacket, a peplum, white stiff collar and cuffs, a leather two-inch belt with a lion's head brass buckle . . . and a slim, slightly-flaired [sic] skirt. One uniform was wool for winter dress affairs, one was silk for such events in summer, and one was cotton for work. Over the cotton uniform we wore a white cotton apron with a bib and straps, and the belt over the apron . . . . A white veil was worn with all these uniforms. A navy blue suit for 'walking out' was worn with a light blue shirt from Morgan's' Boy' Department. . . with [a] navy blue tie, either wool or silk. We wore very smart navy blue brimmed felt hats by Stetson, with a ribbon band and the Medical Corps badge up front.[61]

Brown leather gloves, white scarf, brown 'sensible' walking shoes, black 'pumps' for social affairs, navy blue raincoats and greatcoats, a purse, a lace handkerchief for the jacket pocket, rank designations and the Canada badge completed the outfit. RCN nurses wore the darker color of the Navy, a maroon distinction cloth with the gold lace and RCN insignia. RCAF nurses began their first year without a military uniform except for the veil (with RCAF wings embroidered on the back) worn with their basic white uniform. They continued to wear white uniforms for patient care but adopted an Air Force blue dress uniform based on the RCAMC model.[62]

Wearing the uniforms properly was a matter of pride and discipline but these uniforms also contrasted to the starkness of the 1930s for many nurses. NS (Dietician) Elizabeth Dean said she loved wearing them "because I'd grown up in Depression years and now I had all these uniforms."[63] The dress uniform served for all public functions, from parade grounds to weddings and dances (unlike some American nurses who traveled with evening gowns).[64] There were plenty of occasions to exhibit ladylike behaviours, especially in England, when royalty and dignitaries visited the medical units or at various teas, receptions, and cultural events where nurses were used to represent the Canadian forces. NS Surgenor recalled that RCN nurses had an active social life and were expected to be present when battleships came into port, whereupon they were "treated like queens" at the Captain's table. "You were somebody special. . . . You also dressed accordingly. I mean your uniforms had to be right, too. I mean you had an image to keep up."[65] Ironically, this was almost the only occasion when Navy nurses were permitted on ships. NS Lamont pointed out the association of self-respect and self-worth with the uniform: "I think because we suddenly felt that we were valued, that we were respected. We were known by our uniform. We felt good in our uniform. People knew who we were by our uniform."[66]

Admonished not to 'disgrace' the uniform and regulated to wear it, nurses of all three branches were constantly reminded of embedded behavioral expectations. At the HMCS *Stadacona* in Halifax, the policy permitting 'civvies' on Sundays quickly changed when civvies proved too provocative. NS Surgenor stated, "In those days, you wore a white blouse usually and a sweater. And it was fairly tight-fitting. I think we had about a month-and-a-half of Sunday dinners with the Admiralty house, when we got a message that we were not to wear civvies anymore on Sundays. The sweaters were too tight! We had to wear our uniforms."

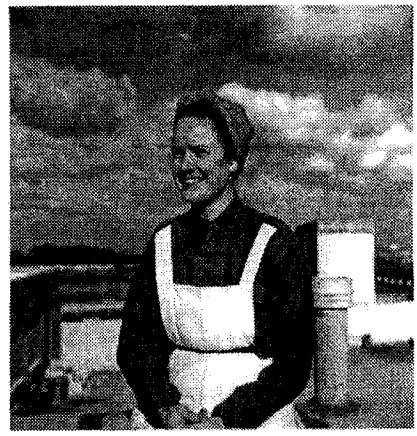
Nursing Sisters wore bibbed aprons and veils with the cotton duty uniform. Beyond any utilitarian function, aprons were reminiscent of student training days as well as nursing's subservient, domestic roots, while veils were reminiscent of nursing's association with religious sisterhoods and the care of strangers as a charitable duty performed by middle class ladies. Nurses had long been portrayed as angels and sacrificial mothers.[67] These symbols and metaphors constituted important tools to shape nurses as respectable women in contrast to disrespectable 'camp followers.' They served as visual reminders for nurses, patients, male officers, and the public alike. One officer escorting nurses at night under London's blackout conditions is reported to have remarked, "You know I'm not protecting you, you're protecting me [from prostitutes]."[68]

The veil was a particularly evocative symbol. Nurses took great care to starch, iron, and wear it properly. NS Van Scoyoc told how "the officers liked to play a trick, to try to take our veils off. We were not properly dressed if the veil was pulled off or askew. It was considered a great misdemeanor."[69] It remained a powerful symbol of Nursing Sisters' association with the military: their rank and privilege, patriotism, and shared experiences in aspects of war forbidden to other women. As NS Lamont explained, former Nursing Sisters working in DVA hospitals postwar wore their civilian uniforms but retained the veil. In her words, "We wore our veils you know. . . . We were so proud to have been in [the war]."

When posted to active theatres of war, however, nurses stored the 'Blues' and adopted British-issued Khaki battle dress. As NS Sloan wrote, "We packed our blue uniforms and white

veils, donned khaki uniforms, berets, and high leather boots, and headed for Yorkshire for a toughening up period prior to D day." She continued, "[but] when the rains came . . . everyone worked in gas capes, tin hats, and gumboots, completely shattering the illusion of 'ministering angels.'"[70]





Photograph 4 (left). Nursing Sister Estelle Tritt Aspler, used with permission. Photograph 5 (right). "Close-up of Head nurse in Khaki," North Africa, n.d. PA 213776, photographer unknown. Department of National Defence, National Archives of Canada.

The transition from Blues to Khaki signified becoming "one of the boys" although there were still concessions regarding femininity such as khaki skirts during the day, while khaki bandanas and berets replaced the veil. Long pants provided necessary protection against malaria-carrying mosquitoes after sundown although nurses were not greatly pleased to have to wear them to dances. NS Kellough illustrated the sexual fluidity during wartime and gender-bending behaviours with this example:

> We had to wear slacks on account of it being malarious [sic], and danced in our heavy boots. We said we looked very alluring with our mosquito cream on our face . . . [At] the American hospital near us, their Colonel allowed them to wear skirts and we weren't. So one of my beaux or escorts, whatever you like to call him, he said 'if you wear those darn pants, I'm wearing a kilt.' I said, 'O.K., take out an American girl—she can wear a skirt'. . . .There were situations that you had to accept because the Orders came from the Colonel.[71]

There were other situations in which authorities questioned nurses regarding the use of khaki uniforms and trousers, especially during travel where they represented Canadian womanhood to the European public. NS Tritt felt the Matron in Brussels was 'out of touch'—not only with nurses' realities but also with Canadian wartime changes on the home front:

> Some of us were posted to Bramshott (to 8 General) again. Matron MacDonald told us to travel in our battle dress--which was the only thing (if you were traveling in an ambulance or in trucks usually). So away we went, to stop over in Brussels overnight at headquarters. And Matron Shaffner was quite shocked to see us in battle dress. "How can you come in battle dress to Brussels—a city? You wouldn't see people wearing, women wearing slacks in Toronto or Montreal!" When I got off the train at Bonaventure Station, there was my mother and my three sisters . . . . [M]y three sisters were in slacks. So I felt like writing "Dear Matron Shaffner, people are wearing slacks."

Battle dress was practical given the living and working conditions even though it became a liability to have to dance in pants and heavy boots.[72] Water was severely rationed and cleanliness was a challenge as some nurses reported surviving four months or more with only sponge baths that had to serve as laundry water afterwards. As NS MacBain wrote, "Khaki turbans kept our hair well hidden. Our shirts were also khaki so that solved our dirty shirt problem, it was such a neutral colour. We had only three shirts and not enough water to wash them so we rotated daily, hung them up to air and sprinkled them with Chanel No. 5. We had more of that than water."[73]

Nurses from the *Santa Elena* as well as those whose supply ship was sunk in the Augusta harbour at Sicily were extremely grateful for replacement men's khaki when all their clothing was lost. But they found that there were only a limited amount of small sizes, the proportions were definitely masculine instead of feminine, and there was no underwear. NS MacLean wrote to her brother stationed in England, asking him to send an assortment of bras because there were none in Army stores. NS Cox grieved because she had 'big feet' and her 'nice new shoes' had gone down with the ship. But she scrounged new ones from an American supplies dump. And only one woman had abandoned ship carrying a tube of lipstick (the only make-up that survived among the entire group).[74] Nurses of No. 5 CGH also lost their clothing and personal possessions when their supply ship was sunk in Augusta Harbour just as they

landed there. But unlike most units that had adopted Khaki en route to active theatres, NS Nicolson's unit arrived in Sicily dressed as ladies instead of 'one of the boys':

> We got into the harbour and got down off the ship. Down the ladders into the landing craft with our [vomit] bags, in case we were sick. And our helmet, and our knapsack, and all the rest of it--with our silk stockings on still, and our suits, and our fedora hats. . . . Skirts, of course! . . . We were lucky nobody fell in. We did get down the ladders and get in. Again, some airplanes came over and our ship was--the rudder was slightly damaged. And we lost our supply ship. We didn't know at the time, but our supply ship went down with that bombardment. We lost all our equipment and our tropical gear that we were to wear. We were still dressed up as if we were going out for a nice walk in the country or whatever.

In unexpected ways, the uniform helped Kay Christie and May Waters survive as Japanese POWs. They had to cut up their uniforms to make shorts, and their aprons to make 'sun tops' when clothing wore out. Christie described how she used flooring to make slab shoe soles and tied them to her feet with strips of the blue uniform as clogs. When they were repatriated as part of an American prisoner exchange, Christie reported that on the exchange ship, "The Canadians were so raggedy that we were called down first to the store. Everyone else could have either a dress or a skirt and sweater but because we were so poor, we could have more."[75]

Nurses identified so closely as members of the military in khaki that sometimes it was difficult to distinguish them from the fighting forces.[76] It was also sobering for those who realized this. NS Irene Stephenson wrote about landing on the famous Mulberry harbour at Arromanches, coming ashore in landing craft, being met on the beachhead by a soldier with mugs of hot tea. "Then," she wrote, "[I]t was into the trucks and across the dusty roads to Bayeux. I felt like I was about to save the world until we passed a group in a field and an elderly woman pointed to her bandaged knee and shook her fist at us. I guess she connected us to her injury somehow, and dressed in khaki battledress and steel helmets we all looked like soldiers anyway."[77] Just as the uniform made the soldier, the uniform also made the military nurse.

Historian Mary Sarnecky attributed the low morale and disciplinary problems within the United States Army Nurse Corps partially to a lack of appropriate military nursing uniforms. Apparently, the Army was unprepared for the large number of American nurses who were

ultimately required, the production of smaller sizes, or the distinctions between the nursing service and the women's divisions. Sarnecky called the United States Army Nurse Corps uniforms "varied and sometimes confusing," often impractical, and "vested with much confusion, pain, energy, and emotion." Several uniforms were proposed and developed; some nurses had to go overseas initially without uniforms. She wrote that "morale frequently plummeted as a result of dowdy, baggy, or uncomfortable uniforms. During the Second World War, the Army Nurse Corps learned the importance and significance of the military uniform."[78] There are volumes of silences in her discussion in relation to implications for the control of women and women's behaviours when the uniform is not present as a visible symbol of expectations. For most of the Canadian Nursing Sisters', however, their military uniform was a source of great pride, symbolic of national identity, and shaped by class and gender to represent military nurses visibly as officers and as ladies.

Experiencing the Contradictions

Being "an officer and a lady" was not always congruent with military realities, however. There were at least three, "career limiting" life events that affected military women differently than military men: aging, marriage, and pregnancy. At the beginning of the war, the armed forces enlisted nurses who were very experienced, and who typically brought additional training in administration, supervision and teaching. In 1941, the "Report of the Committee on Nursing and Nurse Education in Canadian Hospitals" reminded civilian hospitals that: "[I]t must be borne in mind that there is a definite need for mature, self-disciplined women, experienced in leadership, to represent Canadian nurses overseas. Even in the so-called rank and file, military nurses are called upon to undertake supervisory duties and often under extraordinary conditions."[79] The military clearly sought to limit the number of nurses during this early phase. They filled positions slowly, and used these nurses to train medical assistants—putting nurses' abilities in administration, supervision, and teaching to good use.

But the military also preferred these older, experienced nurses for another purpose—as 'safe' women who could control and supervise younger, less-experienced nurses (both professionally and socially) when the number of younger nurses increased after 1943. The combined effect of training and post-graduate experience positioned nurses as 'older sisters' and even sometimes as 'mothers' to the average soldier, whom they almost always referred to as 'our boys.'[80] Age difference partially de-sexualized the physical care of relatively healthy, young male bodies. One nurse recalled that "the boys were proud of their Sisters—almost as if we were their own sisters,"[81] while another wrote that: "[M]ost nursing sisters had experienced young casualties of all nationalities, crying for 'Mum.' She was always there to talk, give him a smile, a pat on the shoulder or squeeze his hand."[82]

This preference also contributed to an aging nurse population as the war continued and the workforce remained surprisingly stable. One-quarter of the Nursing Sisters served between four and six years while almost one-half served between three and six years. Many of the Nursing Sisters were entering their mid-thirties and forties by the end of the war. By 1943, there were sufficient nurses in place and they had developed enough expertise in aspects of 'military nursing' through four years of war that the armed forces shifted policy to include much younger nurses with far less experience, in preparation for large scale campaigns in the active theatres.

At the end of 1944, the RCAMC began recalling all nurses over forty back to England from Italy. The RCAF recalled their nurses who were over forty back to Canada. Now redundant, they became known internally as "WOOFs" or "women of over forty". Many of them were deeply angry at their forced departure, based solely on age and not on their performance.[83] NS Dorothy Macham wrote in her diary, "I can't give any particulars but I think I am returning to England shortly. I guess I have had my 'fightin'. I will be sorry to go but I really think I am beginning to take these moves with a little less concern."[84] But another nurse was so angry that she wrote a letter of resignation (August 1944), unhappy in "having been returned to Canada as over age for overseas duty."[85] It was also difficult for younger nurses who became the replacements, as NS Bray noted: "I'd missed out on all the pre-training and felt so sick at heart because I knew I was

replacing an old stalwart type. And I felt really lost . . . ."[86] Sometimes the change was disguised as a 'promotion' to a higher level of responsibility--but within a unit in England or Canada. At other times, nurses were told they were needed for their military experience in Canada. As NS Tritt explained,

> We also saw my old OBS supervisor (Arnodt) who was being sent home. And she heard that one of the other supervisors from Reddy [Reddy Memorial Hospital, Montreal] had just come over, and she was yelling, "If McCaffrey is under 39 then I'm sweet 16." Because they were sending the older girls home at 39. One reason was, when the fellows came back from overseas and landed in Canadian hospitals with younger nurses, they weren't paying any attention to them, [meaning] "After all, you haven't had our experience." And the older girls came back.[87]

The RCAMC initiated a plan in November 1944 to return nurses to Canada based on the date of their enlistment—a policy that compounded the anger and accelerated the withdrawal of older nurses from the active theatres. NS Pepper wrote, "[I]t seemed odd that it should happen at the height of what we now felt was our final campaign."[88] NS Bond said the 'first over' rule was particularly disappointing because the new nurses "had taken our place where we should have been."[89] NS Dorothy Potts spent V-E Day alone after being recalled to Canada when "I would have been there with them."[90] The recall of long-term nurses and WOOFs frequently disrupted well-established teams in the field, removing the most-experienced nurses and preventing a sense of closure so near to the war's end, ostensibly because the military felt younger women were needed closer to the front. It is unclear why the military suddenly implemented these policies. An abundance of civilian nurses on enlistment waiting lists, as well as a large number of military nurses requesting overseas postings when available, made it possible to exchange older nurses for younger ones. There is no evidence that older nurses were less capable or less willing to serve on the frontlines. But age became a liability, instead of an asset that came with nursing expertise.

Marriage constituted a second liability. Although the armed forces' policy on marriage was consistent with social expectations that married women resign from the work world, obligatory resignation became unenforceable as the need for experienced nurses increased. NS Eleanor Jones married secretly in March 1942. When her husband was killed in a training

accident seven months later, she was charged with 'Conduct Unbecoming to an Officer' or 'Conduct Prejudicial to Good Discipline,' paraded before a Brigadier, and given a Reprimand for marrying without permission. As she wrote, she had to have a series of interviews with her Adjutant that "always left me in tears" and although the policy changed in 1943, the Reprimand was still on file at her discharge several years later.[91] When the number of nurses who married and resigned became increasingly significant, a policy change permitted married nurses to remain in the service whereby the forces retained military nursing expertise--just in time for the major Italian and European campaigns of 1943 and 1944. Marriage became a career limiting move, however, because married nurses could not serve in an active theatre. They were re-posted to stay in England when their units left for the Mediterranean in 1943, and those who married after arriving in an active theatre had to return to England.[92] These military policies were consistent with prevailing discourses and reflected social expectations regarding women, protection, and safety. This consistency was necessary to assure continued public support for women within the armed forces.

Pregnancy was a third liability that not only limited a military nursing career, but terminated it. Unlike male officers, nurses were preferably to remain single for the duration and if they were unmarried, they bore the primary consequences of pregnancy. Yet one nurse described the military situation as 'a female paradise' where "there were all kinds of men. And even the most unattractive person was really 'rushed.'"[93] Another nurse called it "an abnormal way of life," explaining that: "You were over there mixing with married men and single men, and all of them were lonely, but the married men were perhaps the loneliest of all. There were a lot of affairs going on. If nurses got pregnant, they were sent home."[94] The anti-malarial drug, Mepacrine (or Atabrine), was reputed to cause sterility and as a result, many male personnel avoided taking it, but as NS Irene Henderson noted, "[It] proved not to be a birth control pill either, to the surprise of many!"[95] My sources reveal that at least 6.5% of the military nurses were pregnant on discharge and that pregnancy was the chief reason for medical repatriations, as it was among female military personnel in general.[96] Many pregnant nurses were single, and it

remains unclear how many marriages may have resulted from prior pregnancies. The pregnancy rate increased after the policy changed, permitting married nurses to retain their commissions. It increased again in the months after V-E Day as the war wound down, and as women had less reason to avoid pregnancy in order to stay overseas. Nurses recalled returning to Canada on discharge, designated officially as the 'walking wounded,' or having a 'physiological tumour,' or just plain 'pregnant.'[97]

Pregnancy did become sufficiently problematic during the war that the Army decided to test women prior to embarkation overseas. NS Ciceri recalled: "One morning, throughout the two huts, you could see long lines of specimen bottles. A few nurses didn't get to go overseas."[98] Meanwhile, according to a memo from the London County Council Public Health Department in 1944 regarding Friedman (pregnancy) tests, "Rabbits are scarse [sic] and expensive" and the RCAMC was asked "to avoid excessive number of tests."[99] One nurse managed to conceal her pregnancy until the eighth month when it was considered unsafe to return to Canada. A civilian physician delivered the baby who was placed for adoption, and the nurse was discharged as 'not well adapted to military service.'[100]

Sexual desire required restraint if not outright denial. Nurses brought a de-sexualized subjectivity with them from their training years, where they had learned through complex and often contradictory processes, how to care for the bodies of strangers (and men in particular) within the bounds of respectability.[101] But the military's need for nurses to serve in dual heterosexual roles, as nurses and as women, added yet another level of complexity to nurses' sexuality. Effectively, the 'conduct of a lady' principle applied to appropriate sexual relationships with 'boarding out' (discharge) and the loss of benefits as the penalties for misconduct.

My sources contain veiled references and noticeable silences on sexuality other than in relation to pregnancy. The majority of Nursing Sisters described an extensive and active social life, the large disproportion between men and women, the easy availability of male escorts, and camaraderie with medical officers. Most nurses either denied or avoided discussion on unwanted sexual behaviours and/or same sex relationships. As NS Sloan said,

> I've had the medical officers put their arm around my shoulder and talk to me about a patient or something. Or you're sitting at the little six foot folding table in the so-called 'office' and the guy comes around and sits on the bench beside you, and puts his arm around you, and talks to you about a patient or something. Well, if that's harassment, we had that. And they'd come by and give you a pat on the bum and say, "Come on, let's go." Or give you a slap on the back and say, "That's a good job."[102]

But NS Fletcher occasionally expressed her annoyance with British officers in letters home. She wrote after one dance, "These damned Englishmen have only two ideas in their heads, & the first one is to get tight, & let the second one follow. I left the party in disgust at 11 P.M., & know of three other girls who simply walked off & left their partners. I know that our lads aren't angels, & we wouldn't ask them to be, but at least they have a little finesse about the whole thing."[103]

Nurses spoke and wrote about the large number of weddings toward the end of the war, as well as their own marriages to men they had often known for a very brief time.[104] NS Bower wrote of several relationships in which she almost married men she had known for a very short time, and of one man that she did marry. She also wrote and spoke of difficulties with military discipline and lifestyle, her general unhappiness overseas, sexual harassment, and a need for counseling that might have prevented her disastrous decision to marry.[105] Other marriages, however, were formed just as quickly and lasted for a very long period.[106]

Occasionally, Nursing Sisters referred to friends, lovers, and husbands they had lost to war. But they seldom spoke of sexuality or how war and the military may have imposed constraints or facilitated relationships. Those who did confirmed a blurring of social conventions related to sex, married officers, sexual 'teasing,' harassment, abortion, venereal disease, and same sex relations. NS Carter related an incident at No. 1 CGH where the Matron and a number of nurses petitioned for the removal of a Colonel who 'made passes' at them. She also claimed to have known lesbian nurses in some the units where she was posted.[107] NS MacGregor described a nurse named Dorothy who "radiated sex" and "would stand at the foot of the bed while Purdy was trying to take out stitches from an appendectomy, and do a lot of very seductive wiggling. The patient reacted the way any healthy young man would react, and be terribly embarrassed while Purdy (muttering unkind things about Dorothy) tried to finish the job."[108] NS Fletcher wrote to her family about an experience during night when she put on an "evening dress"

for the benefit of the duty sergeant. In her example, class intersected with gender to construct the Nursing Sister as sexually unavailable to non-officers:

> [The Sergeant] was rather homesick & longing for a feminine female instead of one with a Sam Brown belt & a couple of pips—so he asked me if I would please get dressed up in it & just show him what a Canadian girl looked like in a Canadian evening dress. By that time it was 3:30 A.M. & nobody [was] very sick, so I sent him into the kitchen, & climbed into the whole thing, shoes & all. His only remark was "This is the first time that I have ever wished I was an Officer."[109]

Numerous accounts reflected nurses' difficult position as predominantly single women living and working closely among predominantly married men. The war lasted for six years and many of these women enlisted during their prime marriageable years. Some felt they were too old to marry after the war, or they left relations with married men behind them on return. Others lost significant relationships during the war and were unable to acknowledge or grieve their losses for a variety of reasons. Matron Macham explained that in the case of her male friends, "[W]hen they returned home, most of them returned home to wives and families where they had been from (whom they'd been away from), in some cases quite a number of year, and so you lost those friendships."[110] NS Fletcher wrote that she was too old for marrying and most of the men she knew had wives: "I shall miss all my Army friends very much, & no doubt be most awfully lonely when they all go back to their wives. But it has been fun borrowing them from time to time. We have had a lot of fun & no one has been burned."[111] Being an officer *and* a lady was not always an easy role to enact.

Summary

Becoming officers while remaining ladies, required the Nursing Sisters to demonstrate their worthiness as "one of the boys" while simultaneously, demonstrating their femininity as "one of the girls" and as "ladies". Relative rank and distinctive Nursing Sisters uniforms symbolized in a highly visible manner, the embedded behavioral expectations for femininity and respectability. With time, the armed forces learned to deal with the logistics of Nursing Sisters as part of the

medical units, and turned the occasional 'blind eye' to their indiscretions. The re-shaping of gender and class boundaries was an integral part of learning to perform the military nurse role but it was "for the duration" only, as far as the military was concerned. Nurses lost some of these wartime relationships and changed others significantly, on their return to the postwar world.

The armed forces accepted nurses primarily because medical technology legitimated their presence in the military-medical-technological system. Their daily nursing practice, in Canada as well as overseas, consisted of salvaging men as key human resources in order to achieve military objectives, rehabilitating them for civilian life if salvage was not possible, and providing as much comfort as possible to them as they died. The Nursing Sisters already knew how to nurse when they enlisted. The majority of them also had a substantial level of experience prior to enlistment. But they had never encountered the massive number of traumatic casualties, the extensive wounds and burns, or the rapid pace of triage and evacuation that would be required of them as military nurse during a war. This will be the subject of the next chapter.

Endnotes

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[2] Jean Ellen (Wheeler) Keays, audio-taped interview with Sheila Zerr, 16 August 1994 at White Rock, British Columbia, Oral History Collection, Registered Nurses Association of British Columbia, Vancouver, B.C. [hereafter cited as RNABC].

[3] Margaret Van Scoyoc, audio-taped interview with author at Ottawa, Ontario on 13 June 2001.

[4] See Ruth Roach Pierson, "Wartime Jitters Over Femininity," in *The Good Fight: Canadians and World War II*, eds. J. L. Granatstein and Peter Neary, pp. 141-168 (Mississauga, Ontario: Copp Clark, 1995) and *"They're Still Women after All": The Second World War and Canadian Womanhood* (Toronto: McClelland and Stewart, 1986).

[5] Jean (MacBain) MacAulay, in *Military Nurses of Canada*, v. II: 111.

[6] Kathryn McPherson, "'The Case of the Kissing Nurse': Femininity, Sexuality, and Canadian Nursing, 1900-1970" in *Gendered Pasts: Historical Essays in Femininity and Masculinity in Canada*, eds. Kathryn McPherson, Cecilia Morgan, and Nancy M. Forestell, pp. 179-198 (Don Mills, Ontario: Oxford University Press, 1999): 180-181.

[7] Kathleen (Dickey) Allan in *Military Nurses of Canada*, vol. I: 358.

[8] Lotta Dempsey, "Canada's Blitz Sisters," *Maclean's Magazine*, 1 September 1943: 24.

[9] M. Leslie Newell, "'Led by the Spirit of Humanity': Canadian Military Nursing, 1914-1929," Masters Thesis (Nursing), University of Ottawa, 1996 cites the "Report of the Department of Militia and Defence for the Dominion of Canada for the year ending March 31, 1921": 28.

[10] Paragraph 193, *King's Regulations and Orders for the Canadian Militia, 1939* (Ottawa: King's Printer, 1939 and revised, 1947).

[11] W. R. Feasby, ed., *Official History of the Canadian Medical Services, 1939-1945*, vol. I: *Organization and Campaigns* (Ottawa: Queen's Printer, 1956): 324.

[12] By way of international comparisons, the British Nursing Sisters were auxiliary units of the armed forces rather than integrated members of the military. They received 'emergency' commissions with equivalent rank in 1941, and became "Nursing Officers" in 1942. In a similar manner, Australian military nurses received rank in 1943, but were not integrated into the military until 1951. [See:] Arthur Salusbury MacNalty and W. Franklin Mellor, eds., *Medical Services in War: The Principal Medical Lessons of the Second World War Based on the Official Medical Histories of the United Kingdom, Canada, Australia, New Zealand and India* (London: H.M.S.O., 1968): 77-78; Juliet Piggott, *Queen Alexandra's Royal Army Nursing Corps* (London: Leo Cooper, 1975): 73; and Jan Bassett, *Guns and Brooches: Australian Army Nursing from the Boer War to the Gulf War* (New York: Oxford University Press, 1992): 3, 99, 142, 151, and 165.

[13] Margery MacLean Root, audio-taped interview with author at Ottawa, Ontario on 15 June 2001.

[14] Letter from Margaret Fletcher to her family, 3 July 1943, Margaret Fletcher fonds: 1933-1945, SC042, University of Victoria Archives and Special Collections, British Columbia Archives [hereafter as the Fletcher letters].

[15] Helen K. Mussallem, audio-taped interview with Cynthia Toman at Ottawa, Ontario on 24 September 2001.

[16] Eva Wannop, audio-taped interview with author at Toronto, Ontario, 25 April 2001.

[17] No. 1 CGH War Diary for 29 January 1941, RG 24, C-3, vol. 15666, serial 282, NAC.

[18] "Status of Nursing Sisters serving with the RCAF," memo dated 13 November 1942, RG 24, series E-1-b, vol. 3365, 400-2-1, vol. 1, NAC.

[19] G. W. L. Nicholson, *Seventy Years of Service: A History of the R.C.A.M.C.* (Ottawa: Borealis

Press, 1977): 141.

[20] Harriet J.T. Sloan was one of the very few nurses selected for the permanent forces. She served continuously until her retirement in 1968, eventually becoming Matron-in-Chief of the Canadian Forces Medical Services with the rank of Lt. Colonel. See Jean E. Portugal, *We Were There: The Army, A Record for Canada*, vol. 5 (Canada: Royal Canadian Military Institute Heritage Society, 1998): 2283-2284.

[21] The RCAF did recognize the Matron of the St. Thomas Technical Training School hospital as the senior nursing service personnel by consulting her on matters related to the Nursing Sisters but they effectively denied her the position and title of Matron-in-Chief. See Feasby, *Official History of the Canadian Medical Services,* vol. I: 440.

[22] See Feasby, *Official History of the Canadian Medical Services*, vol. I: 439-442 and G. W. L. Nicholson, *Canada's Nursing Sisters* (Canada: Samuel Stevens Hakkert & Company, 1975): 182-183.

[23] Letter from #2 RCAF Training Command at Winnipeg to National Defence (Air), 16 March 1942, E-1-b, v. 3365, HQ400-1-1, NAC.

[24] P. Wetzel, "Draft Narrative for the History of the RCAF (WDs) re. Women Medical Officers, Nursing Sisters, Physiotherapists, Orthopists, and Opthalmical Assistants," 181.003(D1467), DHH. See also: letters from H. A. Peacock to Commodore R.W. Ryan, 29 May 1942 RG 24, E-1-b, v. 3365, part 1 and from Marion Lindeburgh to C.G. Power, 20 November 1942, RG24, series E-1-b, v. 3365, 400-2-1, part 1, NAC.

[25] Letters of 29 September and 2 November 1940 from Major A.D. Kelly; 27 May, 8 June, and 20 July 1942 between Elizabeth Matron-in-Chief Smellie and J. A. Sully; memo of 4, 17, and 20 August 1942; "Nursing Sisters, RCAF: Appointment of, policy governing," file 400-2-1, v. 3365, series E-1-b, v. 1, RG 24, NAC.

[26] Feasby, *Official History of the Canadian Medical Services*, vol. I: 439-442.

[27] Marjorie (Cowan) Horton in *Military Nurses of Canada,* vol. I: 553.

[28] Evelyn A. Pepper, Gaëtan (LaBonté) Kerr, Harriet J.T. Sloan, and Margaret D. McLean, "'Over There' In World War II," *Canadian Nurse* 62, no. 11 (November 1966): 32.

[29] Military discourse permeates a sociological analysis of the American Nurses Association postwar study conducted in 1950. The authors describe hospital uniforms as sorting people into "publicly acknowledge ranks" and calls standing in the presence of physicians the "hospital salute." See Everett C. Hughes, Helen MacGill Hughes, and Irwin Deutscher, *Twenty Thousand Nurses Tell Their Story* (Philadelphia: J.B. Lippincott, 1958): 62.

[30] Frances Ferguson Sutherland, audio-taped interview with Cynthia Toman at Edmonton, Alberta on 10 October 2001.

[31] Betty Young Ramage Hamilton, audio-taped interview with author at Edmonton, Alberta on 12 October 2001.

[32] "Nursing Service, RCAMC." *Canadian Nurse* 38, no. 10 (October 1942): 781-782.

[33] Margaret H. Mills, audio-taped interview with Margaret Allemang on 5 April 1991, MMA.

[34] Eleanor MacGregor, "Defending the Empire," unpublished paper given to the author by retired Nursing Sister Pauline Lamont Flynn, May 2001.

[35] Ruth Littlejohn McIlrath, audio-taped interview with Nina Rumen at Vancouver and Burnaby, British Columbia on 20 October 1987 and 23 November 1988, RNABC and Ruth (Littlejohn) McIlrath in *Military Nurses of Canada,* vol. III: 18.

[36] Florence Louise Jamieson, audio-taped interview with Margaret Allemang at Toronto, Ontario on 24 April and 3 May 1987, MMA.

[37] Jamieson interview, MMA.

[38] Margaret Helena Kellough, audio-taped interview with Margaret Allemang on April and May 1987, MMA.

[39] Kellough interview, MMA.

[40] Margaret Van Scoyoc, interview with Lisa Weintraub, 4 June 1984, ISN 167825, NAC.

[41] Doris Carter, *Never Leave Your Head Uncovered: A Canadian Nursing Sister in World War Two* (Waterdown, Ontario: Potlatch Publications, 1999): 4.

[42] Carter, *Never Leave Your Head Uncovered*: 12.

[43] Memo, 12 May 1941, Department of External Affairs, E-1-b, v. 3365, HQ400-1-1, NAC.

[44] Evelyn Pepper in *Military Nurses of Canada*, vol. 1: 50.

[45] Mary M. Bower White, audio-taped interview with Cynthia Toman at Surrey, British Columbia on 20 October 2001.

[46] Mills interview, MMA.

[47] Rita Donavan, *As for the Canadians: The Remarkable Story of the RCAF's 'Guinea Pigs' of The Second World War* (Ottawa: BuschekBooks, 2000): 128.

[48] McPherson, "'The Case of the Kissing Nurse': 184.

[49] Jamieson interview, MMA.

[50] Estelle Tritt Aspler, audio-taped interview with author at Westmount, Québec on 13 August 2001; Van Scoyoc interview with author; and Margaret Roe Dewart, audio-taped interview with author, Edmonton, Alberta on 15 October 2001.

[51] Hutton in *We Were There*, vol. 5: 2243.

[52] Kellough interview, MMA. Georgina Rideout recalled similar incidents of "double duty" in Joyce Hibbert, *Fragments of War: Stories from Survivors of World War II* (Toronto: Dundurn Press, 1985): 83.

[53] "Responsibilities of Members of Nursing Sister Service," Course in Aviation Nursing, Course No. 12 -- August 23rd-Septmber 14, 1944, Barbara R. Carr fonds, Royal Canadian Military Institute Library, Toronto.

[54] Van Scoyoc interview with author.

[55] Amy White, letter to her parents, 12 January 1944, M. Amy White fonds, MG 30 E508, NAC.

[56] "Army Nurses are on the Go," *Canadian Nurse* 39, no. 7 (July 1943): 499.

[57] "Navy Nurses are Busier than Ever," *Canadian Nurse* 39, no. 9 (September 1943): 633.

[58] "Unprecedented times? Unprecedented problems," *Canadian Nurse* 39, no. 8 (August 1943): 555.

[59] "War Effort Speeded by New Success over Athlete's Foot," *Canadian Nurse* 40, no. 5 (May 1944): 349.

[60] See one description of the uniform in "Nursing Service, RCAMC, CASF," *Canadian Nurse* 36, no. 2 (February 1940): 87-88.

[61] Carter, *Never Leave Your Head Uncovered*: 6-7.

[62] "The RCAF Nursing Service," *Canadian Nurse* 40, no. 3 (March 1944): 164-166; "The Royal Canadian Naval Nursing Service," *Canadian Nurse* 40, no. 2 (February 1944): 96-98; and Nicholson, *Canada's Nursing Sisters*: 183.

[63] Elizabeth Dean Doe, audio-taped interview with author at Ottawa, Ontario on 30 June 2001.

[64] Carter interview.

[65] Surgenor Maddock interview.

[66] Pauline Lamont Flynn, audio-taped interview with Cynthia Toman at Ottawa, Ontario on 3 April 2001.

[67] John Murray Gibbon even wrote a song about Canadian Nursing Sisters, describing them as 'Fairy Queens' who waft care away in the battle clearing station, flitting along the tent: "Our Canadian Nursing Sister," *Nursing Songs of Canada* (Toronto: Gordon V. Thompson, 1946): 8-9.

[68] Kellough interview, MMA.

[69] Van Scoyoc interview, NAC.

[70] Pepper, Kerr, Sloan, and McLean, "'Over There' in World War II": 26 and 28

[71] Kellough, MMA.

[72] Constance Betty Nicolson Brown, audio-taped interview with author at Ottawa, Ontario on 3 June 2001.

[73] Jean (MacBain) MacAulay, in *Military Nurses of Canada*, vol. II: 115.

[74] MacLean Root interview; Pauline Cox Walker, audio-taped interview with author at Kingston, Ontario, 13 June 2001; and Margaret Moss, in *Military Nurses of Canada*, vol. I: 299.

[75] Kay Christie, audio-taped interview with Joan Williams, 20 November 1975, ISN 196090, NAC; Kathleen G. Christie, audio-taped interview with Margaret Allemang on 5 April 1992 and 3 June 1992, MMA; and Kay Christie, "Behind Japanese Barbed Wire—a Canadian Nursing Sister in Hong Kong," *Royal Canadian Military Institute Year Book* (Toronto: RCMI, 1979): 11-13.

[76] Elizabeth M. Norman made a similar point when she argued that American nurses shifted in their self-perception to become soldiers as the 'Battling Belles of Bataan.' They thought of themselves initially, as healers but when confronted with danger and deprivation, they became 'women at war.' See, *We Band of Angels: The Untold Story of American Nurses Trapped on Bataan by the Japanese* (New York: Random House, 1999): 39.

[77] Irene (Stephenson) Mercier in *Military Nurses of Canada,* vol. I: 224.

[78] Mary T. Sarnecky, *A History of the U.S. Army Nurse Corps* (Philadelphia: University of Pennsylvania Press, 1999): 231 and 273-275.

[79] "Report of the Committee on Nursing and Nurse Education in Canadian Hospitals," Bulletin #36 (1941): 39, RNAO fonds, 96B-5-14, Archives of Ontario.

[80] Lamont Flynn interview.

[81] Grace Patterson, audio-taped interview with Joan Williams, 18 November 1975, ISN 196088, NAC.

[82] Pepper in *Military Nurses of Canada*, vol. I: 57.

[83] RCAF memo 8 June 1944, HQ54-27-93-15 FD15 (Personnel 1B), RG24, E-1-b, v. 3365, file 400-2-1, part II, NAC; Evelyn Pepper, Elizabeth L. (Burnham) Lowe, and Jessie Morrison in *Military Nurses of Canada,* vol. I: 51, 57, 158, and 241; Dorothy A. Macham interview with Norma Fieldhouse at Toronto, 10 February 1988, MMA; and Nicholson, *Canada's Nursing Sisters*: 124 and 140-141.

[84] Dorothy Macham in *Military Nurses of Canada,* vol. I: 320.

[85] NSD records, used with anonymity as required.

[86] Mary Bray Hutton, in *We Were There,* vol. 5: 2244.

[87] Tritt Aspler interview.

[88] Evelyn Pepper in *Military Nurses of Canada*, vol. I: 57.

[89] Constance Bond Young audio-taped interview with Ella Beardmore on 4 July 1989, MMA.

[90] Dorothy Agnes Potts, interview with Margaret M. Allemang, 30 September 1987, MMA.

[91] MacGregor, "Defending the Empire."

[92] Lenore Lancaster Menard, audio-taped interview with Terina Rindal at Lethbridge, Alberta on 14 March 1995, AARN.

[93] Patterson interview.

[94] Anne Farries, "War Nurse Recalls Second World War Experiences," *Cranbrook Daily Townsman*, Cranbrook, BC, 10 November 1992.

[95] Irene Henderson Greenwood, in *Nursing Sisters' Association of Canada: Commemorative Issue and Membership Directory*, June 1994: 25.

[96] Between June 1944 and June 1945, the official incidence of pregnancy was 53.2 per 1000 enlisted women in the Army according to M. J. Tuttle, "Analysis of Medial Repatriations: Canadian Army Overseas," *Journal of the Canadian Medical Services* 3, no. 3 (March 1946): 211.

[97] Mary Beatrice (Nelson) Weir's "physiological tumour" was born on Armistice Day according to her account in *Military Nurses of Canada*, vol. II: 237. See also Eleanor (Wallbridge) Lloyd, *Military Nurses Of Canada*, vol. III: 57; Lois Bayly Tewsley, audio-taped interview with author at Ottawa, Ontario, 11 June 2001; and Amy White, letters of 9 October 1944 and 19 February 1945, M. Amy White fonds, MG 30 E508, NAC.

[98] Jean Mary Ciceri, audio-taped interview with Nina Rumen at Victoria, British Columbia on 13 January 1987, RNABC.

[99] This memo was found in a military nurse's file but under the constraints imposed on this research, I cannot use identifying information.

[100] I have preserved this nurse's anonymity on request.

[101] The best analysis of this phenomenon is found in McPherson, "'The Case of the Kissing Nurse': 181-185.

[102] Harriet J. T. Sloan, audio-taped interview with author at Ottawa, Ontario, 14 March 2001.

[103] Margaret Fletcher, letter to her father from No. 16 CGH, 13 November 1943, Fletcher letters.

[104] Eleanor MacGregor's second marriage in the military took place within a month of being introduced to the man. See "Defending the Empire."

[105] Mary M. White wrote about numerous situations of harassment, love, and marriage in her memoir, *Hello War, Goodbye Sanity* (Canada: author, 1992)*: 34, 43-45,* 72-73, 86-88, 91-95, 99-100, and 105. She was particularly adamant in her interview with the author regarding her need for counseling and the loneliness she experienced in the military.

[106] For some examples, see the interviews with Dean Doe, Nicolson Brown, and Doris Taylor Rasberry, audio-taped interview with Cynthia Toman at Pointe Claire, Québec on 19 June 2001.

[107] Karen Duder's research found that there was much same sex antagonism in the postwar armed services. Military men and women were subject to intense scrutiny of their sexual behaviour and gender performances with censure and dismissal for nonconformity. "'That Repulsive Abnormal Creature I Heard of in that Book:' Lesbians and Families in Ontario, 1920-1965," in *Ontario since Confederation: A Reader*, eds. Edgar-André Montigny and Lori Chambers, pp. 260-283 (Toronto: University of Toronto Press, 2000): 270.

[108] MacGregor, "Defending the Empire."

[109] Margaret Fletcher, letter to her father from No. 16 CGH, 27 October 1942, Fletcher letters.

[110] Macham interview, MMA.

[111] Margaret Fletcher, letters to her family, 17 February and 16 April 1945, Fletcher letters.

CHAPTER 4

LEGITIMATING MILITARY NURSING PRACTICE THROUGH MEDICAL TECHNOLOGY

Shifting medical care requirements resulted in several reorganizations of the military medical units during the different phases of the Second World War, along with re-thinking the delivery of nursing services. As the Canadian troops became much more involved in active theatres during and after 1943, there was an increasingly large number of casualties. Military discourse has portrayed the Nursing Sisters primarily as 'morale builders,' while the dominant public discourse has portrayed them as tea attendees, shoppers, sight-seers, and brides. But medical discourse frequently attributed a reduction in the official morbidity and mortality rates to the presence of nurses within these medical field units.[1] They were located in a vast 'no man's land' where medical units formed key components of the tactical planning for major invasions, where treatment decisions for troops *and* prisoners of war were part of military strategy, and where medical science was classified 'top secret' to prevent its benefits from reaching the enemy. Military nurses enjoyed an elite professional status during the Second World War that has been linked to their relative closeness to two frontiers: the frontline of combat and "the frontier of the military's medical technology."[2] As NS Margaret Allemang said, "If you'd been to the front, you were special."[3]

For their part, military nurses welcomed expanded roles and responsibilities that resulted from these reorganizations, to further legitimate their presence in the armed forces. It is unclear if these opportunities actually let nurses 'out of the cage' of gendered, civilian nursing roles,[4] or if war merely 'moved the cage' because the same physicians and nurses who staffed civilian hospitals were those who staffed the military medical units.[5] The purpose of this chapter is to examine how the war shaped medical technology and military nurses' work, and conversely, how military nurses shaped medical technology in relation to military and civilian practice.

I argue that the Nursing Sisters capitalized on opportunities to build further technological expertise, and to become essential actors within a military-medical-technological system, but that much of their newly-acquired expertise was lost to civilian hospitals after the war. Nurses embraced a variety of medical technologies, demonstrating their ability to greatly expand practice roles. The extent to which they could do this was contingent on the geographical setting, the availability of medical officers and medical orderlies, and the social construction of specific technologies as either women's or men's work. In general, there was more role flexibility and autonomy closer to the front lines where patient acuity was higher, skilled personnel fewer, and risk-taking more acceptable.[6] Nurses re-shaped these medical technologies as 'shared' practices, through the addition of nursing perspectives. And when no technological solutions were readily available, they relied on their own body of nursing knowledge to deal with patient care issues. But when their skills were no longer required to maintain a fighting force, very few Nursing Sisters returned to civilian hospitals, and their experience with expanded roles did not necessarily carry over into the postwar profession. Nonetheless, they exerted an important impetus for change through their absence from the workforce, as hospitals sought alternate ways to meet the increased demands for nurses during a period of severe nursing shortage.

This military-medical-technological system was similar to other large technological systems—comprised of multiple actors with diverse interests.[7] It included a wide array of individuals, organizations, political entities, universities and research laboratories, regulating policies and regulatory bodies as well as industries that stretched across the Allied countries (and likely Axis nations as well).[8] Historian Donald Avery comes close to identifying military medicine as a military-medical-industrial complex, in his analysis of Canadian science during the Second World War. But he stops short of using this term, acknowledging that medical science constitutes a major gap in his research.[9] Historian Alex Roland argues for his part that, "The dividing line between military and nonmilitary technology is not nearly as absolute as is usually assumed."[10] For my part, I found that decisions regarding medical research, the implementation of medical

technology, and the organization of medical care were based on complex negotiations among actors with unequal power within the system.

This chapter uses gender analysis and the concepts of "technological systems" and "actor-networks" to examine war as nurses' work.[11] Both human and non-human actors (or actants) bring a set of relationships (or an actor world), and engage in the enrolment of other actors through the process of translation (an interpretation of potential benefits to meet the desired objectives of those being enrolled). In the process, both human and non-human actors are transformed.[12] In actor-network theory, technology is understood to be both society-shaping and socially-constructed—that is, all actors have power and there is tension between agency and structure. In actor-network terminology, the Nursing Sisters were "enrolled" as an essential part of the medical care for soldiers as well as agents of the state to "win the war."[13] In turn, they "enrolled" the military and the state to achieve their own objectives as nurses and as women.[14] The Canadian Nurses Association became part of the total war effort from the very beginning, through articles in the *Canadian Nurse*, a call for civilian nurses to stretch both human and non-human resources, the investment of Canadian Nurses Association funds in war bonds, and the donation of three surgical units to the armed forces.[15]

Nursing in the Context of Medical Technology

There is a very small, developing body of historical research focused on nursing and medical technology in general.[16] Synthesis of this body of literature suggests that the interaction between nurses and technology was context specific. Prior to the 1880s, medical and nursing technology consisted primarily of "kitchen physic" that was used in patients' homes—domestic artifacts and techniques that were commonly available and familiar to lay people, as well as trained nurses.[17] With the rise of Western science between the 1880s and the Second World War, nursing sought professional status through claims as a scientific discipline, achievement of provincial registration of nurses, and standardization of nursing education. To legitimate claims

that nursing had a specialized body of knowledge that differentiated trained nurses from untrained care givers, nurse leaders emphasized the scientific principles of antisepsis and asepsis (related to sterile procedures, surgical techniques, and patient care environments), concepts of measurement (such as temperature, fluid intake and output, and medication calculation), and the routinization of nursing care under the rubric of scientific management.[18] It was this legitimacy that Nursing Sisters parlayed into coveted work as military nurses. Along with other historians, I have argued previously that as hospitals and medical technology expanded during the decades after the Second World War, nurses assumed increasingly technological roles in the form of "delegated medical acts" while using technological skills to secure a degree of power for themselves by becoming "essential to the system."[19] Since at least the 1980s, nurses have expressed considerable ambivalence regarding the amount and type of technology in patient care. Their relationship to technology can be best described as contested.[20]

Two major debates dominate this literature, both framing technology dichotomously.[21] One debate frames technology as either an impetus for stability or an impetus for change, while the second debate frames technology as either a liberating force or an oppressing force. Historians of technology, medicine and nursing have typically framed the Second World War as a "watershed" for technological innovation, followed by a proliferation of medical technology linked to increased prosperity, hospital insurance plans, rapid expansion in the number and size of hospitals, and a rapid population growth after the war. There is a general consensus in the medical technology literature, which is dominated primarily by sociologists, that the Second World War constituted a critical period for innovation.[22] Stuart Blume thus writes that, "World War II intervened with its unprecedented mobilization of scientific talent. . . . They [the scientists] took [their expertise] back with them to their laboratories, and they brought about a transformation of biology. . . . All of this was of great consequence for the development of medical technology."[23]

Existing military medical histories have focused on specific innovations associated with the war.[24] They provide good descriptive and chronological accounts regarding drugs such as penicillin, sulphonamides, anti-malarial drugs, and sodium pentothal; infusions of saline, glucose,

blood, and plasma; inoculations for gas gangrene and typhoid; the Tobruk splint; extensive surgical debridement; Trueta's method of open wounds enclosed in plaster of Paris casts; triage and the chain of evacuation; advances in reconstructive (or plastic) surgery; advances in vascular techniques; and the development of DDT. But while the Second World War has been perceived as a pivotal period related to medical technology, there has been little direct examination of this perception. Few accounts have considered these medical technologies from either social history or history of technology frameworks.[25] We know little about the transfer of medical technology to nurses during this period, or the perspectives of military nurses whose very presence within the military medical system made frontline technological care possible.

As Margarete Sandelowski points out, it is difficult to isolate medical technology that belonged exclusively to nurses: "[W]hile women might arrange flowers, nurses cared for them as part of the management of the environment around the patient. Women might make beds, but nurses used beds to comfort and treat patients."[26] On the other hand, nurses also shared specialty objects (such as thermometers, hypodermic syringes, catheters and more) with physicians.[27] While their use of these objects supported physicians' orders related to diagnosis and treatment, nurses also transformed these objects into nursing technologies by using them for purposes of the comfort and support of patients through an illness experience. Thermometer readings gave diagnostic information to physicians, but these same readings also guided choices nurses made about bathing, feeding, and activities for the patient. Pain medications were prescribed by physicians, but nurses often made key decisions regarding the dosage and timing of administration to maximize patient comfort related to dressing changes, ambulation, or need for sleep and healing.[28] Sandelowski's concept of "shared technology" is useful in this thesis for understanding the shifting roles and responsibilities among military nurses, physicians, and medical orderlies.

I pointed out previously that the Nursing Sisters have been portrayed as working in relatively normal, safe settings. But the early fall of France in 1940, the fall of Hong Kong in 1941, and the failed Dieppe Raid in 1942 altered Allied thinking about the number and type of

casualties that could be expected, as well as the nature of medical care required. As the concept of an all-volunteer armed force gave way to the full conscription of men, the availability of expert medical care gained significance related to recruitment endeavours and public support for war. Medical research, technology, and practice became important adjuncts to 'total war' (the mobilization of all aspects of civilian society toward the international war effort), assuring the public that soldiers would have access to the latest and best in medical therapeutics, as well as expert medical personnel.

Nurses and Prewar Medical Technology

Nursing Sisters were already quite familiar with technology. In training schools and graduate practice settings, they had used a variety of implements, mastered hundreds of procedures, and adapted patients' environments for the prevention of illness and the pursuit of healing or a peaceful death.[29] Graduate nurses like Edna Rossiter, for example, described pouring chloroform by mask for obstetrical deliveries at the Royal Jubilee Hospital in Victoria in the 1930s (hoping the physician might arrive in time for the birth). She described the use of various types of plasters, stupes, fever sponges, as well as applications of heat, cold, and chemicals—all of which, she said, were "much more physically strenuous without antibiotics."[30]

As technology increased in hospitals during the 1930s, the Canadian Hospital Council passed a resolution requesting to delegate specific technologies to 'specially trained graduate nurses' based on "the shortage of interns and the increased use in modern medicine of various clinical procedures, such as intravenous medication, blood pressure readings, administration of oxygen, etc. . . . ."[31] It considering their request, the Canadian Nurses Association decided at its meeting in 1940 to survey the types of clinical procedures already being performed by nurses in 130 hospitals across Canada. The results of the survey, along with the questionnaire and descriptive data, were published in 1941 as the "Report of the Committee on Nursing and Nurse Education in Canadian Hospitals." This report provides a good snapshot of the technological

skills that were, or were not, already part of civilian nursing practice at the beginning of the war. One question listed ten procedures and asked hospitals to indicate which of them were performed by nurses, the level of qualification required, and how nursing personnel coped with the additional workloads. The report then analyzed data by hospital size and whether or not the hospital had intern services (Table 4.1).

Findings of the report indicated that general duty nurses did not typically perform the ten technological skills included in this survey, and student nurses were not permitted to carry out the procedures. When specific hospitals delegated such responsibilities to graduate nurses, the nurses had to acquire them through so-called 'post-graduate courses'. These procedures comprised 'gray areas' of responsibility that shifted from medicine to nursing based primarily on a perceived intern shortage. Comments from the report astutely noted that larger hospitals did not typically assign these duties to nurses, while medium-sized hospitals had to rely increasingly on nurses with special preparation, and the smallest hospitals gratefully used any available graduate nurse to perform them.

When the Canadian Hospital Council and Canadian Nurses Association met jointly to consider the survey results, nursing leaders contested the assumption of these additional responsibilities without additional staffing as a workload issue. They also argued that these procedures and technological skills were medical acts and as such they were beyond nursing's scope of practice—raising further concerns over the legality involved and the hospitals' liability if nurses were to perform them. But they stopped short of refusing to accept the delegation. Instead, the Canadian Nurses Association restricted delegation of these skills to nurses who had been "carefully selected and trained for this work," and only in hospitals without adequate intern service (which happened to be 90% of those surveyed).[32]

TABLE 4.1: SUMMARY OF REPORT ON CLINICAL PROCEDURES PERFORMED BY NURSES IN CANADIAN HOSPITALS, 1940-1941[33]

Procedures	Hospitals with less than 50 beds (n=38 hospitals)	Hospitals with 50-99 beds (n=24 hospitals)	Hospitals with 100-499 beds (n=30 hospitals)	Hospitals with 500-1000 beds (n=6 hospitals)
Blood Pressure readings	G (13%) SP (18%) NP (68%)	G (33%) SP (17%) NP (50%)	G (10%), SP (50%), NP (40%)	G, 2 hospitals
Interstitials	G (26%) SP (32%) NP (42%)	G (17%) SP (38%) NP (46%)	G (6%) SP (57%) NP (33%)	NP (100%)
Intravenous saline or glucose	G (8%) SP (18%) NP (74%)	G (8%) SP (21%) NP (71%)	G (3%) SP (37%) NP (60%)	NP (100%)
Other intravenous medication	G (5%) SP (8%) NP (87%)	G (8%) SP (8%) NP (83%)	SP (2%) NP (77%)	1 hospital, SP
Intramuscular injections (pituitrin, ergot)	G (45%) SP (45%) NP (11%)	G (54%) SP (42%) NP (4%)	G (10%) SP (63%) NP (17%)	SP (50%) NP (50%)
Removal of sutures	G (37%) SP (34%) NP (29%)	G (38%) SP (42%) NP (21%)	G (6%) SP (57%) NP (37%)	NP (100%)
Taking of blood for Wassermann test	G (8%) SP (34%) NP (58%)	G (8%) SP (42%) NP (50%)	G (3%) SP (40%) NP (50%)	NP (100%)
Ordinary dressings	G (37%) SP (50%) NP (11%)	G (54%) SP (42%)	G (10%) SP (63%) NP (1%)	4 hospitals, G 1 hospital, SP 1 hospital, NP
Clinical history (exclusive of physical)	G (5%) SP (16%) NP (79%)	G (29%) SP (21%) NP (38%)	G (3%) SP (47%) NP (50%)	1 hospital, G 5 hospitals, NP
First assistant in major operations	G (34%) SP (40%) NP (26%)	G (17%) SP (29%) NP (54%)	G (13%) SP (18%) NP (68%)	NP (100%)

Legend: G = any graduate nurse; SP = graduate nurses with special preparation; NP = not performed by nurses.

Although the Canadian Hospital Council and the Canadian Nurses Association eventually reached an agreement regarding the delegation of these technologies, the Canadian Medical Association refused to endorse it.[34] And since hospital administrative boards were dominated by physicians, hospital policies governing nursing practice were slow to change until staffing shortages forced them to do so. By 1943, the Committee on Nursing and Nurse Education in Canadian Hospitals reported: "Nurses have had to measure up to responsibilities that have been decreed theirs through force of circumstances alone . . . . [They have] entered fields that before were unknown to her and is meeting many additional responsibilities very effectively. [They are] doing so at home and overseas."[35]

Many contemporary sources claimed that the war introduced an unacceptable burden of expanded medical technology onto civilian nurses and hospitals; however, this Canadian Nurses Association survey suggests that delegation was already a contested issue prior to the war. The Second World War did shape where, when, and how medical technologies were introduced to support military objectives, but it did not instigate a radical change from previous nursing practices. Most of the surveyed technologies became standard military nursing practice: blood pressures; intravenous infusions, including blood and blood products; intramuscular injections; taking blood samples; changing ordinary (as well as not-so-ordinary) dressings; serving as first surgical assists; and more.[36] The Nursing Sisters used these opportunities to develop further skills and expertise, while becoming essential within the medical units.

The Nursing Sisters Database (NSD) contains the names of the schools of nursing from which 1052 Second World War military nurses graduated, and their date of graduation. Analysis shows that they graduated from 187 different hospital training schools and four baccalaureate nursing programs.[37] The largest number of nurses came from the Montreal General Hospital (6%), the Toronto General Hospital (5.5%), and the Royal Victoria Hospital in Montreal (5.1%). Each of five other hospitals graduated from 1.9-3.4% of the Nursing Sisters while the remainder of them (70.4%) graduated from 174 hospitals. Clearly, no single hospital supplied a large proportion of military nurses, and neither did nurses come primarily from the large teaching

hospitals. They represented a broad cross-section of Canadian nurse training programs and it is reasonable to assume that their procedural skills reflected those surveyed by Canadian Nurses Association.

Becoming Essential to the System

Nurses assumed roles during the initial stages of the war in which their work was familiar and closely resembled prewar civilian nursing practice, except that almost all of their patients were male and young. They prepared both patients and equipment for a variety of procedures, assisted physicians and surgeons during procedures, and cleaned up after procedures—as they had done in civilian hospitals before the war.[38] They quickly became involved in immunizations, sick room (infirmary) services related to a high incidence of contagious diseases such as mumps and diphtheria, and the pre-operative/post-operative care of patients having remedial surgeries. Each of these activities aimed to maximize the number of men available for military service, and to delay or minimize the need for conscription. Most of the first Nursing Sisters served in military hospitals within Canada, only gradually moved to England where they awaited assignment to field medical units. Thus, there was little need for change in practice at the beginning of the war, and existing medical technology was basically familiar to nurses. As Bassett suggested, during this early phase, the 'cage' merely moved from civilian to military settings, while roles and relationships remained relatively unchanged.

The Second World War and the armed forces brought graduate nurses together in unprecedented numbers as a highly-experienced workforce from a wide variety of Canadian hospitals to work in medical units.[39] Civilian hospital nursing care was primarily the domain of a student workforce under the guidance of a few graduate nurses as instructors, supervisors, and administrators. Graduate nurses typically worked in isolation with individual patients in private homes or 'specialed' private, paying patients within the hospital. NS Betty Nicolson pointed out the difference this made for military nurses: "You see there was no supervision. Remember, we

were all graduates--were all old enough take on responsibilities. So nobody particularly checked us."[40] But flexibility and autonomy in nursing roles depended partially on the geographical setting. There was less difference in Nursing Sisters' roles and responsibilities within Canada and more differences in the military hospital units overseas. The greatest changes in roles, however, were experienced in active theatres as military nurses moved toward the various fronts.

Prior to the war, various large urban hospital schools thought of themselves as superior to small hospital schools of nursing. War brought the Nursing Sisters together as an all-graduate nurse workforce while it also broke down traditional barriers among hospital training schools by posting graduates from different schools together in mixed units. Military nurses began to shift from strong identification with local training schools toward identity as a national nursing service. Fanny Munroe described such differences brought about by military nursing for readers of the *Canadian Nurse* when she wrote, "[I]t must be recognized that there is no one best way of doing things; that no one hospital is better than all others; that no one school is superior; that no city or province can claim superiority over another. Thinking nationally and not locally, will bring a willingness to admit that new ways can be good."[41]

NS Pauline Cox was a member of one of the first integrated units to go overseas and she told how nurses used the trip to England to get to know one another professionally as well as socially. So did NS Joan Doree and Ruth Littlejohn who served on the *Lady Nelson* hospital ship. Indeed, the *Lady Nelson* was purposefully staffed by a Matron and eleven nurses selected to represent as many of the provinces as possible.[42] Littlejohn recalled that they used the first voyage as a training or trial run where they had to re-think all of the procedures, adapting not only to one another but also to conditions that existed on a ship (minimal space and equipment, perpetual and unpredictable movement, and swinging berths, for examples). Blended units provided nurses with opportunity to share procedures, techniques, and knowledge from their diverse backgrounds. They frequently described learning from one another, especially from the

Saskatchewan nurses who were 'Depression-trained' and known to be extremely innovative.[43] As one of the younger and more novice nurses, NS Harriett Sloan said,

> I was a reinforcement. That unit had been in England a long time where they had lots of time to look after accidents and things--that experience I hadn't had. But they were wonderful teachers, I thought I knew everything about nursing when I finished [school] and I found these ladies from Saskatchewan (who had worked for 'peanuts' and maybe board and room)--could they nurse! I learned more from those nurses than I ever learned, I think.[44]

The RCAMC also implemented a policy of nurse exchanges in 1943, partially to address nurses' strong desires for postings to active theatres and partially to assure an increasingly experienced workforce as the Army began to enroll younger nurses in preparation for major offensive campaigns. NS Elizabeth Pense referred to the dual purposes of these exchanges: "We were moved around for experience . . . for the experience you could bring in, and the experience you could take out."[45] The policy had less positive results when a personnel exchange disrupted cohesive teams however. For example, NS Margaret Fletcher complained in a letter home that the Army had 'gone nuts' because recent exchanges had reduced the overall level of competency within her unit.[46] Most of the interviewed nurses reported an unusual level of mutual support and teamwork, compared to their previous civilian experiences. With time and experience, a critical mass of competent and confident military nurses did develop which facilitated the delegation of medical technologies to them. As NS Pauline Lamont remarked:

> We suddenly became self-confident. We knew that people relied on us, trusted us, and that brings out the best in everybody. We also weren't too afraid to try new methods and new techniques, and we had to improvise a lot. And we weren't . . . supervised so minutely as civilian nursing. . . . I hadn't seen any of [these wounds] before (shrapnel, abdominal wounds, terrible tank burns, amputations). You know, chest, all kinds of injuries. . . . I did dressings and things I had never seen before. . . . We were given trust. We were given responsibility and we knew we could do it. And when we came back, we knew we had done it.[47]

Physicians and surgeons had been used to working primarily with student nurses in civilian hospitals where there was a constant flow of novice learners giving bedside care. Through closer association within military medical units, they gained a fuller appreciation for what graduate nurses knew and could do at the bedside--particularly in the smaller forward units and specialty teams that focused on specific types of patients (head injuries, chest injuries, burns, or

shock patients). NS Eva Wannop noticed a big difference working in the plastic surgery unit at Basingstoke. As one of four or five nurses who worked with a physician, an anaesthetist, and a dentist until the unit enlarged and moved to Hackwood House, she had more responsibility and autonomy:

> I do know that there was a lot that you catered to the doctor in civilian life but there was none of that there . . . . They used to come around once a day and check everything, and if there were any questions or that. And then you carried on. And if you were concerned about something, you knew you could always call them but they gave you a lot of responsibility. . . . You see we were such a small unit that Colonel Gordon used to (once a week), you know we would gather together and have talks. . . . [H]e was very helpful—but we were such a small unit. I don't know what they did in the big, in the large units.[48]

United by a common goal to 'win the war,' medical teams challenged traditional divisions of labour as they seldom did in civilian practice. Nursing Sisters frequently referred to the camaraderie and trust between members of the medical staff. Small units positioned in the 'forward' areas, located near or in battle zones, afforded opportunities to teach and delegate new skills as well as opportunities to develop the associated knowledge (for observation, monitoring, and supportive care) related to those skills. In addition, mass casualties provided a large volume of patients who needed similar procedures which allowed nurses to consolidate newly-acquired skills. NS Nicolson contrasted her experience to what she did as a civilian nurse:

> [W]hen we were in the Army, you really . . . had to think right on the spot to do things. And you certainly did just do things that you . . . just never did in training or in the hospital situation . . . . And you never hesitated. You just did. You improvised lots of times--things like that. You know, something had to be done so you did it, in other words. Regardless. And even if you weren't just sure, you did it anyway, to the best of your ability. . . . There were so many other people relying on you too, you know. So military nurses were a little different I think.

But when nurses who had served in the forward units returned to England, the previous constraints were re-imposed and they had to relinquish expanded roles. NS Lois Bayly proceeded to follow through on medical orders as she usually did in the Casualty Clearing Stations (CCS) in Europe: "I just did it automatically because I had been doing it . . . like starting the intravenous and the Wangensteen . . . ."[49] She was warned however, that she had to wait for a physician to do these same procedures now.

Younger nurses who enlisted near the end of the war perceived far less change in military nursing practice. First, they were seldom posted outside of Canada or in frontline units because senior nurses had priority for these postings—although a few younger Nursing Sisters made it to England as reinforcements for the WOOFs near the end of the war. When novice nurses did arrive in overseas units, Matrons typically placed them in larger base hospitals and in more central areas where they could be supported and mentored by nurses experienced in military aspects of nursing.[50] Second, younger nurses were less likely to experience the same level of collegiality or camaraderie that older Nursing Sisters had with the medical officers. There was a wide variation in ages between the 'reinforcement' nurses and the 'original' nurses who had been older on enlistment and had already served in the armed forces from four to six years.[51] Age and experience placed them in different generations, socially and professionally. Third, younger Nursing Sisters perceived less change between civilian and military nursing practice, because the civilian hospitals had already begun to integrate new medical technologies toward the end of the war, making them familiar for newer graduates.[52]

Nursing education was active in disseminating practice changes as well as in taking advantage of federal funding for such programs. Refresher courses at the School of Nursing of the University of Toronto during 1943 included "Developments in the Field of Medicine, given Emphasis in War Time" and in 1944, "Some Aspects of Nursing Care in War Time." Over 900 nurses registered each year for these eight-week courses.[53] Older Nursing Sisters, who had enlisted at the beginning of the war, brought years of experience with them but it was experience primarily acquired in private duty, where they had less contact with innovations in medical technology.[54] Thus, the reinforcements were in a contradictory position, with more technological familiarity and yet, with less seniority and military experience by which to secure postings in frontline units where there were substantially expanded roles.

In addition to geographical settings, military nursing roles were contingent on the availability of male officers and orderlies. Work was gendered female when it became routinized and simple enough for women to do, when it required meticulous attention to detail or involved

fine hand work, or when it became widely-used and required a large labour force. These attributes were not limited to military nursing work but they were accentuated in the military-medical-technological system because of a great need for men in combat and the reluctance to move women into active theatres. Military nurses functioned professionally in relation to two distinct groups of men—medical officers (who were physicians and surgeons) and medical orderlies (who were non-commissioned soldiers posted to medical units). Nursing practice shifted according to the availability of both groups.

Personnel issues shifted based on socially-constructed, gendered roles and the perceived importance of a technology to the war effort. Nurses could replace physicians related to some procedures but, as we have seen, they could also replace medical orderlies related to physical care when orderlies were re-classified for combat roles. When medical officers were required for surgery or at regimental aid posts during battles, or when medical technologies became labour intensive and/or inconvenient, nurses comprised an expandable workforce that could assume more responsibility. NS Lily Clegg served with No. 2 CCS where, as she said, "During a big battle the nurses just went from one patient to another . . . . We finally had to give blood transfusions because we didn't see the surgeons at that point so we had to learn right then and there to put up and handle and change our own intravenous."[55] NS Constance Bond stated that nurses learned from each other when necessary:

> When the doctors were really busy in France, we had to start intravenouses, but we hadn't had that training. But two of the nurses had been in England for a year before, Lily Clegg and Bea Curtis. They were in England at Paddington Hospital and they were taught there because the British nurses could start intravenouses and so they taught us to do that . . . nurses teaching nurses . . . Because when the doctors were in the operating room all the time, you just had to start them [IVs]. And often it would be plasma. I don't know that we ever gave blood. I think that was done in the operating room. It would be started [there] anyway.[56]

In an interesting gender reversal, military nurses were also able to shift some traditionally female domestic roles to male orderlies, while retaining key technological roles as nurses' work. As Rawling noted, orderlies could do a 'remarkably efficient' job if under the guidance of a Nursing Sister. They relieved nurses of routine tasks such as bathing, feeding, and transporting patients,

so that nurses could focus on medications, dressings, skilled assessments, and something else called 'morale.' But orderlies could not replace nurses.[57]

The technologies of blood transfusion and penicillin provide two good examples of socially-constructed roles performed by military nurses. The transfusion of blood and plasma, and the administration of penicillin have received widespread credit for reducing mortality and returning soldiers to the front lines during the Second World War. Almost every military nurse identified them as the key medical technologies that emerged during the war. From the framework of Actor-Network theory, both technologies comprised elaborate technological systems of their own, each requiring international collaboration and social construction that designated them as essential components for the war effort, in addition to huge monetary investments.[58] Initially, both technologies were introduced into the military patient population on a limited scale. Both were the responsibility of physicians who experimented with the route of administration and dose of drugs, or the rate and volume of blood products, as well as the medical conditions for which they were used. Once transfusion and penicillin had been routinized and simplified, however, the military needed a readily available and reliable workforce in order to capitalize on potential benefits. A comparison of these two technologies illustrates similarities and differences in how they became part of military nursing practice.

Whole blood was transfused by the direct, syringe method from donor to recipient on an experimental basis during World War I but it was not until the Spanish Civil War (1936-1939) that Norman Bethune successfully demonstrated its capacity for long-term storage, transportation, and use on a large scale.[59] Transfusion science and the treatment of shock had evolved during the interwar period[60] but there were still issues associated with anti-coagulation and blood compatibility that constrained wider use in civilian settings until the early 1940s when the Allied forces used massive amounts of whole blood and plasma for the treatment of shock. Dr. Charles Best and the Connaught Laboratories of the University of Toronto (in collaboration with the National Research Council and the Canadian Red Cross) were involved in extensive research and production of dried plasma for overseas military use.[61] Plasma was produced from pooled

donations in specific proportions from all blood types and could be given without any typing or matching.[62] The armed forces also decided to use only type O blood to eliminate many of the compatibility issues as well as lack of facilities and time for cross-matching blood types. These developments simplified the technology, making it possible to also routinize it.

With a rise in casualties and re-organization of the medical services during 1942-1943, surgical care and transfusion moved forward from CCSs to the front lines in an attempt to reduce deaths from shock and infection. As discussed, there was a concerted effort to avoid moving Nursing Sisters forward with these units.[63] Medical orderlies were trained to assume nursing roles on surgical teams until it became clear that professional nurses made a substantial difference that could not be easily replaced. The field transfusion unit operated as a small mobile team to deliver blood and plasma at regimental aid posts, advanced surgical centres, field dressing stations, or CCSs as needed. Medical officers and medical orderlies were posted to these field transfusion units. But nurses were not, although they served with other forward units.

The technical aspects of delivering blood products to the front were resolved by a uniquely-designed, self-contained metal container that arrived ready to use.[64] As NS Sloan pointed out, this unit was as much a 'miracle' because nurses didn't have to clean it, as it was for its life-saving results. She said, "There was a whole service devoted to blood transfusion and they brought all the 'giving' equipment (and the whole blood). And we just had to hang it up and give it. What was wonderful--we didn't even have to clean any of it afterwards (the tubing or anything). We just threw it back in the packing cases that the new blood came in. It was marvelous." The development of this special container reduced the procedure to a relatively simple task of inserting a needle into a vein, making it easy for untrained personnel to administer transfusion even at the regimental aid posts. Orderlies (with very few weeks of training) performed venipunctures and gave transfusions in spite of initial constraints placed on nurses' practice.[65]

Interestingly, surgical centres, field transfusion units, and CCSs soon added 'resuscitation wards' to their units. NS Teresa Woolsey described the resuscitation ward as a

small area (either a room or a tented space) located next to operating room, X-ray machine, laboratory, and dispensary. It was equipped with whole blood, plasma, oxygen, Wangensteen drainage, suction machines, and minor surgical trays. As she said, "it drips with bottles and tubes."[66] According to NS Helen Bright, her "first and foremost thought and duty was to keep all tubes and bottles working."[67] Resuscitation wards reached capacity later in the war and transfusions became routine while nurses assumed more and more responsibility for them. One medical report noted that all cases involving surgery of the abdomen, amputation, and compound femurs got a routine transfusion pre-op and that in units forward of the CCSs, these surgeries typically constituted eight out of ten cases with a typical volume of five or six bottles (550 cc each).[68] NS Fletcher described her work as 'just keeping an eye' on her patient's transfusion as she wrote home from No. 6 CGH in September 1944:

> It is most interesting here at this field hospital. We get cases straight from the advance dressing stations. The bad ones only are kept here, and the rest sent on to a Base Hospital like 16. They all come to my recussitation [sic] ward from Admitting-- & from there they clear through our O.R., or a Field Surgical unit that is attached to us. . . . At the moment we are using good Eng. blood on our friends the enemy—but they are just as sick as our boys, & pretty glad to get taken care of. One is due for surgery P.D.Q. & I'm just keeping an eye on his transfusion while I write.[69]

A month later, she was working in the resuscitation ward of No. 2 CCS getting the 'boys' ready for surgery during a particularly busy period when she described the process as follows: "Well, resuss started to boom & little Margie was on the run. They all get Penicillin, anti gas, anti Tetanus & transfusion routinely."[70]

At times, nurses embodied the technology, becoming part of it. NS Frances Ferguson described how they used rubber bulbs as hand pumps to infuse blood at a rapid rate and even as blood donors when supplies were insufficient:

> We also gave intravenouses and blood transfusions . . . . It was almost a case of pumping it in sometimes . . . with a bulb. This just made it go a little faster but there we were, using blood and trying to discover if we were over transfusing . . . . You know, it had to be ordered properly. But it was a matter of saving a life. And we did it in a hurry, too. But I don't think I ever remember us having any bad reactions. Maybe we were fortunate. . . . Anybody who knew they were 'universal,' was vulnerable. I was universal but I never gave blood. I wanted to, I had offered to, but I never did. . . . But we all knew our blood type anyway, so I don't think they took time to cross match. As long as you were universal, you felt fairly safe giving it.[71]

Blood transfusions had been given in limited amounts and limited situations for shock resulting from blood loss since the Great War. But during the Second World War, plasma gained recognition for its osmotic properties and benefits for reversing shock in burn patients.[72] NS Wannop worked with burn patients extensively for almost five years. She recalled treating these patients for shock with plasma and intravenous fluids, 'doing' their blood work, monitoring the results, and charting their fluid balances. Nurses moved beyond the tasks of inserting needles into veins and infusing blood products to incorporate a wide variety of assessments and monitoring skills, understanding changes in patient conditions, and making decisions based on that knowledge. Wannop described her responsibilities this way:

> That was one of the first things after we treated them for shock, we'd do the blood work . . . . [T]hen we'd go from there. And the doctors were so busy that they would, you know, leave it to us when to start the Penicillin . . . And oh, we'd take cultures when they'd first come in, just to see, you know, what the organisms were. And then, when they'd get them ready for operations, they'd leave it to us to tell them when they were ready for the operation.

Penicillin, like transfusion, emerged from the war as another life-saving miracle, as a 'war weapon' to 'kill' wound infections,[73] and as a military secret that gave the Allies an advantage by reducing the loss of life due to infections.[74] Its introduction and the development of associated nursing roles, however, were somewhat different. Penicillin was not in use as a therapeutic agent prior to the war and it required considerable research before military medical units conducted clinical trials with it during the invasion of Sicily (October 1943). Nurses did however have limited experience during the late 1930s with sulphonamides, another promising group of sulfa drugs that included Prontosil, Neoprontosil and Sulfanilamide.[75] Medical knowledge was still limited regarding the therapeutic ranges for these drugs with substantial toxic side-effects. They, along with Salvarsan as an antisyphlitic and Atebrin as an antimalarial drug, represent a conceptual shift in thinking about "chemotherapies" or the use of pharmacotherapeutics in infection, that led ultimately to the penicillin family of drugs.[76]

The story of penicillin is fascinating and multi-faceted. Governments, universities, and commercial interests collaborated in an intensive effort to produce adequate quantities for the

military first, for civilians next, and for POWs last--waiving patent rights until end of war. Historian John Sheehan summarized penicillin as "a technical triumph wherein scientists were heroes, doctors were holy men, and the 'man' who controlled its distribution was a god."[77] From Alexander Fleming's discovery in 1929 to Howard Florey's demonstration of its use in 1935 and large scale clinical trials in 1943, penicillin was carefully guarded and controlled. By March 1945, three companies in Canada were producing sufficient quantities for both Canadian military and civilian needs.[78] Germany attempted to develop the drug (1942-1943) with little success and Japan initiated a research program based on translated medical publications in February 1944, followed by limited production at the beginning of 1945.[79] Interestingly, the main impetus behind penicillin development was the military's interest related to wound infections and venereal diseases (VD)—based on the likelihood of recovery and the importance (or incidence) of the disease to the war effort.[80] One RCAMC sapper recalled the amazement in his unit when one of their buddies returned to the unit within three days after treatment with penicillin for VD—they had assumed he would be gone for a month as usual![81]

But unlike transfusion technology, medications were not considered technical tasks that could be delegated to orderlies—probably because of associated toxicity and therefore, the need for knowledgeable observation and monitoring of patients who received them. One or two Nursing Sisters were typically in charge of large wards of 40-60 patients with the assistance of orderlies who gave most of the routine care while medications, treatments, and dressings were reserved acts for nurses.[82] Regarding the administration of sulfanilamide directly into the wounds of burn patients for example, NS Wannop explained:

> But you see, everything was new and experimental, and we didn't know what the saturation dose was for the sulfanilamide so we would have to watch very closely. . . .You dusted [the wound] with the sulfanilamide and then you would put what they called a 'tulle gras' on. A tulle gras was Vaseline on a little net gauze. And that would be Vaseline and we'd put [a gauze soaked with saline] on top. . . . And you'd change the saline, not the tulle gras, but you changed the saline solutions. I think it was twice a day anyway. . . . practically all their body. . . . The orderlies didn't [do dressings]. They would help in the bath but not for the dressings. We did the dressings.[83]

When penicillin was introduced, it was clearly experimental in dose, route, and indications for use. Physicians gave the drug by direct injection into wounds, chest cavities, joints, veins, and muscles; they dusted it with a device called an insufflator into wounds; they experimented with giving it orally and rectally.[84] NS Helen Mussallem was an operating room nurse in England when she encountered penicillin for the first time. She spoke of physicians and nurses learning together, admitting that:

> We didn't know enough about it and when we injected it into the men, they used to say, "Oh, please, I'd rather do without it." So we had this one badly-wounded leg and we scrubbed it so well--the debridement was fairly successful. So we just poured the penicillin into it. We didn't know a lot about penicillin then. It was supposed to be injected but it was very painful. Those brave young men could hardly take it. And I am not sure whether it was (I guess it was) good penicillin then or not. You see, we never knew. That was the trouble with that situation--you never knew what happened. . . . As I say, we misused it by pouring it into the wounds. And I don't know whether that was good or not. We thought it was a good idea. . . . So we poured it into the kneecap. And then, we also injected it but it was very new. We didn't know a lot about penicillin then. It wasn't the same quality of course, as later. Impure penicillin.[85]

After NS Fletcher attended lectures on penicillin given by Professor Florey in London, England she wrote, "[W]e had never heard of penicillin. . . . We had our lecture and he showed us pictures; we simply could not imagine that he was telling us the truth. He showed us pictures of what they had been doing in the Mediterranean and it was absolutely astounding. So time and a half went by and we were allocated a little bit of penicillin for our worst cases."[86] In Italy, a Canadian Penicillin Team attached itself to various units when introducing the drug into practice.[87] A fact sheet from January 1944 ended with the caveat that: "If penicillin should fall into your hands and you do not know how to use it do not 'play about with it.' It is extremely difficult to produce and supplies are inadequate."[88] Penicillin was considered to be so scarce and so valuable that in some medical units, POWs did not receive the drug or else they received it surreptitiously as NS Gaëtane LaBonté described.[89] In other units, they attempted to recover penicillin excreted in the urine. NS Tritt said, "When it was first brought in, it was used very sparingly because there wasn't enough to go around. And also, we had to save the patient's urine because there was some thought of reclaiming the penicillin."[90]

Once clinical trials determined standardized dosages and the intramuscular route as the most effective method of administration, these injections had to be given every three hours (day and night) to maintain a therapeutic blood level—and penicillin became a nursing responsibility. NS Claudia Tennant wrote, "Regulations demanded it must be given by a qualified surgeon by injection and every three hours, day and night. It proved a major task . . . as the surgeons just would not respond to calls after they were asleep and who could blame them!"[91]

Medical units developed a variety of strategies to deal with the increased workload involved in giving routine injections to all wounded men. Matron Evelyn Pepper added extra Nursing Sisters to her CCS in Italy because of the workload. Yellow tags tied to the outside of the soldiers' uniforms quickly identified those who needed the injections en route between units and these tags became the documentation forms, so that doses would not be missed.[92] As NS Lamont said,

> I just remember being aware that this was some miracle drug. We made it up in our own pharmacy. It was sort of gray colour. . . . And then quite often, we'd take a 10cc syringe because it was tight (when you have 20 beds on each side, and all wounded, and trying to do that). So you'd just go down the row. They all knew what was coming. . . . I think most of the patients (90%) all got penicillin. But on the other hand, I don't think everybody would have it because it wasn't that plentiful yet. . . . When the convoys came in, each man had on his tag, a description of his wound, if he had been given morphine, etc., if he had had penicillin . . . . I remember, that we had to keep track of the penicillin (as much as we did morphine, practically) because it was so precious.[93]

Many nurses described using a large syringe (10 or 20 cc size) to give 1-2 cc doses to multiple patients—with or without changing the needle based on the prevailing idea that penicillin was a 'self-sterilizing' agent.[94] Those who changed needles spoke of the challenge to re-sterilize needles between patients when equipment and time was limited just as water was often scarce for sterilizing them. Nurses described barely completing one round of injections when it was time to repeat them for the next round.[95] Orderlies assisted with sterilizing needles and waking men so that they would not 'come up fighting' from a deep sleep.[96] In some units, one nurse would be assigned to give penicillin for the entire shift, earning titles such as the Penicillin Queen and Penicillin Mary or poems about nurses and penicillin written by patients.[97] Interestingly, NS

Margaret Kellough reported having to teach civilian physicians about penicillin in postwar practice based on her extensive experiences with it during the war.[98]

Both transfusion and penicillin became part of nursing practice based on frequency of use and the need for a skilled labour force with a constant presence at the bedside. Military nurses enabled the extension of these technologies to the frontlines of medical care, demonstrating their ability to expand practice roles and building valuable knowledge in the process.

Technology as "Dirty Work" and "Women's Work"

While the transfer of technology to nurses was partially contingent on the geographical setting and on the availability of both physicians and orderlies, it also depended on a social construction of that technology as "women's work"—defined as work associated with the body, manual dexterity, repetition, and a need for meticulous attention to detail. Recent research by Jocalyn Lawler and Margarete Sandelowski builds on Strauss' concept of body work, referring to work performed *on* patients' bodies and *with* nurses' bodies as the primary tools. The term has also been linked to "dirty work" or work that may be "designated dirty" because of its degree of inconvenience, its relative invisibility (and therefore lack of status), or its unsatisfying nature (as repetitive, exhausting, routinized, stressful, or physically dirty). In most cases, authors have used the term with a decidedly derogatory meaning, problematizing nurses' work for its association with physical care of the human body.[99]

From these perspectives, body work and dirty work certainly applied to military nursing because of the centrality of soldiers' bodies and physical care. It is difficult to imagine the work involved with the care of mangled and burnt bodies where there were multiple wounds, missing limbs and other body parts, faces without features or lower jaws, whole wards of colostomy patients,[100] exposed lungs and intestines, and more. Besides extensive trauma, the bodies were just as likely to be filthy and lousy. Conditions were not necessarily much better further back the

line where patients arrived with foul-smelling casts and maggots in their wounds after ten to thirty days of the Trueta method whereby dressings were intentionally left unchanged for extended periods.[101] It is difficult to imagine work that was any more stressful than the long stints on duty in wards or operating theatres during a battle, or working under enemy fire. It is hard to imagine work that was more repetitive or routinized than the assembly line medical care required for one hospital unit to admit and evacuate 1200 casualties in twenty-four hours.

The Nursing Sisters that I interviewed agreed with the awfulness of war-torn bodies and the wastage of youth, but they clearly had a different perspective than that expressed by sociologists and historians. They never described their work as derogatory or demeaning. Nurses on the front lines were doing what they had enlisted to do and they were working where they wanted to be working. The tedious and repetitive work involved in malaria and wound care technologies easily fit the definitions of dirty work. These technologies comprised a large portion of nurses' work (along with administration of medications) but they also required strong observational skills, decision making, and sound knowledge of aseptic principles, self-discipline, and meticulous hand work—all features that limited their delegation to orderlies.

Malaria was a major cause of morbidity in the Mediterranean theatre in spite of extensive measures that included protective clothing, mosquito repellents and nets, environmental and personal application of DDT, and prophylactic drugs such as Mepacrine. In Sicily during August 1943, there were 1184 actual or suspected cases and diagnostic laboratories were unable to keep up with the demands--"an epidemic of serious proportions" according to historian Feasby.[102] Diagnosis through microscopic examination of patients' blood was critical for treatment decisions since not all fevers were caused by malaria, not all mosquitoes carried the particular causative agent, and not all forms of malaria were treated in the same manner. NS Doris Carter describes nurses' diagnostic and treatment roles in her memoir. She points out the importance of accurate diagnosis for both the immediate treatment with medication and the long-term implications to soldiers:

> We did blood smears to find the special microparasite that causes the disease, which is left in the body from bites by the anopheles mosquito . . . . A drop of blood was taken

> from a patient's finger, put between glass slides, and placed under a microscope. This was done when the patient's temperature was high—103 degrees or more—and during a chill caused by the activity of the parasite. We had to be accurate with the tests; if the diagnosis was positive, the patient was put on medication specific for malaria. Besides, such a diagnosis could also affect the patient's future medial coverage and pension, when he returned to Canada.[103]

When interviewed, Carter's description of the process indicated it was labour intensive and unpredictable work that also required nurses to make decisions regarding the test and the outcomes: "[W]e'd have one microscope, and we'd have about four little glass slides, and we were always taking a little drop of blood. . . . Then when we found [the organism], we had standing orders to give them medication. . . . [T]hey'd have to be in the throws of a chill. And if you can't find it in one chill . . . then you'd have to wait until the next chill."[104]

The dressing of wounds consumed a major portion of nurses' time regardless of the theatre of war. The hospital survey of 1940-1941 indicated that 'ordinary dressings' were not necessarily a standard component of civilian nursing roles. Graduate nurses did dressings in only four of the six largest hospitals while 42-63% of the middle- and small-sized hospitals required nurses to have special preparation prior to the delegation of dressings. Bertha Harmer's popular nursing textbooks corroborated that nurses' prewar roles with wound dressings were primarily assisting the physician, preparing the patient and the equipment, and cleaning up following the procedure—reflecting much of nursing practice since the turn of the century.[105] According to the 1939 edition, the physician prescribed the nature of the dressing for the wound and applied it while the nurse helped "provide the conditions that prevent discomfort and infection and promote healing."[106] The nurse, however, had complete charge of the dressing carriage that contained the equipment.

Most Nursing Sisters had completed post-graduate courses, many of which were in operating room technique that prepared them for added responsibilities related to dressings, assessment of the healing process, and identification of infections. But no amount of prior experience prepared them for the number, complexity, or type of wounds encountered during war. NS Margaret Roe called them "more invasive wounds, exploding wounds, inside [of which] there would still be shrapnel."[107] NS Lamont describes the difference as follows:

> It was just a totally different feeling, and they were all so wounded. A lot of civilian nursing is medical and long term. These were all terrible wounds that we had never seen in civilian nursing. So we did different dressings and different things that we would have never had to do in civilian nursing. . . . Shrapnel, abdominal wounds, terrible tank burns, amputations . . . chests. . . . The MO [medical officer] would write the first order and then after that you used your common sense. You would just decide the thing to do or maybe they should have some more morphine or something. You sort of judged the condition and passed that on to the MO. And they were very good about taking your word.[108]

Different types of wounds required initial field dressings to be applied immediately without cleaning them, re-applications during evacuation that may or may not have included cleaning and/or surgical debridement, and extensive surgical dressings applied after remedial or reconstructive procedures were performed. Thus the primary focus of wound care changed from preventing blood loss to preventing infection but always with the goal of saving lives first and optimizing rehabilitation second. The vast majority of surgical procedures involved serial operations on wounds in which repairs were done in stages. Only essential work was done at each stage as soldiers moved further back the chain of evacuation toward base general hospitals in England. Rather than suturing wounds shut and risk gangrene as well as other infections, the medical units adopted Trueta's method of excision, drainage, and immobilization of open wounds within plaster casts. This method was used so widely, that the Second World War became known as the 'Plaster War.'[109] NS Cox was a Field Surgical Unit (FSU) operating room nurse in Sicily and Italy, where she described the process of 'debriding' wounds:

> [W]e had two doctors, one surgeon, and one anaesthetist, and another nurse—two nurses with myself. And we had a couple of the boys with us. And the place we were in was a hotel . . . [T]he big lobby area was the recovery area (where they would prepare people for operations) and they would have these various rooms on either side. . . . Wounds were not being cleaned up quickly enough after injury. And they figured that they would improve (and certainly survive a lot better) if this was done more quickly . . . so, we did a lot of debriding. . . . And they were in bad shape—an awful lot of maggots and ooze, and that sort of thing. . . . And or course, they leave some of the maggots in because naturally, they were going to clean [the wound] and put it in a cast. So we were putting casts on, too. And then they would go back into that recovery area. Then somebody else would come in . . . . And everything was written on the cast, just exactly. And "maggots" was written in big letters. So that wherever they went, the first hospital they went to, that they would know . . . . [W]e didn't attempt to clean it up completely. No, I mean we cleaned the wound but we'd leave some maggots there.[110]

NS Margaret Van Scoyoc spoke of expanded roles in field hospitals where "we were not only the nursing assistants but the doctors' assistants."[111]

At Falaise (France), in Belgium, and in the Liri Valley (Italy), there were whole wards of post-operative colostomy patients due to abdominal injuries that required extensive surgical repair. These patients remained in CCSs for ten to twelve days, to stabilize them prior to evacuation.[112] NS Mary Bray admitted she was 'green' but before she knew it, her ward was "full of the sickest people I have ever seen. . . . They'd be five days on intravenous and stomach lavages and then all we had to feed them was stew which they couldn't have. . . . It was very confusing if you looked down one of these wards with all those bottles hanging and to be sure what bottle was what."[113] NS Barbara Ross recalled that, "I had a whole row of colostomies, (the belly wounds) which had to be dressed frequently . . . and after we'd done our stint, we'd go out and walk up and down the beach to get the smell out of the nose because it was so bad."[114] NS Fletcher described two cases where she questioned the long-term implications of extensive technological interventions: "Then there is the lad from the Seaforths who got a bullet through the intestine and bladder. He has both a colostomy & suprapubic drainage. The third lad got a bullet in the groin, & now has osteomyelitis of the pelvic girdle, & lower spine. A cable telling of a loss would be much preferable to either of these."[115] Several months later, Fletcher reported that one FSU did fifty-seven colostomies in the first one-hundred cases.[116]

Medical Officer and historian W. R. Feasby pointed out that surgeons in the forward units quickly learned that resuscitation and surgery "were frequently of no avail if not followed by adequate post-operative care and nursing." He cited the notes of two surgeons who worked in the forward surgical units, in which they are explicit that orderlies "do a grand job but the patients seem to do better both practically and psychologically when sisters were there."[117] Feasby also listed twelve essential technologies for abdominal surgeries. He included professional nursing care along with morphine, oxygen, gastric suction, sulphadiazine, and penicillin as the nurse again became an embodied technology. His description of 'nests of abdominal cases' in the Liri Valley where patients "lay in reasonably comfortable beds, gastric suction tubes in place,

intravenous fluids running, and carefully tended by skilled orderlies with one or two nursing sisters in each centre of 12 to 20 beds"[118] obscures the nature of the embedded nursing care involved with gastric suction.

Continuous gastric suction was also known as Wangensteen Suction, and it employed a closed system of glass bottles and tubing based on a principle that water flowing from one level to a lower level could be used to produce a partial vacuum and thereby drain the stomach or duodenal area following surgery to permit healing and prevent post-operative distension. Patients were connected to the system (consisting of a metal pole, two large glass bottles, various tubing, connectors, and clamps) by way of a nasogastric tube and the entire system had to be maintained airtight—no simple task during wartime.[119] Although gastric suction had been used in civilian hospitals, nurses had to adapt the equipment to wartime conditions by improvising basic components. As NS Sloan said, "[T]hey had gastric suctions that they made up themselves with tubing that they had. You know--any old tubing and a stomach tube, and using intravenous bottles, and hanging them from the tents. And they had another bottle down beside the bed and they improvised all their gastric suctions because they didn't have gastric suctions."[120]

Although military nurses were well-prepared in terms of civilian nursing skills and experience, they were relatively unprepared for the large number and complexity of wounds and dressings, or wartime working conditions that contrasted with the ideal conditions described in textbooks, classrooms, and hospital procedure manuals. One nurse wrote to her alumnae association that "all our ideas of good nursing technique shattered completely. Every drop of water is as precious as gold, and has to be carried."[121] NS LaBonté agreed that "there was so very little in the way of technique. You did what you could with what you had. And it wasn't always the right thing but it produced often the same result"[122] and NS Beatrice Cole recalled that "[Y]ou didn't fuss with a lot of things that we had been trained to do (the way you did it in civilian practice)."[123] Matron Grace Paterson put it more positively: "In the Army we found out that we could do things just as well and a lot more quickly. The rituals we thought had to be followed weren't necessarily giving better nursing care."[124]

Nurses not only improvised technique and equipment but they also had to deal with dust, dirt, bombs, and flies among other challenges. NS Kellough recalls: "I can remember one day we were operating . . . on stretchers and this bomb fell outside the window and the dust flew and the surgeons just calmly covered the incision with a towel and carried the stretcher to another room and carried on with their surgery."[125] NS Patricia Moll recalled that in No. 1 FDS, "We didn't remove the clothes. . . .Their tag would say what was wrong with them and we would operate on the parts. We would cut the uniform open and off then we would let them back to the follow up tents." [126] NS Cox remembers the conditions as 'filthy' with the rain and mud in Italy, while NS Roe was with No. 4 CGH receiving casualties from the Normandy Invasion at Aldershot where, as she said, "They were just full of the dust and the dirt and everything else on them. . . . First, I liked to get them a little bit cleaned up, as well as you could. You worked on them in stages, and then drawing blood and stuff. . . . They were very grateful to get cleaned up and freshened up. They went through a lot of hell for a few days."[127] NS Pense recruited recovering patients to assist her with dressings in North Africa where flies swarmed over the wounds as the base hospital for the Sicily invasion, No. 15 CGH, admitted 1000 casualties from Cassino where "they just poured in":

> And with the heat, the condition of their wounds when they got back, it was the first time I ever saw maggots. And the flies! When I was doing dressings, I used to get the patient with the strongest stomach to stand by with a fly swatter to shoo the flies away. And none of them could stand it for more than about ten minutes and I'd get somebody to take over the system. . . . I know in my own ward I was doing dressings on a ninety-six bed ward. . . . At the time of Cassino, I went on duty at eight in the morning, stopped for lunch and for dinner, worked until ten o'clock at night doing dressings . . . .[128]

When it was not possible to re-sterilize instruments in make-shift autoclaves, nurses used 'cold sterilization' (a method of soaking equipment in disinfecting solutions) between operations. And instead of individual sterile instrument sets as in civilian hospitals, they used a common instrument table for several concurrent surgeries in the same tent. NS Van Scoyoc described this innovation as follows: "We would have them on a table—all different types of instruments would be on a table because we were so short. And the doctor would just take the one he wanted, or he'd ask you for the one he wanted. And so, that you didn't have a set up (a tray) for a certain operation."[129] QAIMNS nurse, Brenda McBryde explained that she compensated for the lack of

aseptic conditions by using the 'no touch' technique for procedures in which sterile forceps are used to handle everything that actually comes in contact with the wound site.[130]

Origins of the triage model within medicine have been attributed to the Napoleonic Wars, where field surgeons sorted and treated the most seriously-injured casualties first.[131] Thus, the grouping patients for care, was not a new phenomenon during the first half of the twentieth century. But the criteria used, and the decisions based on that criteria, did shift during the Second World War. Triage determined not only the priority for care, but where that care would take place and how much care would be given prior to the next level of evacuation. Those who were most seriously injured did not necessarily receive top priority. In situations where human and non-human resources had to be stretched and used efficiently for the greatest number of casualties, decisions were based on which casualties could reasonably expect to recover and to return to combat. This approach was different from civilian practice, where the sickest patients and those who could most afford medical treatment, typically received the most expert and time-consuming care. NS Roe explained the difference:

> When triage came into being . . . it was hard to grasp that at first. Then you could see the necessity in wartime for it. . . . There would be some terribly injured people but they wouldn't go to the top of your list (the doctors decided this) because they needed people to fight—bodies, to put it in terms like that. And those that were recoverable--get them going. Get them up and going, and prepared. The ones in gradation--there is no use in spending all your time on the top few. I'm not saying don't spend your time but don't concentrate on them first. But you are going to give just as much care as you possible can. It's the logical approach in the military. People couldn't get that through their heads at first, you know.[132]

The field medical cards attached to a casualty's uniform determined the triage category and what procedure(s) were to be done next.[133] But as NS Nicolson said, "The very serious went right to hospital ships . . . . And we got the ones that we could do something for, and look after, and [could] send back."[134] CCSs had more resources than the forward mobile units and patients could remain there for slightly longer recovery periods. The exceptions were those cases that required immediate life-saving surgery or transfusions in order to survive evacuation to rear units for more extensive repairs. Casualties in the lowest priority category (without reasonable hope of recovery) were not abandoned however. NS Sloan explained, "Everybody wanted everybody to

get better or to at least be comfortable before they died. . . . It was a simple palliative care but that was one of the things that was important . . . . Again, they were separated out in the triage tent."[135] Some nurses reported giving morphine to the most seriously injured, hoping they would sleep through the evacuation process to their destination.[136]

Casualties did not usually have a formal medical record until they reached a CCS or CGH. Key information was added to the field medical card or recorded on casualties' bodies in a manner that was highly visible and quickly accessible. For example, NS Roe explained that, "On the stretcher cases, if they had been given morphine, it was in red on the forehead and also on the paper with the time. And then, we had any information stuffed inside this envelope and a survival package."[137] In a similar manner, the letter 'T' on the forehead indicated there was a tourniquet in place and it would need to be assessed frequently.[138] Plaster casts also made good communication devices since they were not likely to be misplaced in transit. When the details of the injury were recorded on the plaster, the technology became known as a "plastogram."[139] Ultimately, triage was a strategic technology designed to selectively salvage men for quicker return to the frontlines. It resembled the Scientific Management or Efficiency movement of the early 1900s.[140] It also resulted in work 'speed up' and fragmentation as casualties only received the essential care at each stage of evacuation.

Triage and rapid evacuation was inconsistent with nurses' prior training, and while they understood the rationale behind treatment decisions, they also sought to mediate the effects of triage for individual soldiers where possible. Nurses learned to treat patients individually and comprehensively in civilian practice, where typically, they remained with their patients throughout the course of an illness or surgery—getting to know them well, and seeing the results of their care.[141] In the military, however, casualties arrived en masse and the chain of evacuation called for rapid assessment, treatment, and evacuation. CCS surgical NS Clegg explained: "We weren't able to make friends with them, because nobody was conscious most of the time we had them."[142] NS Van Scoyoc recalled that:

> You would just see the patient and then they would go. . . [W]e had six tables when I was in Bruges. . . . When the patients came in, one of the most skillful medical doctors would

> prioritize them. And you know, they had the field card, and it had [the procedure] on the card. . . . So we had nothing to worry about that. We just went from one table to the next table—the next patient, I should say. . . . Because you know, when we had a lot of casualties, we never even had a chance to clean up the floor! Until there was a lull, and then you'd do it. So you know there wasn't great technique. And that's why penicillin was so important.[143]

Many of the interviewed nurses spoke about these differences and what it meant to not have follow up or closure with their patients. They were not comfortable with assembly line techniques although they recognized the utility for managing mass casualties. As NS Cox said, "it was just a matter of operating and this is it. So it is not a very satisfying type of experience."[144] Some casualties were labeled as the 'walking wounded' and NS Sloan described her ward in Holland this way:

> Now these people came in (in droves), in ambulances and it meant that they were not so badly hurt that they couldn't move around. So when they came in, all we did for these people . . . they just filed in and lay down. And essentially what you had to do in this sort of situation was check their dressings to see if they needed reinforcement, check their medical evacuation cards to see that they had the appropriate anti-gas gangrene shots. . . . We checked to see if they needed another penicillin shot before they left. . . .So that knowing a patient as an individual was almost impractical, they were coming and going so quickly. . . . There were so many. Those sorts of things were very hard. . . . You wouldn't know them. And they wouldn't remember where they were. . . . There weren't any signs that said, "This is 8 Canadian General Hospital." They never knew where they'd been.[145]

But once the rush ended, NS Lamont recalls: "You know, you wouldn't bother to straighten the castors or clean the bedside tables . . . . [Y]ou had your priorities. And when the time was there, you made them comfortable--chat and have fun. . . . They wanted to talk. The boys wanted to talk."[146]

Many Nursing Sisters achieved a new level of confidence with a variety of medical technologies, as they rose to the challenge of expanded roles. They learned to innovate, improvise, and adapt in different settings. According to one war diary: "Except for a few difficult cases requiring assistance by an M.O., sisters were starting all blood, plasma, and saline infusions, taking blood pressures, and giving all serum and penicillin injections."[147] As NS Lamont explains, "I think because these responsibilities were thrust on us, you learned how to improvise,

make good judgments, and make do with what we had. . . . We suddenly became self-confident."[148]

Re-shaping Shared Technology

Nursing Sisters used medical technologies to legitimate their presence in the male military domain, and in the process, they incorporated nursing perspectives that partially re-shaped these technologies. Sandelowski has argued that civilian nurses shared equipment with other non-nursing women and physicians, noting that nurses did not typically have technologies reserved exclusively for their use. In a similar manner, military nurses shared medical technologies with physicians and orderlies. Even relatively straight-forward medical therapeutics, such as drugs, took on additional nursing perspectives at the bedside (or stretcher) level. For example, NS Surgenor pointed out the importance of fluids and monitoring the intake of patients on sulfa drugs when she said, "the sulfathiazole drug was first initiated and that caused a lot of joy. But we had to drink, and drink, and drink because as I guess as people know today, sulfa was a terrific drug but it affected the kidneys and made crystals in the kidneys."[149] The provision of adequate fluids for individual patients was only one challenge, as thousands of casualties could be admitted and evacuated within a twenty-four-hour period, and water supplies could be uncertain due to enemy action as well as mobility. Just giving tablets of sulfathiazole to a casualty with a tracheotomy tube required a great deal of skill, monitoring, and time as NS Sloan explains:

> A lot of them had tracheotomies, of course, so that was very heavy work. In contrast to civilian hospitals who might have one tracheotomy or two tracheotomies in six months, we would have maybe six or seven on a ward. . . . [You] had to be fast and very observant. . . . The back of the tongue would flip back and cut off their windpipe (their trachea). You had to flip them over fast and give them oxygen and you just had to be on your toes all the time. . . . I think the exceptional cases were the ones that we had with the maxillo-facial teams (and very, very challenging). They were on sulfa too, (most of them) and it takes an awful long time to grind up one sulfathiazole table in water and then put sips on the end of a spoon and hope they would be able to swallow--because of face wounds and tongue wounds, jaws shot away. Talk about challenging. Very, very challenging. That sort of thing. Or trying to get some food into them. Long, long time.[150]

In reality, most medical care involved shared technologies. At times, nurses were mediators or buffers between the technology and patients—interpreting, and adapting procedures for individuals while assuring compliance to medical treatment regimes. Two major examples of shared technology, where nurses made substantial contributions, include the care of burn patients and the care of psychiatric patients.

Prior to the war, nurses' experience with burns in civilian populations was relatively limited. Hospitals rarely handled large numbers of burn victims, and students received minimal training in their care.[151] In the Army, incendiary bombs and tanks produced horrific burns to large proportions of the body. In the Air Force, men who survived air crashes typically sustained major burns. In the Navy, destroyed ships spread fuel and flames across the surface of the water to any survivors of the direct hit. The burns encountered during the Second World War posed significant challenges for medical and nursing care—not only of the immediate injury but for long-term recovery as well, provided the patient survived during this period prior to antibiotics and before extensive use of plasma and intravenous fluids in burns.

Certainly, the medical treatment of burns changed greatly in relation to wartime research and development but a major portion of treatment depended on nursing care for wounds, nutrition, comfort measures and pain management, as well as the psychological support to cope with months and years of rehabilitation. Two excellent and detailed accounts of burn treatments appeared in the *Canadian Nurse* during 1943—one written by NS Dorothy Macham while serving overseas and the other by two Montreal General Hospital nurses, Kathleen Clifford and Katherine Miller.[152] Clifford and Miller emphasized that, "The treatment of burns has always been in large measure a nursing problem."[153]

Tannic acid sprays and dressings comprised the most common treatment for burns at the beginning of the war but that changed rapidly as emulsions of sulfa drugs (and later, penicillin) became available. The formation of specialized units and mobile teams to treat burns enabled early standardization of treatment that included: morphine for analgesia; fluids, blood, and plasma for resuscitation; saline compresses and baths; surgical cleaning and debridement of

dead tissue under anesthesia; tulle gras dressings; skin grafting to cover large areas and to re-construct missing body parts such as eyelids, ears, and noses; and close monitoring of blood work for hemoglobin, plasma protein, and blood urea nitrogen levels.[154] NS Wannop recalled the need to monitor blood work and careful observation of the patient for signs of drug toxicity in relation to the sulfa medications.[155] Nurses had major roles and responsibilities in the care of these patients from the beginning, but especially after the European invasion, as Medical Officer Feasby pointed out: "[T]he nursing problem became acute and more nursing sisters had to be added to burn wards. . . . [The technology] entailed a great deal of nursing care, but the results justified the procedure."[156]

There were two main specialty centers for the treatment of Canadian burn cases as the military experimented by clustering patients with special care needs and medical/nursing staff with specialized skills together in these units: the RCAMC wards at No. 1 Neurological and Plastic Surgery Hospital at Basingstoke, and the RCAF Canadian wing at East Grinstead's Queen Victoria Hospital. Basingstoke had two burn units of forty patients each where NS Doree found, "The stench of forty severely burned people lying in two long rows in a Nissan, hit like a blow every morning."[157] Nurses were responsible for all the dressings and they seemed to never have enough staff, equipment or supplies at Basingstoke. In one case, Doree said:

> Most of our patients received intravenous injections of four-times concentrated plasma to counteract the colossal loss of body fluid through their burns. This dried, life-saving plasma . . . came in bottles to which we added 100cc's of fluid instead of the usual 400cc's. Then, as the bottle had to be shaken vigorously for some time to dissolve the plasma, it was not uncommon to see a nurse shaking the bottle with one hand and carrying out another procedure with the other hand.[158]

During the European Invasion, so many patients had burns of both hands and were totally dependent on nurses or orderlies to partially replace their fluid losses, that duodenal tubes were used on a limited basis to supply a slow but continuous source of drinking water.[159]

The East Grinstead wing began as a small unit within a British hospital but as burn casualties increased, a special Canadian wing for fifty patients was built and in operation by July 1944. It became well-known for its somewhat novel approach to treatment (psychologically as

well as physically). The emphasis was on restoring normalcy by integrating patients into local community activities (particularly the pub life), relaxing discipline (with regular clothes and beer permitted on the ward), and the inclusion of patients in decisions regarding re-constructive surgeries. Patients had the opportunity to go into operating rooms and watch surgical procedures prior to consenting for their own surgeries, especially for innovative grafts such as reconstructive pedicle grafts. But as one anonymous author wrote, "Much work was done in repairing and rebuilding distorted hands and faces, but fully as important was the restoration of personal morale and self-assurance which, almost inevitably, were burned away simultaneously with the normal features. . . .It required both the most highly specialized surgical skill and psychological ability."[160]

Nurses embodied the technology at East Grinstead by becoming therapeutic measures themselves. Rita Donovan claimed that the chief plastic surgeon (Dr. Archibald McIndoe) "recruited the best-looking nurses he could find" for the unit: "Not only were they able to alleviate discomfort, but their female presence, their interest and concern in a patient, validated his ego and assisted his recovery. . . . Their role was clearly larger than that of medical support for they were also to assist in rebuilding the confidence of these damaged men."[161] NS Fran Oakes recalled being 'detailed' along with other nurses to accompany patients to the local pubs after working twelve hours, in addition to walking the four miles to work and back to their billets: "This is the only place I ever knew . . . [where] there was beer kept [on the ward]. And Mr. McIndoe'd say, 'Go and get yourself a drink now. . . . [G]et down to the pub tonight. Get the girls to take you to the pub. And don't be sitting thinking to yourself. There's people worse off than you.'"[162]

But not all burn patients received treatment in these specialty units—at least not for the initial care. NS Ferguson was with No. 6 CCS near Caen, France where "the burn cases and the tank injuries that came out of there were horrendous." She described how this care became routinized:

> They were sedated [with Morphine] and then the clothing and the horrible burned skin would peel off them like a banana. . . . You couldn't touch them until you could sedate them. They were in shock. And then you could handle them quickly because we had to be able to remove their clothing and remove the burn as much as we could. And clean them up and put some sterile dressings and towels, and some clothes on them, and then get them over to Britain. That was our aim. We filled about six stretchers and as soon as

> the stretchers were ready (we had our landing strip near the hospital or near the casualty clearing station) and then, they filled [the rest of the plane] up with walking-wounded and they were over in Britain in just a few hours. . . . But the teamwork was excellent. You could almost go ahead and do the job—boy, after boy, after boy without talking very much. You knew the routine. You knew what was going on. As long as they were labeled properly and you entered all the information about the sedation and everything onto the cards, why they were cleaned up and ready to go.[163]

At the *HMCS Niobe* in Scotland, one of NS Amy White's patients had third degree burns to his arms, thighs, perineum, face, and back. She wrote to her physician father explaining that she thought he would be interested in the 'new' ways of treating burns and describing two different methods used on this patient as an experiment: one arm and hand were treated with a sulfa emulsion dressing inside of a plaster cast while the other was enclosed in a plastic bag device filled with oxygen and irrigated with hydrogen peroxide three times a day. In addition, "The rest of him is done up in sulpha emulsion & elastoplast. He had four bottles of blood plasma."[164] NS Surgenor served at the *HMCS Stadacona* in Halifax where burn patients were debrided in surgery and wrapped with penicillin emulsion and 'cotton waste' as "one of the first improvements for burns that I can remember."[165]

NS Wannop spent most of her military service at Basingstoke with burn patients and developed such expertise that the RCAMC avoided posting her elsewhere. She was particularly articulate regarding her practice there, describing many aspects of patient care and relative autonomy:

> [W]hen the big push would come on and patients would be brought in, you were pretty much on your own. But by this time, you knew pretty well what to do. We would start the intravenouses and that. We'd get them ready and put them in the saline bath and that was routine. . . . And if they were too sick to go in the bath, then we would treat them in their bed. . . . [W]e would lower them in the bathtub of the normal saline. And when they were in that, then we would clean off all the dead debris underneath the water because it was easier for them. Cause most of these were about three-quarter burns, and then lift them out on a sterile sheet and then 'dress' [apply sterile dressings] them.[166]

NS Wannop talked about treating her patients for shock and pain, doing their blood tests and monitoring the results as well as participating in decisions regarding patient readiness for surgical grafting. She also described their needs for psychological support as young people, 16-20 years old, whose lives had been "ruined." As Wannop recalls: "[T]hey'd come in and talk to you about

it, and I guess the talking would be part of the treatment too . . . besides physical treatment. . . . [T]hey had a hard time and they needed a lot of nurturing." Wannop described another patient as "very bad physically and mentally--about eighteen years old", "very angry", and who "swore like a trooper."[167]



Photograph 6: Nursing Sister Dorothy A. Macham and Private Harry Lord at No. 1 Neurological and Plastic Surgery Hospital at Park Prewett, England prior to May 1943. Photograph in possession of Nursing Sister Eva Wannop. Used with permission.

But medical technology had its limits. NS Roe recalled being on night duty in a surgical ward and making rounds with her flashlight when she noticed a burn patient with "these little 'rings of fire' around his eyes. He was all bandaged up to the face. . . . I called the medical officer, but there was not much he could do. But I kept it moist [with boracic acid solution]. Pretty well all I could do. . . . I think I got his address to write to his mother after he was gone."[168] Wannop maintained contact with some of her patients after the war and although the official records deny any suicides among burn patients, she knew of several who committed suicide after returning to Canada. It is difficult, perhaps impossible, to identify professional boundaries that differentiated nursing care and expertise associated with medical technologies. Distinctions

blurred as nurses assumed roles previously enacted by either physicians or orderlies, because whenever they did so, they brought their own nursing perspectives into the technology.

Psychiatry was a contested field during both world wars, as different practitioners sought professional recognition, and the field began to emerge as a distinct medical specialty. During the First World War, the term 'shell shock' represented "a variety of conditions ranging from cowardice to maniacal insanity."[169] It included psychoneurosis, hysteria and neurasthenia as three forms of the same condition. A shell-shock diagnosis risked being associated with or attributed to cowardice. Medical officers were required to certify a man's fitness for court martial and punishment, as well as to witness the execution if convicted. Other soldiers inflicted non-life-threatening wounds upon themselves to avoid combat. They were called S.I.W.s (for self-inflicted wounds) and the classification was often closely associated with aberrant mental status.[170] The term shell shock fell into disfavor and was replaced with 'battle exhaustion' or 'battle fatigue' during the Second World War, in an attempt to suggest a mild and recoverable condition, avoid the stigma of a psychiatric diagnosis, and facilitate the medical officer's administration. But the change in labels didn't fool anyone.[171] Instead of execution, S.I.Ws were sentenced to two to five years of hard labour and loss of wartime credits, a strong deterrent after the recent Depression.[172] Soldiers with mental disorders were treated more often as medical patients than as disciplinary cases.

Historians Terry Copp and Bill McAndrew have traced the development of psychiatry in relation to the Canadian military during the 1930s and 1940s including the prewar use of Insulin-induced coma therapy, Metrazol-induced convulsions, and electric shock treatments. In their view, key academic medical men from McGill and the University of Toronto who saw themselves as neuropsychiatrists were instrumental in the establishment of a psychiatric branch within the RCAMC by 1941. But psychologists, through the Canadian Psychological Association, challenged their monopoly in the armed forces, by placing the emphasis on intelligence testing, personnel selection, and screening of recruits for mental stability rather than on active treatment of disorders.[173] This emphasis was more cost-effective initially, by eliminating men from the

military who were potentially pensionable for mental disabilities. During the early phase of the war, when recruitment was relatively easy, the prevailing policy was to discharge problematic personnel rather than treat them.

In a postwar publication on the principle lessons learned during the war, medical historian Feasby claimed that psychiatric disabilities accounted for approximately 30% of all medical discharges, and that less than 25% of those diagnosed with psychiatric problems were rehabilitated to the point where they became "useful forward area soldiers."[174] He also concluded that in comparison to medicine and surgery, "the advances made by psychiatry during the war were not spectacular."[175] The number of soldiers discharged as medically unfit for psychiatric reasons created a large 'wastage' in manpower that increasingly worried the Department of Pensions and National Health, which would be responsible for their rehabilitation and pensions, while the conscription crisis in Canada threatened to topple the government.[176]

The main RCAMC psychiatric unit was located at Basingstoke as part of No. 1 Neurological Hospital. NS Doree wrote that the word 'psychiatric' had been omitted from the hospital name to avoid stigma, but Copp and Andrew note that it was also referred to by the troops as 'No. 1 Nuts.'[177] Twelve nurses from the Montreal Neurological Institute and eight nurses from the Toronto General Hospital staffed the unit initially.[178] Little treatment was available until 1943, other than electric shock and the creation of a special ward for psychotic patients.[179] But with the movement of troops to the Mediterranean and plans for an invasion of Europe, the treatment of psychiatric disorders began to assume greater importance for salvaging available manpower.[180] When the Canadian forces landed in Sicily (10 July 1943), they were the first field formation to go into battle with a psychiatrist on strength.[181] No. 15 CGH in North Africa attached a base psychiatric centre for the evacuation of casualties from Sicily and Italy. It increased in size to 200 beds prior to moving to Caserta, Italy at the end of 1943. Over a twenty-one-month period (July 1943-April 1945), this unit treated 2326 in-patients and 989 out-patients with 22.7% returning to active duty, 62.8% medically re-boarded and reallocated to special work units, and 14.5% evacuated back to England.

In addition, special work units (known as Pioneer Companies) were created during the war in an effort to stretch manpower resources by the employment of illiterates and men with low mental abilities for heavy labour. This strategy was expanded in Italy (as Special Employment Companies or SEC) to include men with disciplinary problems, stress-related and psychiatric problems, and mild physical disabilities in what Copp and McAndrew described as a cross between a penal battalion and a rehabilitation centre.[182] Three such SEC units in Italy absorbed a high proportion of the neuropsychiatric casualties who were unable to return to regular duty, partially becoming a form of work therapy.[183] Overall, at least 5020 casualties received treatment for psychiatric disorders during the Mediterranean campaign.[184]

With the invasion of Europe, the 75-bed No. 1 Canadian Neuropsychiatric Wing from Basingstoke attached itself to No. 10 Canadian General Hospital and built on experiences gained by the units in Italy. It increased in size to 200 beds, staffed by eight Nursing Sisters. Available medical technologies used in this unit included: continuous narcosis with Medinal and Paraldehyde for two to four days; Sodium Amytal to induce suggestible states; psychotherapy; and an occupational therapy program where patients produced surgical dressings and cleaned medical equipment as arranged with the Matron of No. 10 Canadian General Hospital, to which it was attached. While this psychiatric wing also had a convulsive therapy machine, there was no electrical power for its operation during the invasion. In both Northwest Europe and Italy, the main treatment for battle exhaustion and psychiatric problems consisted "simply of rest with sedation, if necessary; good bath facilities; clean clothing, new equipment, and psychotherapy in the form of explanation and reassurance."[185] It was recognized that "the resolution of many of these cases depend[ed] in large part on Nursing Sisters who have had neuropsychiatric experience."[186]

But psychiatric, or mental nursing, was a relatively new field of study and practice for nurses during the 1930s and 1940s.[187] Between 1912 and the mid-1930s, a few Schools of Nursing included several classes on psychiatry in their curricula accompanied by a very brief period of service in a mental hospital.[188] One psychiatrist bemoaned this lack of student training,

characterizing the average experience as a few lectures and "a single Cook's tour through the nearest mental hospital."[189] Two large teaching hospitals did not introduce psychiatric nursing into their curricula until after the war: the Montreal General Hospital in 1950 and the Ottawa Civic Hospital in 1952.[190] Thirty-four percent of the military nurses in my sample graduated in 1936 or earlier, and may or may not have had courses or lectures on the topic since it was not recommended in the CNA curriculum guidelines until that year. Only 1.7% of the NSD sample reported psychiatric or mental nursing experience as a graduate nurse prior to enlisting in the armed forces (Table 2.10, Chapter 2).

NS Jean Ciceri recalled that she went to No. 1 Neurological "completely green." It was a new field that was not part of her training, but psychiatrists at Basingstoke taught the staff about psychoses and neuroses, including battle fatigue and stress. She noted there were not many drugs available, and recalled the methods of treatment as: shock therapy with either electric current or Metrazol until the patient reached 'harsh' convulsions; chemical treatments with Chloral Hydrate, Paraldehyde, Phenobarbital, Nembutal, and Seconal; occupational therapy; diversion therapy (such as sports, recreation, and gardening); exercise; fresh air; and enhanced diets for rapid weight gain and improved well-being.[191] Some patients received injections of sodium pentothal to help them recall experiences and talk about them, and then they returned to their units.[192] Officers had better living conditions, more privacy, and more privileges than the enlisted men in her unit. According to Ciceri, therapeutic narcosis therapy (described as six days of sedation that was supposed to get rid of anxieties) didn't seem to work but nurses tried to make the psychiatric unit a 'fun' ward as they urged their patients to join various groups. Ciceri believed the Nursing Sisters were involved in an early form of 'group therapy' without knowing it. She also attributed the origins of the 'therapeutic relationship' concept to experiences gained by nurses in these units. She admitted, however, that it took a long time for her to realize she was really 'nursing' because it was so different from the busy, skills-oriented, physical work she had always associated with nursing. As Ciceri said, it took a long time to accept that "this *was* nursing."[193]

NS Verna White was one of the nurses who graduated from a joint training program at the Provincial Mental Hospital of Ponoka, Alberta and Calgary General Hospital. She was posted to the psychiatric unit in Italy where she recalled caring for patients receiving 'Deep Sleep' treatments using Sodium Amytal sedation for periods of three days at a time.[194] NS Marjorie MacLean also served in Italy and described her experiences with narcosis therapy:

> [T]he doctor would say, "Wake him up for meals. He doesn't have to get out of bed. He doesn't have to do a thing." Because, well, some of the walk-in patients on another ward--they would be given little jobs. And these weren't given any jobs at all. We were just told to let them sleep but wake them up for meals. Make them have meals. And after a week of this, [the doctor] would say, "Now come down to my office whenever you feel like it." And by the end of the week, they probably would. And then he would talk with them and keep them for another day or so, and then they'd go back to the lines. Well, the Americans couldn't get over this. They had never tried this. If somebody refuses to go ahead in the line, they're apt to be shot or something. I mean they did that in a lot of armies.[195]

In situations where little equipment and few procedures existed for treatment, nurses became the treatment, in the form of reassurance and psychological comfort. NS Anne Farries concluded that sometimes, "The best nurses could do for men driven temporarily insane . . . was to provide some sense of normalcy."[196] It was military policy to keep battle fatigue patients near the frontlines to discourage malingering rather than evacuate them away from the action (unless they were severe cases that were not expected to recover within nine days).[197] NS Nicolson was on night duty in a battle fatigue 'ward' during a night assault on nearby Catania. Her patients lay on stretchers outside where "they could hear the bombs dropping. They could see the flares . . . the whole ward would light up with the lights." She made sure her patients could also see and hear her throughout the bombardment, using her visibility as a nurse and as a woman to create a perception of safety for stressed soldiers: "I just got up and walked back and forth—just so that they could see me. . . . But that's all I could do at the time . . . psychologically. They'd had it really. . . . And were anxious to get away.[198] In a similar manner, NS Ferguson described S.I.W. casualties with compassion and understanding. Policy also kept these patients at the front where nurses like Ferguson used interpersonal skills as therapy: "We never called them S.I.W.s. Somebody else diagnosed them. . . . I felt sorry for those fellows. Most times, they liked to bring

out pictures of family, and talk about family, and that kind of thing. You had to let them do the talking. You became a good listener."[199]

It is difficult to counterbalance these relatively positive experiences with less positive accounts of stress, anxiety, and psychiatric disorders, given the paucity of sources and the limited number of nurses involved in these units. One nurse did leave an oral history account containing a brief reference to such a situation. NS Louise Jamieson served with the SAMNS and during her extended contract in 1943, she was 'farmed' out to No. 84 British General Hospital in Barletta, Italy. Jamieson was on night duty with four female civilian psychiatric patients but there was no psychiatrist on staff and no psychiatric treatment offered. As she said, nurses could only try to prevent patients from hurting themselves, one another, or the staff. The only items in the room were a lantern, a commode, and a screen. Jamieson described how one nurse had to sit on a patient suffering from acute hysteria, another patient required constant observation because she "would chew everything in sight" including the handkerchief from your pocket, and a third patient had to be force fed.[200]

As I will discuss further in the next chapter, Nursing Sisters were also subject to mental disorders related to the various types of danger and risks to which they were exposed. Many of them did not recognize the psychological effects on their lives until years after the war, as they sought to re-establish themselves in civilian workplaces and families.

Relying on Nursing Knowledge and Doing "Real Nursing Things"

Much of nursing care involved (and still involves) interventions to provide comfort and relieve pain, to meet nutritional needs, to support patients through illness and death, and to reintegrate patients socially. When NS Bayly was asked to describe her work with a CCS, she explained: "All I was doing, was trying to make them comfortable: bathing them and doing all the real nursing things."[201] 'Real nursing things' often involved invisible work, such as the skilled observation and assessment of changes in a patient's condition that could prevent complications

during recovery. It also involved nursing decisions regarding a range of therapeutic measures other than drugs, to deal with comfort or pain. NS Roe explained, for example, that troops carried small, prepared ampoules of morphine packaged with their field dressings and self-administered while waiting for stretcher bearers to pick them up after being wounded. As a nurse, she was concerned to make them comfortable without overloading them with narcotics that might mask important diagnostic signs and symptoms or that could impair respiratory and neurological functions.[202] For her part, RCN Matron Rae Fellowes wrote on the care of 'Immersion Foot' as experienced by sailors, pointing out how important constant nursing vigilance and attention to detail in restoring circulation to the feet of North Atlantic survivors could be.[203] And NS Cole recognized the need for touch in the care of a patient almost completely enclosed in a plaster cast:

> I had gone all around this 45-bed-ward doing the various things that had to be done, trying to get the bed patients comfortable, giving medications, and this sort of thing. And I was just about at the end and I came to this bed where this fellow was encased in a plaster cast from his toes up to his arm pits. And I always tried to say something to them rather that just go ahead and do the treatment or whatever--and ask them what unit they were with, where they had been, where they were from. And so I stopped at this bed and started doing whatever I had to do. I guess he was in plaster so I was trying to rub [to touch] what was available--you know, at the cut out area at the back.[204]

Not all wounds happened on the battlefield. NS Cole decided to break the rules for a young, single woman serving in the Women's Division who had just delivered a baby. She recognized the woman's need for closure to a difficult experience, saying: "We weren't supposed to let them see their babies. She said, 'It's the hardest thing in the world for me to have to give him up. . . . For his sake, I have to do it.' And I've always remembered her crying when I was bathing the baby."[205] The internment camps where NS Kay Christie and NS May Waters spent twenty-two months as prisoners of war in Hong Kong and the emerging psychiatric units of the Mediterranean and Europe constituted two other areas where there were relatively few medical technologies and where nursing care became more visible.

Ironically, nursing changed with distance from the front, as well as with proximity to the front. In the 'backwaters' of Hong Kong, where Nursing Sisters May Waters and Kay Christie

served, nursing took on different meanings.[206] During the eighteen days of fighting that preceded the British surrender, nurses' first concerns were for safety in the midst of bombing, shelling, and snipers, as they moved patients continuously to lower floors and then, to bomb shelters wherever possible. They placed a folded mattress across the top metal bar of traction frames as protection for patients who could not be moved out of bed, and they got under the beds of the sickest patients in order to still be available for assistance during air raids.

After the surrender, the Japanese army declared the Bowen Road Military Hospital to be "Prisoner of War Camp A," put barbed wire all around it, and patrolled the wards with armed guards. Medical supplies became increasingly scarce, and then absent, as they were used up. Nurses' own survival and the survival of their patients depended more and more on basic nursing knowledge and skills related to dietary deficiencies, dysenteries, basic sanitation and cleanliness, and the re-use of gauze bandages.[207] Christie was appalled with the conditions, which were much worse than what she experienced as a graduate nurse during the Depression years in Ontario, where even then she "wasn't used to luxuries" in nursing care.[208] The nurses stretched their dwindling supplies of medications by giving them only once a day, until the drugs were gone, instead of the usual three or four doses per day. They also stretched dressing supplies by changing dressings infrequently and by washing the used ones for re-application. Christie wrote, "Before long we were not only re-using bandages that normally would be discarded, but were washing out and boiling gauze dressings, then re-using them. Ingenuity and the ability to improvise, yet preserve some semblance of surgical technique, became a constant challenge."[209] Although the drainage from wounds leaked through patients' casts and they were "high" (meaning they smelled horribly), there was no material to change the casts and they had to be left in place indefinitely.

In spite of the lack of technological resources that challenged patient care, Christie reported that their main problems as POWs were: hunger, idleness, severe restrictions, lack of privacy, and a constant uncertainty regarding their fate. They had months, and then years, of enforced idleness interspersed with work and intimidation tactics from their captors. In August

1942, the nurses were separated out from the rest of the troops and moved to a civilian internment camp (Stanley Camp) where they continued under the same restrictions and privations but without the benefit of meaningful work. This was extremely difficult for Christie who explained: "Well this was bad enough for nurses (not to be able to care for your patients properly) but to leave them without any nurses, well, we thought this was the lowest thing they could do to us. And we had nothing to do at the Stanley Camp."[210]

Thirteen months of idleness was "dreadful" for Christie, although she took the advice of a Roman Catholic priest who warned them to find something to do. She arranged French classes from a fellow internee and learned to play bridge which she said 'saved her' because she was able to "forget the surroundings and what is going on." There was a small civilian hospital 'of sorts' for the 2400 internees at Stanley Camp, but civilian nurses were in charge of it and initially, they refused the assistance of the military nurses. Christie attributes this rejection to contentious relationships between the civilian nurses and the Matron of the QAIMNS nurses. By April 1942, however, the two Canadian Nursing Sisters were asked to help on night duty although their assignments consisted of only one or two weeks of work every four to five weeks.[211]

Two particular cases, based on Christie's experience, illustrate the nature of nursing care and medical technology in POW and internee camps. Bud Sweet was a "young kid—freckles across his nose, a lock of hair down over his forehead. He should have been out in the streets playing marbles, not away over there. He looked about 14." Bud had been injured and was already a hospital patient when Japanese soldiers attacked and bayoneted him as he tried to escape death a second time. He 'played dead' and ultimately lost his left arm to amputation in addition to the original compound fracture of the scapula. Christie focused on healing both wounds but she also knew the importance of adequate nutrition for healing, so she 'scrounged' extra nourishment for him. Bud refused to take the extra rations on the ward with other patients. As Christie wrote, "To give extra nourishment to one particular patient I had to hide him behind an opened cupboard door while he guiltily, but ravenously, ate whatever I had been able to scrounge

from any source; however, he still had to be assured that these extras were a form of required medication."[212]

Telegrapher Quinn was eighteen years old and had lost his left leg, subsequently developing a "horrible pressure sore at the base of his spine" through which "you could get a wipe on a forcep [sic], put it in through the pressure sore, [and] bring it out through the amputation site."[213] He required a bed with a Balkan frame on it, at least two hours of nursing care each morning, and had become addicted to Morphine. Christie described the improvisation of his care, saying:

> I strung him up in a hammock (which I thought was quite appropriate for a Navy boy to be strung up) . . . to try and keep his back off the mattress. Oh, it used to take me an hour and a half, two hours, every morning for his basic care and he would scream and swear. I didn't blame the kid, you know, I wasn't too sure how I would act if I were in the same state he was in. But it did bother two young Navy boys--they were called Able-bodied Seamen, which I believe is the lowest form in which the Navy walks. Gray and Ward, (kids again, you know, skinny) and it bothered them the way he would speak to Sisters. And so anyway one morning he'd been particularly abusive, and when I finished with him and I went out to the bunk to get rid of the bath and dressing materials, these two followed after me and they stood very strictly at attention, saluted me and said, "Sister, on behalf of the Royal Navy, we wish to apologize for Quinn." Well, really, I could have cried. . . . Some weeks after, early one morning, Quinn mercifully died.[214]

Waters and Christie had little medical technology according to conventional definitions but they used nursing knowledge and expertise for the benefit of patients even under extreme adversity. Their ability and opportunities to provide nursing care was beneficial to their patients while it also provided purpose and meaning for the nurses themselves.

Military medical technology included a wide variety of equipment, skills, procedures, roles, and knowledge during the Second World War. Nursing practice was contingent on: the specific technology; where it was used; who was available with the necessary skills and knowledge to assume responsibility for it; how the technology was constructed socially; and what was at stake (militarily, professionally, and socially). A shift in any of these variables had implications for the rest of them.

'Civvy' Street' and the Postwar Legacy

Nurses were relatively successful in embracing and sharing technologies, while also using them to become essential to the system. But their expanded expertise and knowledge did not significantly influence postwar hospital nursing practice. When their skills were no longer required to maintain a fighting force, very few of the Nursing Sisters returned to the civilian bedside in spite of a rapidly increasing nursing shortage across Canada. Social expectations, political strategies, the media, and employment policies that disadvantaged working women combined to reinforce 'home' as the ideal place for most White, middle-class, married women after the war. But nursing was a female domain wherein few men or women with diverse race or ethnic identities competed for nurses' jobs. In effect, there were far more postwar nursing positions than nurses who wanted them. Nursing Sisters were under pressure from the postwar profession but the majority of them were absent from 'Civvy Street,' as they called the civilian practice world.

There are currently two dominant assumptions about postwar military nurses and civilian nursing practice.[215] One claims that nurses used their considerable experience as a 'leg up' in the profession through their veterans' credits and educational opportunities. Another asserts that military nurses' success with technological changes during the war resulted in substantial postwar changes to hospital nursing practice. With the exception of McPherson's work on the fourth generation of Canadian nurses and the transformation of nursing during the postwar period, there has been little or no examination of postwar practice directly related to Nursing Sisters.[216] However, my research clearly indicates that very few military nurses returned to hospital practice and that the Nursing Sisters influenced postwar civilian practice by their absence as much or more as by their presence. By their refusal to resume traditional nursing roles, they forced hospitals to implement recruitment and retention strategies for graduate nurses such as those discussed by McPherson. And while it is unlikely that Nursing Sisters directly shaped postwar hospital nursing practice, public health and community nursing were potential beneficiaries of their expanded postwar educational opportunities.

Nursing leadership had expressed great concern over repeated calls to enroll more students, and to graduate them in less time, as a civilian nursing shortage began to emerge during the early 1940s. Their concern was partially related to the anticipation of military nurses' demobilization after the war along with a professional memory of severe unemployment for nurses during the 1930s. Nursing leaders exercised caution and were determined to participate in federal postwar planning endeavors as well as to initiate committees of their own. Articles appeared in the *Canadian Nurse* regarding an emerging nursing shortage by February 1941 when Editor Ethel Johns wrote, "Already our hospitals are beginning to feel the effects of the withdrawal of 'key' nurses in increasing numbers as they enter military service. . . ."[217]

As the nursing shortage deepened through the war years, the profession began to rely on the Nursing Sisters as their solution to the shortage. Their focus shifted from protection of civilian jobs, to strategic recruitment from the military ranks. The Registered Nurses Association of Ontario (RNAO) established a Placement Service Advisory Committee, partially to match discharged Nursing Sisters with existing civilian vacancies, while the Canadian Nurses Association appointed a Committee on Reconstruction for postwar planning within the profession.[218] Overseas nurses were surveyed regarding their discharge plans and the CNA developed brochures to steer returning nurses toward 'opportunities' and gaps in the civilian system. But the Nursing Sisters did not necessarily conform to these professional, societal, and military agendas designed for them.

We have seen how the postwar military nursing quota severely reduced the Permanent Forces' nursing service to a mere eighty nurses among the three branches, and how the Department of Veterans Affairs (DVA) counseling service viewed nurses as a solution to civilian nursing shortages rather than as an employment problem—in contrast to other returning soldiers whom they feared would flood the labour market. The NSD contains information from the discharge interview summaries of 1052 nurses: marital status at discharge, educational preparation prior to enlistment, current educational goals, immediate discharge plans, the level of credit available for re-establishment, and the counselor's recommendation(s) regarding how the

nurse should use her veteran's credits. From these sources, we can profile the Nursing Sisters at the point of discharge, including their future plans.[219] Clearly, the great majority of military nurses did not remain in nursing and those who did avoided a return to hospital (or bedside) practice, in preference for jobs in public health, teaching, supervision, and administration.[220]

Several groups of military nurses left the profession immediately upon discharge. One group (29% of the sample) typically indicated that the "nurse" would be "establishing a home for her husband" or "having a family." Included in this group were: nurses who married prior to, or during, enlistment; nurses who planned to marry within the immediate future; and unmarried nurses who were pregnant. As one councilor wrote of a married nurse, she was already "happily rehabilitated"—assuming heterosexual marriage as the norm and ideal state. A second group consisted of nurses who planned to remain connected to the military or to the nursing care of veterans. They had accepted positions with one of the armed forces branches (2.9%) or with DVA hospitals (12.0%).[221] Nurses who planned to work, but not in nursing, made up a third group (5.1%). For them, "civilian nursing had little appeal."[222] As NS Tritt said of her friends, "They wanted something different. . . . They would not have been happy at a civilian hospital—having the doctors try to order them around."[223]

Then there were nurses who planned to work as supervisors, teachers, and administrators in either hospitals or community agencies (20% of the sample). Many of these nurses were looking for non-traditional practice settings or looking to replace their wartime experiences with work that would offer similar challenges—such as outpost nursing, Northern nursing, work with the United Nations Rehabilitation and Relief Administration (UNRRA),[224] nursing in other countries (China, South Africa, Persia, or Ceylon) or industrial nursing (with South American oil companies, insurance companies, or on steamships). A note on one nurse's file read: "Hesitates to return to civilian nursing, not through lack of interest or qualifications, but due to civilian patients' failure to appreciate her efforts . . . now realizes her capabilities from a professional point of view and more fully understands the opportunities open to her."

Some nurses became patients themselves, when discharge medicals revealed health problems such as tuberculosis, brucellosis, arthritis, psychoneurosis, fractured spines, burns requiring plastic surgery and rehabilitation, hemolytic anaemia, deafness, and cancer. Others accepted responsibility for the care of sick family members (1.6%). Another group of nurses had not yet decided, while some planned to take a holiday before deciding, or simply did not indicate their plans (5.8%). A meager proportion of the Nursing Sisters (8.9%) planned to return to hospital nursing practice, although it is likely that many of those who did not have definite plans at discharge also stayed in nursing, or returned to the profession later in their lives.

Those nurses who used their credits for university, enrolled in public health, supervision, teaching, and hospital administration—the primary courses available to nurses in Canada.[225] Many of these nurses also married and left nursing after completing these courses, as my interviews corroborate. Taking into account those who indicated plans for marriage, transfer to the permanent forces, employment with DVA hospitals, private duty nursing, other non-hospital nursing, x-ray or lab technician employment, and non-nursing employment—there were at least 69% of the Nursing Sisters who either left or planned not to return to civilian hospital nursing at the end of the war (Table 4.2).

Some of the NSD comments referred to military nursing as a patriotic endeavor only. One councilor wrote, "Miss __ is in the fortunate position of not having to work for a living. She studied nursing as a war duty and does not intend to continue to practise [sic] her profession." Another councilor noted that the interviewed nurse was "definitely giving up nursing. She was not nursing before enlistment [she was a typist] and only came back to this profession because of the war."

TABLE 4.2. SUMMARY OF THE SECOND WORLD WAR CANADIAN MILITARY NURSES' DISCHARGE PLANS, NSD[226]			
Category of Plans	Description	Number	Percent
Marriage	Nurses who married in the service and nurses planning to marry in the immediate future	290	27.6
Pregnancy	Both married and single nurses, where pregnancy was the stated reason for discharge	66	6.3
Permanent Forces	Only those nurses actually accepted	31	2.9
University	Nurses who requested courses leading to a recognized degree or certificate: BA, BSc, and Master's degrees; Occupational Therapy, Physiotherapy, Public Health, Medicine, and Law	136	12.9
Post-graduate courses	Typically 6 months in length: operating room technique, x-ray and lab technique, teaching, supervision, and hospital administration	206	19.6
Business courses	For a Doctor's office or a small business	6	0.6
DVA Hospital		126	12.0
Private Duty		43	4.1
Hospital Nursing	Graduate Duty Nursing	94	8.9
Hospital Supervision	Supervisors, Teachers, Administrators	29	2.8
Non-Hospital Nursing	Public Health, District Nursing, Doctor's Office, Industrial Nursing, Civil Service, UNRRA, Stewardess	181	17.2
X-ray/ Lab Technician		28	2.7
Non-nursing	Nurses who clearly indicated the desire to get out of nursing completely	26	2.5
Rest and/or Holiday		18	1.7
Medical Treatment	Nurses admitted to TB or DVA hospitals for care	10	1.0
Care for a Family Member	Typically a parent, aunt, or veteran husband	7	0.7
Unsure or No Plans		21	2.0
Not indicated		22	2.1

Nurses who did not want to continue in the profession indicated a wide variety of plans. Some were starting small businesses (either alone or with a partner): grocery stores, a hardware store, a tea room or a bar, a ski lodge, a leather goods store, beauty shop, a restaurant, hotel

management, or a tourist camp. Others wanted to go into advertising, farming, interior decorating, or handicrafts. Several planned to study art. One planned to become a musical accompanist. Although it is likely that many other nurses remained in nursing out of necessity more than choice, one file clearly stated the situation. As the councilor explained:

> This nursing sister appears to be a restless rather unhappy girl. She is 'fed to the teeth' with nursing and unable to break away from it. She has financial responsibilities which include the maintenance of a house and care of an aunt who is dependent on her. Miss __ is an orphan and the care of this relative devolves mostly on her shoulders. . . . [She] is hopeful that in taking public health training she may be able to obtain employment more congenial than general duty nursing.[227]

The Second World War military nurses whom I interviewed made similar decisions. However, a small portion of these who married and left the profession initially returned to the profession (at least on a part-time basis) during the 1960s and 1970s, after their children were grown. Two interviewed nurses married overseas, five married on discharge, and six more within the first year—for a total of thirteen (54.2%) who left nursing although five of them worked part-time at a later date. Only two nurses (8.3%) returned to bedside nursing at discharge. One worked while her husband attended university to become a pharmacist, and then she resigned. The other nurse had a baby but her veteran husband, who was an amputee, cared for their baby while she worked part-time for several years because the hospital "pursued" her due to the severe nursing shortage. Two nurses (8.3%) went to work in DVA hospitals but after a brief period, retired to marry. Eight nurses (33%) used veterans benefits to go to university—five of these for public health courses or degrees. Two eventually completed doctorates and had careers in teaching and supervision, moving away from direct patient care. Four nurses (20.8%) joined the permanent force nursing service (two in the RCAMC and two in the RCAF) while another Nursing Sister re-enlisted within a year but only stayed briefly prior to marriage. She found the postwar military situation different as it no longer offered the challenges and opportunities she had experienced during the war.

The interviewed nurses were unsettled and restless when the war ended. NS Roe considered going to California or Costa Rica but, she said, "I wasn't ready at that time, mentally. .

. . I had a chance to go back to university but I just wasn't ready for it."[228] NS Cox recalls that, "It took us awhile to adjust to civilian [settings]. . . . [I]n the Army, you have your meals, you have your work, and everything is pretty much uniform and taken care of. And you were suddenly out doing it all on your own when you come back. It's an entirely different scene. And the very thought of working in civilian hospital didn't attract me at that point."[229]

If the nurses were restless, the profession was getting desperate and there were far more jobs than could be filled. Dr. C. B. Parker, Assistant-Superintendent (Medical) wrote to the Air Commodore (RCAF) J. W. Tice in a series of letters concerning the shortage of nurses at the Toronto General Hospital, suggesting the secondment of armed forces nurses to civilian hospitals "where the need is urgent." He argued that it would not only relieve the situation, but also benefit the Nursing Sisters by providing them with civilian practice experience. Tice replied that the RCAF did not second nurses; although he anticipated the release of a considerable number of nurses in the near future, he could not control where they went or the work they chose once they left the RCAF.[230] In 1945, the Canadian Nurses Association's Postwar Planning Committee attributed the need for more bedside nurses to the extension of DVA hospitals, the delegation from physicians, unfilled positions in tuberculosis and psychiatry, and new practice areas such as industrial nursing.[231]

The committee projected a need for more nurses and nursing instructors related to plans for postwar hospital expansion and the implementation of hospital insurance programs.[232] By 1946 RNABC President Evelyn Mallory wrote an editorial that explained the civilian situation bluntly:

> We tell ourselves that we have worked hard during the last few years trying to keep civilian services going and to meet the nursing needs of war; but the war is *over* and the danger is passed. . . . [T]he Canadian people have been very patient with us. We have been unable to meet their needs for nursing service, either in quantity or quality. But there was always the answer, 'There is a war on!' . . . . We went to the Dominion Government and we said: 'It is because of the needs of war that we have not enough nurses. . . . We can no longer say that military needs are depleting the civilian service. Yet the shortage of nurses seems more acute than ever! . . . There will be no glamour, and no awareness of a common danger to unite us [emphasis in the original].[233]

Initially, the professional literature exuded with an understanding attitude toward the de-mobilizing Nursing Sisters. Later, the messages became more urgent and more critical. Some hospitals were downright deceptive in "trapping" nurses for their communities. NS Cole had just been discharged when a small, rural hospital begged her to come for just a few days of relief for their one and only nurse. Once Cole arrived, she realized there wasn't another train out for a week—and the nurse she was replacing did not come back on it. She had to do everything: admit patients, 'pour anaesthetics' during operations, and prepare baby formula: "I had to wash the damn diapers because they had no laundry service and I can remember washing the diapers on a scrubbing board, and crying into the tub: How did I get myself into this?" Cole remained six months because they were telling her how desperately they needed staff. But she finally decided, "I've got to get out of this."[234]

As the military discharged nurses, the Canadian Nurses Association and provincial organizations sought to match civilian needs to nurses' availability. A two-page spread in the *Canadian Nurse* classified available opportunities into two categories: positions open to newly-graduated nurses and positions open to nurses with experience or advanced preparation.[235] It classified the employment opportunities as institutional nursing, public health nursing, nursing education, and private duty with accompanying salary grids.

The RNAO Placement Service reported fifty-four inquiries in March 1946 (of which eighteen were recently-discharged Nursing Sisters) but a total of 672 nursing vacancies in Ontario. Of the eighteen Nursing Sisters, the service referred five to interim placements while they waited for university courses. Another nurse never showed up for her placement. Two more went to the Toronto General Hospital as general duty nurses but "proved very unsatisfactory as they resigned after two days duty." Two nurses were placed successfully, two nurses placed themselves, and two more presented "definite problems related to handicaps."[236] By September 1946, the Placement Service report was even more disparaging. It noted a declining interest in bedside nursing and an "alarming" number of nurses seeking work in industry, clinics, and doctors' offices, but "unwilling to accept individual responsibility for hospital needs."[237] Discharged

Nursing Sisters did not solve the postwar hospital nursing shortage and since so few of them remained in nursing, it is important to examine the experiences of those who did.

Returning military nurses made it clear that they were not interested in assuming previous practice roles and to some degree, the profession partially acknowledged that change was necessary. One writer called for cooperation between civilian and returning nurses:

> War nursing . . . has its own techniques, practices, methods and discipline . . . .A sudden change-over to duty in a civilian hospital after five years' absence will test the tolerance, understanding and patience of all concerned. . . . [M]any of the overseas nurses on discharge will feel the need for at least some re-orientation, and others will find satisfaction in taking a post-graduate course. As there is such urgent need for nurses in the administrative and teaching specialties every encouragement should be given the returned nurses with the necessary qualifications to take training along these lines. Their recent experience, so rich in providing an opportunity for a broader outlook and greater understanding, should be the best possible foundation on which to build future leaders in the nursing field.[238]

The *Canadian Nurse* initiated a "Nurses to Know" section (later called "Nursing Profiles") during 1945. Nursing Sisters were prominent in these features at first but by 1948 much of the interest seemed to have waned. Their profiles are interesting, however, as these military nurses are portrayed as extraordinary women, heroines, and leaders in the profession. The profiles provide glimpses of their postwar careers, as nurses who did remain in the profession. These profiles corroborate the NSD and the oral history interviews that I conducted. Almost without exception, the Nursing Sisters who stayed in nursing used their benefits for university courses in supervision, teaching, administration—and overwhelmingly, for public health courses.[239] Those who stayed in more direct practice typically chose operating room technique and psychiatric nursing courses that lasted six months. NS Tritt went to the McGill University School for Graduate Nurses for one year, taking courses in teaching and supervision after which she taught briefly at a hospital school of nursing until she married. She explained that she only took the one year course and received a diploma because she didn't have the qualifications for regular university admission (grade 12)—like many nurses of that period.[240]

For the most part, nurses made choices that were consistent with their prewar career patterns. Most of them had already been in positions of leadership or had moved away from

bedside practice into public health, industrial nursing, education, supervision, etc. For them, military service had been a 'leg up' that was followed by a second 'leg up' in the form of further education or advanced opportunities. DVA councilors typically described Nursing Sisters as ambitious. One said, "Like many of these nurses she is very disappointed at not having had the opportunity of serving overseas. She is anxious to improve her value as a nurse now and take a post-graduate course in Lab work." Another councilor described a nurse as a "small wiry girl of 29. She has worked hard for her opportunities to take advanced schooling and hospital training. In the process her outlook has become cautious, and she has learned to drive a good bargain." One francophone nurse planned to use her credits to enhance language skills related to opportunities for home nursing. As her councilor explained, she was "très désireuse de suivre un cours afin de devenir aussi bilingue que possible car elle considère, et avec raison, que la connaissance des deux langues pourrait lui être d'un précieux appui dans l'exercise de ses functions comme infirmière-visiteuse."

During the 1945-46 academic year, there were 160 Nursing Sisters registered in universities across Canada and there were more applicants than could be accommodated.[241] As NS Mussallem recalled, "You even had to sit on the steps—they were just overflowing, and a lot of them went back. [T]hat was a tremendous boost for Canada, wasn't it--all those nurses?. . . It should have ultimately ended in better health care. Some of them were going for certificates and diplomas. . . . Others were completing their baccalaureate degrees."[242] There was a great influx of war veterans (not just nurses) and as Mussallem explained, the overflowing courses tended to be general education ones and not necessarily nursing courses. The Canadian Nurses Association successfully lobbied the federal government to extend the time limit for nurses to use their credits, arguing that returning nurses were also needed to help with the shortage.[243]

The nursing profession and two university schools of nursing in particular, McGill and the University of Toronto, benefited from the war and nursing shortage, through special grants to expand their nursing education programs. In the *Canadian Nurse*, Ethel Johns urged nurses to 'seize the priceless opportunity' to push for university education for nurses in 1941, when she

argued: "The community will accept financial responsibility for educating nurses if we prove that we are indispensable to health and welfare."[244] Recruitment efforts had already begun in 1942 when Canadian Nurses Association lobbied for funding to prepare educators and supervisors in order to increase the enrollment of students in the schools of nursing.[245] The W. K. Kellogg Foundation announced grants for nursing education to a maximum of $4000 per school of nursing for 115 institutions in the United States and Canada.[246] In the same year, the Canadian government provided the Canadian Nurses Association with a grant of $115,000 for recruitment, teaching facilities, and the preparation of graduate nurses in teaching, supervision, and administration.[247] Federal grants amounted to $250,000 for 1944-45 and to $159,970 for 1945-46.[248] While these sources of funding were very important, they were inadequate for long-term support, especially for nursing programs that had not been able to secure firm positions within universities to that point. The great influx of nurses under the Veteran's Charter of benefits was instrumental in placing these two university nursing programs on solid economic footing—regardless if nurses took certificate courses, diploma courses, or completed a degree. Comparing the pre- and postwar situation at the School for Graduate Nurses at McGill University, NS Tritt concluded:

> During the Depression, McGill wanted to close the school. They finally agreed if nurses could raise enough money to keep it going, they could keep it going. So Miss Lindeburgh and all her staff had rummage sales, had card parties, had everything and anything to raise money plus many of the girls who couldn't afford it, handed in money. And they gave extra classes and they gave anything and everything. . . . Well then I guess about 1945, the Kellogg Foundation gave them a grant. So that put them on a better footing. Then, with all the girls coming back from overseas who took post-graduate [with their veterans' benefits]—that really set them up. So from then on, it was a going concern.[249]

Approximately one-third of the Nursing Sisters used their educational benefits, but few returned to hospital nursing where the greatest shortage of nurses existed.[250] Almost 20% took certificate or diploma courses, and only 12.9% completed degrees.

Returning Nursing Sisters found themselves in contradictory positions related to postwar medical technology. Many feared they had been away from civilian hospitals too long, and that medical technology had changed too much. On one hand, they were more familiar with penicillin,

transfusions, intravenous therapies, triage, burns, and wound care. But on the other hand, their expertise lay in a narrow domain associated primarily with trauma and young men. Civilian hospitals did not typically have a large proportion of young male patients, mass casualties, or the type of wounds caused by bombs, shells, and artillery. NS Jean Wheeler said, "I felt I needed to be re-trained . . . . I was afraid to go into a general hospital" because of all the changes that had taken place while she was gone and the lack of general experience.[251] And NS Taylor didn't tell anyone she had been a military nurse: "I don't think I ever told anybody that I was an overseas nurse because they might think I didn't know anything. . . . People have different ideas. They just thought we went over to have a fun time."[252]

Many Nursing Sisters also described experiencing a milieu in the military that did not exist in civilian hospitals. They referred to working as a team, being focused on a common goal, and experiencing less competitiveness compared to prewar training school rivalries. NS Van Scoyoc said, "[T]he spirit was so different." She chose to become a DVA hospital supervisor because of her comfort level there. She only worked in civilian nursing after her military retirement:

> I think we felt when you'd been over almost for (over four) years, things had changed. And even if there hadn't been a war, things would have changed. And you felt . . . curtailed in what you had done. But in some other ways you weren't as well-educated as the nurses that were there [in civilian hospitals]. It was an odd feeling. . . . Eventually, I went into civilian nursing after I was in seventeen years after the war. . . . And I always thought I was fortunate (when I went to the Montreal Children's without taking more education)--that they would keep me as a supervisor because most of the supervisors there were well-educated. . . . I don't think that many nurses . . . really got back into the act in the civilian field. . . . There wasn't really much room for these nurses that had been in the very senior positions [in the military].[253]

Other Nursing Sisters also mentioned that they were used to being more independent, and trusted to practice more autonomously. As NS Cole explained, "We were underemployed [regarding] what we were allowed to do . . . . You [had] to call an intern."[254] And NS Oakes felt this way: "I would think it would be difficult to go back to your own hospital and get back into the routine you left. . . . I didn't do that."[255]

Hospitals were also unable to use the skills, knowledge, and autonomy acquired by the Nursing Sisters, because they still relied predominantly on a student workforce for direct patient care. NS MacLean worked for a brief period to support her husband who was studying pharmacy under veteran's benefits. She recalled the difficult workload at the Ottawa Civic Hospital caring for patients who sometimes had to wait an hour. She said, "I ran like mad. And I finally got them all finished—four in this room, and of course they complained. . . . Somebody had written something to the paper [the *Ottawa Citizen*] about the nurses at the Civic hospital."[256] MacLean was referring to editorials that precipitated a judicial inquiry in the state of patient care at the Ottawa Civic Hospital in 1949. In the final report, the inquiry fixed blame for the conditions on the severe understaffing, an increased use of medical technologies, and a student workforce too novice to provide appropriate care.[257] Over the next decades, hospitals struggled with a continuing nurse shortage as nurses moved away from restrictive practice environments.[258] Dr. Lorne Gilday, of the Western Division of the Montreal General Hospital, summarized the situation in 1948: "Nurses come and nurses go, and more seem to go than come."[259]

Although the majority of Nursing Sisters did not return to the hospitals, many medical technologies did become part of hospital practice, such as penicillin, transfusions, and intravenous therapy. As some of the first nurses to work with these technologies, they helped to shape the postwar uses and associated nursing roles based on their reported experiences with mass casualties—in spite of their avoidance of hospital work. Nursing Sisters claimed that their military experiences influenced civilian practice in several other areas: the development of nursing assistant programs; team nursing; specialty units; and early ambulation for patients. For example, NS Ferguson spent a major part of her postwar career working with the training of nursing assistants in Alberta: "I came home convinced that we in nursing needed a second level of nursing to help us. . . . Because the responsibilities were becoming so heavy. . . . [D]octors were getting so many more complicated things to do. . . . [N]urses were being trained as specialists. . . . So we needed a second level of nursing to help with the basics."[260] A program to train assistants in Ontario began in September 1946, and the first class of Certified Nursing

Assistants graduated in 1947.[261] A Montreal General Hospital report referred to nursing assistants, practical nurses and trained attendants in 1945, and by 1948, there was an experimental, jointly-sponsored Montreal School for Nursing Aides.[262] Kathryn McPherson refers to trained attendants or aides, in Manitoba and Québec, as early as the 1920s,[263] while the Weir Report (1932) includes a brief analysis of the extent to which the public hired 'practical nurses'.[264] But it is unclear if these latter were trained or untrained caregivers. Thus, it is not clear whether nursing assistants were the result of wartime experience with medical orderlies in the armed forces, or the result of the nursing shortage that began long before the armistice.

It is also unclear if these assistants advanced nursing practice, or if they exacerbated a festering debate within the profession regarding technical and professional nursing. In many ways, medical technology and war complicated the situation on both ends of the spectrum by adding another level of nursing assistant with less training, and by adding nurses with more education at the university or post-graduate level. Ironically, those technical skills and expertise that military nurses had used to become Nursing Sisters, now provided access to university education and professional advancement through veterans' credits. But professional advancement moved most of the Nursing Sisters away from direct patient care in hospitals where medical technology was proliferating, and this shift inhibited the development of practice knowledge there.

Some Nursing Sisters attributed changes in the *delivery* of hospital nursing care to their wartime experiences. They spoke often about team nursing and team spirit; however, nursing service became increasingly fragmented and organized along functional lines through the postwar period. For example, NS Ruby Hull wrote in 1945 about the benefits of a "special department know as the post-anesthetic Recovery Room" in the RCN where patients could be held overnight if necessary.[265] She described the set up for oxygen therapy, duodenal tubes and Wangensteen suction, the use of sedatives and stimulants, and nursing observation for hemorrhage, shock, plaster casts, and surgical dressings. This was a change from the usual civilian practice of recovering patients on regular nursing wards.[266] Several Nursing Sisters

mentioned a dramatic increase in the use of drugs during the war (compared to previous civilian practice). One unidentified hospital organized a central unit in 1947 (the Penicillin Treatment Centre) where one graduate nurse was responsible for administering all the penicillin throughout the hospital in an effort to deal with the workload this technology created for nurses.[267] Specialty teams and units (such as the burn units, psychiatric wards, and Maxillo-facial plastics team) where patients, equipment, and nurses were clustered for more efficient care were forerunners to specialized units such as intensive care units, coronary care units, and dialysis units that emerged in the 1950s and 1960s.[268]

Wages comprised yet another area, where the precedent created by Nursing Sisters likely made a significant difference, in both wartime and postwar nursing. The armed forces granted equal pay to female and male officers of the same rank and this meant that nurses earned two to three times their typical prewar salaries, plus benefits. A Canadian Nurses Association recruitment brochure for 1944-1945 compared different categories of civilian nurses' monthly salaries: $50-125 plus maintenance for staff nurses; $125 for a head nurse; $125-150 for an industrial nurse; $100-125 plus maintenance for operating room nurses; $125 for public health nurses; $150-175 for supervisors; and $125-150 for instructors.[269] These rates represented a substantial increase over those of the late 1930s and were more in line with military nursing salaries, as the civilian sector had to compete for the same pool of graduate nurses during the war but without the attraction that military nursing held. When there was no relief to the shortage after the war, salary improvements continued to be a recruitment strategy.

For Canadians, this generation of military personnel was also the first to experience a comprehensive health care program, partially to meet manpower commitments overseas, and partially to avoid postwar pension liabilities. Many of the armed forces personnel had gone through the Depression without medical or dental care. On enlistment, they got their teeth fixed and often had minor surgical repairs because those procedures made them fit for active duty. As NS Tritt said, "During the Army, you got everything. Once we got home, we got nothing."[270] Physicians were also aware of this significance for postwar medical care. As the Chairman of the

General Council of the Canadian Medical Association wrote, "Three quarters of a million young men and women in the Armed Forces are being educated to a new form of health care."[271] Military personnel had experienced an early form of universal medical care, and although universal hospital insurance was widely contested, by 1948 the first provincial program was in place in Saskatchewan.[272]

American historian Bonnie Bullough argued that the Second World War led to the acceptance of Blacks, men, part-time and married nurses, among other claims to a wartime nursing legacy.[273] But it is, again, more likely that the nursing shortage was as much an impetus for change as wartime experiences were—at least in Canada. Kathryn McPherson, Agnes Calliste, and Karen Flynn show the extremely slow eradication of racial and ethnic barriers in the profession during the 1950s-1970s, and the links of that eradication to both a growing demand for cheap nursing labour in order to cope with the postwar expansion of health care and the availability of Caribbean nurses.[274] But the Canadian Nurses Association did definitely viewed men as a potential solution to the nursing shortage. They surveyed provincial requirements and legislation for nurse registration, reporting in 1948 that all provincial acts were flexible enough to enable registration of male nurses except for Québec. But the only provincial associations that had accepted men, and registered them into training programs at that time, were Nova Scotia and Ontario.[275] Other provinces trained males as attendants, mainly in mental hospitals. Therefore, it is doubtful that these broader claims for a postwar Canadian civilian nursing legacy can be substantiated.

In summary, Nursing Sisters shaped postwar nursing practice by their absence as much as their presence in the civilian workforce. Substantial changes were already beginning by 1940, and the nursing shortage that developed by the mid-1940s was not significantly exacerbated by the small percentage of nurses who enlisted in the military. Student enrollment actually increased each year, and the profession implemented a variety of changes to retain nurses in practice—ostensibly related to the war effort.[276] But when demobilized nurses moved away from the

bedside and from nursing, it became clear that there were major underlying issues related to hospital working conditions, and that the shortage was not a temporary condition of war.

Summary

Nursing Sisters comprised an essential, but temporary and contingent, actor-network that was enrolled by the military-medical-technological system "for the duration" for the purpose of "winning the war." They enlisted as non-permanent members of the armed forces where they embraced technological roles and responsibilities, enabled the movement of surgical care forward to the frontlines, and used expanded skills to legitimate their presence there. In return, as this thesis demonstrates, military nurses also "enrolled" the system for their own purposes to gain access to further technological skills, more autonomy, increased social status as officers, and relatively stable employment for a period of time. As actor-networks, they shaped medical technologies as shared technologies through the addition of nursing perspectives to the care of soldiers. The work environment often placed medical officers and nurses in closer proximity where skills and knowledge could be more readily shared and developed. In these environments, nurses demonstrated their capabilities to assume expanded roles, but found that gender continued to constrain when and where they could do so.

Medical technology did not necessarily enable or constrain military nurses. Neither did it necessarily liberate or oppress military nurses. My sources indicate that technology was already shaping nurses' work, and the composition of the nursing workforce, before the onset of war. The extent to which Nursing Sisters developed expanded technological skills and knowledge was contingent on gendered social contexts. As they moved closer to military frontlines, and to the frontlines of medical technology, they experienced greater responsibility and autonomy. Military nursing practice was always constructed, however, in relation to the availability of men: physicians and orderlies. Nursing Sisters incorporated roles and responsibilities of both groups, whenever these men were unavailable. On one hand, work that could be characterized as dirty

work was readily delegated by physicians to nurses once it became routinized, boring, inconvenient, or easy enough for a woman to do. On the other hand, nurses were able to delegate much of the routine personal care of patients to medical orderlies, while reserving key technologies, such as medications, dressings, blood pressures, and transfusions for themselves.

Military nursing experiences had a limited impact on the postwar nursing profession. Although some Nursing Sisters had served overseas in expanded technological roles, there were many nurses whose practice remained substantially unchanged. In addition, few of these nurses returned to hospitals or to direct nursing practice. But their withdrawal from the postwar workforce provided an impetus for the reform of hospital working conditions over the next decades. Although much of their practice expertise was lost to civilian hospitals, Nursing Sisters influenced the profession in other ways. Several universities made the transition to stable funding for nursing programs as military nurses capitalized on their benefits for further education. Public health nursing and specialties such as psychiatry and industrial nursing (or occupational health), benefited greatly from an influx of military nurses who brought advanced education, and autonomy that they had developed during the war.

Once the war ended, the vast majority of the Nursing Sisters lost the identity and legitimacy of military nurses that they had enjoyed as part of the military-medical-technological system. In the next chapter, I examine how these losses contributed to the shaping of a symbolic community that continued beyond the war.

Endnotes

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[1] J. L. Granastein, *Canada's Army: Waging War and Keeping the Peace* (Toronto: University of Toronto Press, 2002): 230 and Mark Zuehlke, *Ortona: Canada's Epic World War II Battle* (Toronto: Stoddert, 1999): 290-291. There are a small number of exceptions to the media presentations such as Wallace Reyburn, "Medicine goes to War," *Maclean's Magazine*, 1 September 1943: 18-19, 32, 34-35, and 37. Medical journals however, generally attributed a decline in mortality rates to the availability of nursing care. See F. Mills, "A Letter from a Field Surgical Unit, CMF (Overseas)," *Journal of the Canadian Medical Services* 1, no. 3 (March 1944): 187.

[2] Cynthia Enloe, *Does Khaki become you? The Militarisation of Women's Lives* (Boston: South End Press, 1983): 108.

[3] Margaret M. Allemang, audio-taped interview with author at Toronto, Ontario on 26 April 2001.

[4] Gail Braybon and Penny Summerfield, *Out of the Cage: Women's Experiences in Two World Wars* (London: Pandora, 1987). Braybon and Summerfield argued that new wartime opportunities liberated British women and let them 'out of the cage.'

[5] Jan Bassett, *Guns and Brooches: Australian Army Nursing from the Boer War to the Gulf War* (New York: Oxford University Press, 1992): 2. Bassett suggested that war merely 'moved the cage' for Australian military nurses because the same physicians and nurses, who staffed military hospitals, were those who staffed the civilian hospitals and they brought their former practices with them into the military.

[6] William H. Schneider, "Blood Transfusion in Peace and War, 1900-1918," *Social History of Medicine* 10, no. 1 (April 1997): 105. Schneider pointed out the relative acceptance of increased risk in new medical technologies during times of war was based on the example of blood transfusion. He described a shift in transfusion acceptance from "a medical curiosity and procedure of last resort to a practical and relatively simple treatment that demonstrated its value in saving thousands of lives" in less than twenty years. He suggested war served to perfect and diffuse techniques that were already evolving, during a period when risk taking was more acceptable to the public.

[7] Wiebe E. Bijker and John Law, "General Introduction," in *Shaping Technology/Building Society: Studies in Sociotechnical Change*, eds. Wiebe E. Bijker and John Law, pp. 1-14 (Cambridge, Massachusetts: MIT Press, 1992): 12-13. Thomas Hughes argued that "successful entrepreneurs were those who thought in system terms, not only about the technical character of their innovations but also about their social, political, and economic context" (p. 12). Michel Callon and John Law viewed technology as messy networks that combined technical, social, and economic elements while stressing that these elements were constituted and shaped within those networks, and included both human and non-human actors (pp. 12-13). The Social Construction of Technology (SCOT) approach is associated with Wiebe Bijker, Thomas Hughes, and Trevor Pinch as developed from the sociology of science, wherein scientific knowledge, technologies and technological practices are socially-constructed and negotiated (p.13). Key essays that explain these frameworks include: Trevor J. Pinch and Wiebe E. Bijker, "The Social Construction of Facts and Artifacts: Or How the Sociology of Science and the Sociology of Technology Might Benefit Each Other," pp. 17-50; Thomas P. Hughes, "The Evolution of Large Technological Systems," pp. 51-82; and Michel Callon, "Society in the Making: The Study of Technology as a Tool for Sociological Analysis," pp. 83-103 in Wiebe E. Bijker, Thomas P. Hughes, and Trevor J. Pinch, *The Social Construction of Technological Systems: New Directions in the Social History of Technology* (Cambridge, Mass: MIT Press, 1989.

[8] The links between various components of an actor world are clearly visible in an early description of the United States' Committee on Medical Research published in 1948. There were a total of 593 contracts worth $24.6 million involving 137 organizations in 30 states, the District of Columbia, and the Canal Zone related to World War II medical research—with blood transfusion,

malaria, and penicillin research as the largest components. See Irvin Stewart, *Organizing Scientific Research for War: The Administrative History of the Office of Scientific Research and Development* (Boston: Little, Brown and Company, 1948): 104-105.

[9] Donald H. Avery, *The Science of War: Canadian Scientists and Allied Military Technology during the Second World War* (Toronto: University of Toronto Press, 1998): 4-8. Avery identified four characteristics that support the concept of a military-industrial complex: increased federal sponsorship of research, dominance of national security as an engine of research and development, the appearance of Big Science, and new co-operation with universities and engineering schools. He studied a core group of four military science mandarins (A.G.L. McNaughton, C.J. Mackenzie, Otto Maass, and Frederick Banting) who mobilized the Canadian scientific community for the war effort through the National Research Council and the Department of National Defence but he limited his examination of the medical sciences primarily to Banting's involvement with chemical and biological warfare.

[10] Alex Roland, "Technology and War: The Historiographical Revolution of the 1980s," *Technology & Culture* 34, no. 1 (1993): 126. Roland used the concept of a military-industrial complex as defined by William McNeill in *The Pursuit of Power: Technology, Armed Force, and Society since A.D. 1000* (Chicago: University of Chicago Press, 1982): 118, writing: "According to McNeill it is nothing more nor less than the active collusion of government officials and arms-industry executives in attempting to shape national security policy."

[11] Bruno Latour, *Science in Action: How to Follow Scientists and Engineers through Society* (Cambridge, Massachusetts: Harvard University Press, 198); John Law and John Hassard, *Actor Network Theory and After* (Oxford: Blackwell Publishers, 1999); Michel Callon, "Some Elements of a Sociology of Translation: Domestication of the Scallops and the Fishermen of St. Brieuc Bay," in *Power, Action and Belief: A New Sociology of Knowledge?* ed. John Law, pp. 196-233 (London: Routledge and Kegan Paul, 1986), and "The Sociology of an Actor-Network: The Case of the Electric Vehicle," in *Mapping the Dynamics of Science and Technology: Sociology of Science in the Real World*, eds. Michel Callon, John Law, and A. Rip, pp. 19-34 (Basingstoke: Macmillan, 1986). Feminist historians of technology are not comfortable with current sociological models although they frequently try to find a compromise or make existing models fit. Most often their critiques concern the lack of attention to gender and other variables of difference, in models that assume all technological actors to be equal in power and status, or that focus solely on the privileged level of scientists and engineers with the occasional consumer added. Women are typically invisible in most analyses of the past fifteen years as noted by Rosalind Gill and Keith Grint, "The Gender-Technology Relation: Contemporary Theory and Research," in *The Gender-Technology Relation: Contemporary Theory and Research*, eds. Keith Grint and Rosalind Gill, (London: Taylor & Francis, 1995): 18-19. Also refer to the article by Susan Ormrod in the same publication: "Feminist Sociology and Methodology: Leaky Black Boxes in Gender/Technology Relations": 32.

[12] Mary Ellen Purkis, "Embracing Technology: An Exploration of the Effects of Writing Nursing," *Nursing Inquiry* 6 (1999): 153.

[13] American historian of nursing Bonnie Bullough described health manpower during the Second World War as assuming "an importance in successful warfare approaching that of arms and bearers of arms." See "The Lasting Impact of World War II on Nursing," *American Journal of Nursing* 76, no. 1 (January 1976): 118.

[14] Seldom is the power inherent in nursing care recognized either by nurses or non-nurses. Denise Gastaldo and Dave Holmes advocate the use of Foucault's theory of power/knowledge to "explain nursing . . . as an agency of governmentality in the era of bio-power. The political dimension of nursing care, which reveals power relations between nurses, patients, families, and other professionals, challenges the notion of 'the powerless nurse' and places nursing at the centre of the production of discourses of control and creation of subjectivities." See Denise Gastaldo and Dave Holmes, "Foucault and Nursing: A History of the Present," *Nursing Inquiry* 6

(1999): 238.

[15] Ethel Johns outlined the Canadian Nurses Association's war action plan in an editorial, "The Time and Place of Meeting," *Canadian Nurse* 36, no. 8 (August 1940): 474. It included a statement of loyalty and proffered service, a gift to the government of Canada, and the investment in war bonds. See also, the address of CNA President Marion Lindeburgh, "A New Year Message," *Canadian Nurse* 39, no. 1 (January 1943): 15-16 for a call to total war on behalf of civilian nurses.

[16] American historical research on nurses and technology include Julie Fairman and Sarah Kagan, "Creating Critical Care: The Case of the Hospital of the University of Pennsylvania, 1950-1965," *Advances in Nursing Science* 22, no. 1(1999): 63-77; Julie Fairman, "Alternate Visions;" "Watchful Vigilance: Nursing Care, Technology, and the Development of Intensive Care Units," *Nursing Research* 41, no. 1 (1992): 56-60; and "New Hospitals, New Nurses, New Spaces: The Development of Intensive Care Units, 1950-1965," PhD dissertation (Nursing), University of Pennsylvania, 1992; and Julie Fairman and Joan Lynaugh, *Critical Care Nursing: A History* (Philadelphia: University of Pennsylvania Press, 1998); Margarete Sandelowski, *Devices and Desires: Gender, Technology, and American Nursing* (Chapel Hill, N. C. and London: The University of North Carolina Press, 2000); "'Making the Best of Things': Technology in American Nursing, 1870-1940," *Nursing History Review* 5 (1997): 3-22; "Thermometers & Telephones: A Century of Nursing and Technology," *American Journal of Nursing* 100, no. 10 (2000): 82-86; "The Physicians' Eyes: American Nursing and the Diagnostic Revolution in Medicine," *Nursing History Review* 8 (2000): 3-38; "Venous Envy: The Post-The Second World War Debate Over IV Nursing," *Advances in Nursing Science* 22, no.1(1999): 52-62; "Troubling Distinctions: A Semiotics of the Nursing/Technology Relationship," *Nursing Inquiry* 6 (1999): 198-207; "Ir)Reconcilable Differences? The Debate Concerning Nursing and Technology," *Image: Journal of Nursing Scholarship* 29, no. 2, (1997): 169-174; and "Exploring the Gender-Technology Relation in Nursing," *Nursing Inquiry* 4 (1997): 219-228. In the Canadian context, see Cynthia Toman, "'Trained Brains are Better than Trained Muscles': Scientific Management and Canadian Nurses, 1910-1939," *Nursing History Review* 11 (2003): 89-108; "Blood Work: Canadian Nursing and Blood Transfusion, 1942-1990," *Nursing History Review* 9 (2001): 51-78; and "Almonte's Great Train Disaster: Shaping Nurses' Roles and Civilian Use of Blood Transfusion," *Canadian Bulletin of Medical History* (2003): in press.

[17] The term 'kitchen physic' originated with Roy Porter's discussion of the plurality of medical practice prior to the professionalization movements at the end of the nineteenth century. He examined medicine and the rise of science, noting that ordinary people took responsibility for their own health, choosing from a wide range of folk healers and common household remedies to care for themselves and their families. They engaged in self-diagnosis and self-treatment. According to Porter, kitchen physic consisted of common ingredients (usually botanical in origin)--easily formulated and administered by the lay public. In a similar manner, Toby Gelfand noted that not only medicaments but also prevailing concepts of disease, diagnosis, and available therapies were readily understandable to the educated public. See Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York: W. W. Norton and Company, 1997): 283 and 245-303; see also Porter, "Before the Fringe: 'Quackery' and the Eighteenth-Century Medical Market," in *Studies in the History of Alternative Medicine*, ed. Roger Cooter (Oxford: Macmillan Press, 1988): 1-27 and Toby Gelfand, "The History of the Medical Profession," in *The Companion Encyclopedia of the History of Medicine*, II, W. F. Bynum and Roy Porter, eds. (New York: Rutledge, 1993): 1131. Patricia D'Antonio referred to knowledge and practices shared between nurses, patients, and physicians during the mid-nineteenth century as nursing's 'domestic roots' based on the technologies available for health care. See Patricia D'Antonio, "Legacy of Domesticity," *Nursing History Review* 1(1993): 229-246 and Sandelowski, "'Making the Best of Things.'"

[18] Kathryn McPherson, "Science and Technique: Nurses' Work in a Canadian Hospital,

1920-1939," in *Caring and Curing: Historical Perspectives on Women and Healing in Canada,* eds. Dianne Dodd and Deborah Gorham, pp. 71-101 (Ottawa: University of Ottawa Press, 1994) and *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996): 86-94; Sandelowski, *Devices & Desires:* 72-78; "Thermometers & Telephones"; and "The Physicians' Eyes"; Toman, "'Trained Brains are better than Trained Muscles'" and "Blood Work."

[19] Sandelowski, "Venous Envy" and *Devices & Desires*: 100-102 and 107-117; McPherson, *Bedside Matters*: 5-6, 208, 220-221; Fairman, "Creating Critical Care" and "Watchful Vigilance;" Fairman and Lynaugh, *Critical Care Nursing*; Toman, "Crossing the Technological Line," "Blood Work," "Almonte's Great Train Disaster," and "'Body Work': The In-corporation of Medical Technology by Nurses," in *Women in a Knowledge-Based Society: Proceedings of the 12th International Conference of Women Engineers and Scientists*, CD-ROM (Ordre des ingénieurs du Québec, 2002). Also see, Katherine B. Knuckolls, "Who Decides What the Nurse Can Do?" *Nursing Outlook* 22 (1974): 627.

[20] Zane Robinson Wolf, *Nurses' Work: the Sacred and the Profane* (Philadelphia: University of Pennsylvania Press, 1988); Jacqueline Zalumas, *Caring in Crisis: An Oral History of Critical Care Nursing* (Philadelphia: University of Pennsylvania Press, 1995); Sandelowski, "Ir)Reconcilable Differences" and "Troubling Distinctions;" Donna Zschoche, and L. E. Brown, "Intensive Care Nursing: Specialism, Junior Doctoring, or Just Nursing?" *American Journal of Nursing* (November, 1969): 2370-2374; Marilyn Anne Ray, "Technological caring: A new model in critical care," *Dimensions of Critical Care Nursing 6,* no. 3 (1987): 166-173; and Alan Barnard and Rod Gerber, "Understanding Technology in Contemporary Surgical Nursing: A Phenomenographic Examination," *Nursing* Inquiry 6 (1999): 157-166.

[21] Sandelowski, *Devices and Desires*: 38.

[22] For good examples of this literature, see: Annetine C. Gelijns and Nathan Rosenberg, "The Changing Nature of Medical Technology Development," in *Sources of Medical Technology: Universities and Industry*, vol. 5 of *Medical Innovation at the Crossroads*, eds. Nathan Rosenberg, Annetine C. Gelijns, and Holly Dawkins, pp. 3-14 (Washington, D. C.: National Academy Press, 1995); Joanne Spetz, "Physicians and Physicists: The Interdisciplinary Introduction of the Laser to Medicine," in *Sources of Medical Technology: Universities and Industry*, pp. 41-64; Annetine C. Gelijns and Nathan Rosenberg, "From the Scalpel to the Scope: Endoscopic Innovations in Gastroenterology, Gynecology, and Surgery," in *Sources of Medical Technology: Universities and Industry*, pp. 67-96; Louis Galambos and Jeffrey L. Sturchio, "The Pharmaceutical Industry in the Twentieth Century: A Reappraisal of the Sources of Innovation," *History and Technology* 13 (1996): 83-100; Susan E. Bell, "Technology in Medicine: Development, Diffusion, and Health Policy," in *Handbook of Medical Sociology,* 4th ed., eds. Howard E. Freeman and Sol Levine (Englewood Clifts, New Jersey: Prentice Hall, 1989): 185-204; Bettyann Holtzmann Kevles, *Naked to the Bone: Medical Imaging in the Twentieth Century* (New Brunswick, N. J.: Rutgers University Press, 1997); and Susan E. Lederer, Subjected to Science: Human Experimentation in America Before the Second World War (Baltimore: The Johns Hopkins University Press, 1995).

[23] Stuart S. Blume, *Insight and Industry: On the Dynamics of Technological Change in Medicine* (Cambridge, Massachusetts: The MIT Press, 1992): 72.

[24] W. R. Feasby, ed., *Official History of the Canadian Medical Services, 1939-1945*, vol. II: *Clinical Subjects* (Ottawa: Queen's Printer, 1956) and William R. Feasby, "The Canadian Medical Services," in *Medical Services in War: The Principal Medical Lessons of the Second World War Based on the Official Medical Histories of the United Kingdom, Canada, Australia, New Zealand and India*, eds. Arthur Salusbury MacNalty and W. Franklin Mellor, pp. 469-559 (London: H.M.S.O., 1968); G. W. L. Nicholson, *Seventy Years of Service: A History of the R.C.A.M.C.* (Ottawa: Borealis Press, 1977); and Bill Rawling, *Death Their Enemy: Canadian Medical Practitioners and War* (Ottawa: author, 2001).

[25] Some examples include: John C. Sheehan, *The Enchanted Ring: The Untold Story of Penicillin* (Cambridge, Massachusetts: MIT Press, 1982); Gladys L. Hobby, *Penicillin: Meeting the Challenge* (New Haven: Yale University Press, 1985); and Richard Kapp, "Charles H. Best, the Canadian Red Cross Society, and Canada's First National Blood Donation Program," *Canadian Bulletin of Medical History* 12 (1995): 27-46.

[26] Sandelowski, "'Making the Best of Things.'": 45.

[27] Sandelowski, "'Making the Best of Things.'": 46.

[28] Sandelowski, "'Making the Best of Things.'": 157.

[29] For examples of nursing techniques during the first half of the twentieth century, see: Isabel Hampton Robb, *Nursing: Its Principles and Practice for Hospital and Private Use*, 3rd ed. (Toronto: J. F. Hartz, 1914) and Bertha Harmer and Virginia Henderson, *Textbook of the Principles and Practice of Nursing,* 4th ed. (New York: Macmillan Company, 1939).

[30] Edna Rossiter, audio-taped interview with Nina Rumen at Vancouver on 28 October 1987, Oral History Collection of the Registered Nurses Association of British Columbia Library [hereafter as RNABC].

[31] "Performance of Clinical Procedures by Graduate Nurses: A Special Study by Committee on Nursing and Nurse Education," in "Report of the Committee on Nursing and Nurse Education in Canadian Hospitals," Bulletin # 36 (1941): 48, RNAO fonds, 96B-5-14, Archives of Ontario [hereafter as AO].

[32] "Report of the Executive Secretary of the CNA," *Canadian Nurse* 38, no. 9 (September 1942): 725.

[33] This table has been constructed from data in "Performance of Clinical Procedures by Graduate Nurses: 48-57.

[34] "Report of the Executive Secretary of the CNA," *Canadian Nurse* 38, no. 9 (September 1942): 725.

[35] "Report of the Committee on Nursing and Nurse Education in Canadian Hospitals," (1943): 5, RNAO fonds, 96B-5-14, AO.

[36] Margaret Van Scoyoc, audio-taped interview with author at Kingston, Ontario on 13 June 2001.

[37] Of 1052 Nursing Sisters, five graduated from baccalaureate programs prior to enlisting in the armed forces: two from the University of Alberta and one each from the Universities of British Columbia, Saskatchewan, and Western Ontario.

[38] See previous research by McPherson on the second and third generations of Canadian nurses in *Bedside Matters:* 19-20, 78-81 and "Science and Technique": 71-101. Also see Toman on changes in the relationship between nurses and delegated skills in "Blood Work" and "Crossing the Technological Line."

[39] Based on the NSD sample of 1052 nurses, the three largest sources of graduate nurses were the Montreal General Hospital (6.0%), the Royal Victoria Hospital (5.1%), and the Toronto General Hospital (5.5%). Five hospitals supplied 20-36 nurses (1.9-3.4%) while 174 hospitals supplied the rest. There were 69 hospitals that had one graduate serving in the armed forces and 13 of these hospitals were in the United States and England. This sample included nurses from a total of 187 different hospital training schools across Canada and the United States, clearly bringing together nurses from diverse training contexts to work in military medical units.

[40] Constance Betty Nicolson Brown, audio-taped interview with author at Ottawa, Ontario on 3 June 2001.

[41] Fanny C. Munroe, "Military Nursing Service," *Canadian Nurse* 36, no. 8 (August 1940): 483.

[42] Pauline Cox Walker, audio-taped interview with author at Kingston, Ontario on 13 June 2001. In reality, the nurses aboard the *Lady Nelson* represented only seven provinces due to the constraint that they be selected in pairs with preference given to "self-reliant, good nurses, . . .

[who had] a good friend to go along because of the close quarters" for living and working onboard a ship." See the Marion C. (Story) McLeod Scrapbook on the *Lady Nelson*, dated April 1943, at the Alberta Association of Registered Nurses Museum and Archives [hereafter as AARN]; "Edmonton Service Personnel Aboard New Hospital Ship," *Edmonton Journal*, 15 April 1943; "Canada's First Hospital Ship Prepares for Maiden Voyage," *Halifax Mail*, 15 April 1943; "Nursing Sisters Arrive," *Maclean's Magazine*, 1 September 1943; "From Luxury Liner to Hospital Ship: 'Lady Nelson' Serves in New Capacity," *Canadian Hospital* 20, no. 6 (June 1943): 24-25; Joan Doree, audio-taped interview with Nina Rumen at Vancouver, British Columbia on 11 February 1987, RNABC; Ruth Littlejohn McIlrath, audio-taped interviews with Nina Rumen at Burnaby, British Columbia on 20 October 1987 and at Vancouver, British Columbia on 23 November 1988, RNABC.

[43] Kathleen G. Christie, "Experiences as a Prisoner-of-War, World War 2," interview with Charles G. Roland on 8 December 1982, HCM 28-82, Oral History Archives, Hannah Chair for the History of Medicine, McMaster University, Hamilton, Ontario [hereafter as HCM 28-82].

[44] Harriet J.T. Sloan, audio-taped interview with author at Ottawa, Ontario on 14 March 2001.

[45] Constance Bond Young, interview with Ella Beardmore at Omeemee, Ontario on 4 July 1989, Oral History Collection, Margaret M. Allemang Centre for the History of Nursing, Toronto, Ontario [hereafter as MMA]. Elizabeth B. Pense Neil, interview with Norma Fieldhouse at Kingston, Ontario in March 1987, MMA.

[46] Letter from Margaret Fletcher to her family, 18 September 1943, Margaret Fletcher fonds: 1933-1945, SC042, University of Victoria Archives and Special Collections, British Columbia Archives [hereafter as the Fletcher letters, BCA].

[47] Pauline Lamont Flynn, audio-taped interview with author at Ottawa, Ontario on 3 April 2001.

[48] Eva Wannop, audio-taped interview with author at Toronto, Ontario, 25 April 2001.

[49] Lois Bayly Tewsley, audio-taped interview with author at Ottawa, Ontario on 11 June 2001.

[50] Nicolson Brown interview.

[51] This point was made by Beatrice Cole Hunter, audio-taped interview with author at Edmonton, Alberta on 13 October 2001.

[52] BettyYoung Ramage Hamilton, audio-taped interview with author at Edmonton, Alberta on 12 October 2001.

[53] "RNAO Secretary-Treasurer Report for 1942-44," from the file "RNAO Secretary-Treasurer Report to the CNA Biennial Meetings, 1926-44," p. 3, 96B-6-06.

[54] Advertisements for new nursing textbooks in the *Canadian Nurse* during 1943 and 1944 highlighted revised content related to war and changing medical technologies. For example, the J.B. Lippincott Company described their books as having "many new and important wartime additions" including material on sulpha drugs, poison gases, shock and immunization—in addition to the "newest nursing technics [that] are clearly outlined for each clinical service." The Macmillan Company of Canada promoted their revised nursing textbooks as relevant to "wartime and postwar time needs." See, for example: "New Editions: For Wartime Teaching," *Canadian Nurse* 39, no. 7 (July 1943): 494-495; and "New Books! New Editions and Revisions of Nursing Texts," *Canadian Nurse* 40, no. 11 (November 1944): 889.

[55] Lily Clegg in Jean E. Portugal, *We Were There: The Navy, the Army, and the RCAF: A Record for Canada*, vol. 5 (Shelburne, Ontario: The Battered Silicon Dispatch Box, 1998): 2286.

[56] Young interview, MMA.

[57] Rawling, *Death Their Enemy*: 197, 215 and 220.

[58] For Canadian military use of blood and plasma transfusion, see Feasby, "The Canadian Medical Services": 542-544 and *Official History of the Canadian Medical Services*, vol. II: 277-295. For the history of penicillin, two good sources are: Sheehan, *The Enchanted Ring:* and

Hobby, *Penicillin: Meeting the Challenge*.

[59] For overviews on the history of blood transfusion, see: Ted Allan and Sydney Gordon, *The Scalpel, the Sword: The Story of Dr. Norman Bethune* (Toronto: McClelland and Steward, 1971); Maxwell Wintrobe, ed., *Blood, Pure and Eloquent: A Story of Discovery, of People, and of Ideas* (Toronto: McGraw-Hill Book Company, 1980); Richard Kapp, "Charles H. Best, the Canadian Red Cross Society, and Canada's First National Blood Donation Program," *Canadian Bulletin of Medical History* 12 (1995): 27-46; and Norman Miles Guiou, "Blood Transfusion in a Field Ambulance," *British Medical Journal* (22 June 1918) and *Transfusion: A Canadian Surgeon's Story in War and in Peace* (Yarmouth, Nova Scotia: Stoneycroft Publishers, 1985).

[60] Rawling, *Death Their Enemy*: 131-135.

[61] "The Canadian Serum Project," *Journal of the Canadian Medical Services* 3, no. 4 (May 1946): 374; Feasby, *Official History of the Canadian Medical Services*, vol. II: 277-295.

[62] Feasby, *Official History of the Canadian Medical Services*, vol. II: 277-278. Excellent documentary film sources include: "Canadian Blood Saves Lives on All Fronts," film (n.d.), ISN 82968; "Red Cross Blood Serves Canada," ISN 23851; "Who Sheds His Blood," audio-visual (1939), ISN 160916; "Our Blood for Their Lives," audiotape (1941), ISN 82176; and "Miracle Fluid," film (1950), ISN 19404, all produced by the National Film Board and available at the Division of Documentary Art, National Archives of Canada [hereafter as NAC].

[63] See previous discussion in Chapter 3.

[64] For very good photographs of this self-contained transfusion set and an explanation of how it was used, see J. C. McC. Brown, "A Simple Method of Serum Transfusion in the Field," *Journal of the Canadian Medical Services* 3, no. 2 (January 1946): 144-146.

[65] T. S. Williams, "Resuscitation in Battle Casualties," *Journal of the Canadian Medical Services* 2, no. 5 (July 1945): 525-526 and W. A. Scott, "Letter on Transfusion Service in Sicily and Italy," *Journal of the Canadian Medical Services* 1, no. 2 (January 1944): 108-109.

[66] Teresa M. (Woolsey) Weir, in *The Military Nurses of Canada: Recollections of Canadian Military Nurses*, vol. I, ed. E. A. Landells (White Rock, B.C.: Co-Publishing, 1995): 246 [hereafter cited as *Military Nurses of Canada*].

[67] Helen (Bright) Armstrong, in *Military Nurses of Canada*, vol. I: 183. Brenda McBryde described the British experience similarly in her memoir as a QAIMNS nurse, *A Nurse's War* (London: Chatto & Windus, 1979): 94.

[68] "A Canadian F.T.U.—C.A. Overseas," *Journal of the Canadian Medical Services* 2, no. 2 (January 1945): 113-114 and T. S. Wilson, "Resuscitation in Battle Casualties," *Journal of the Canadian Medical Services* 2, no. 5 (July 1945): 520-530.

[69] Fletcher letters, 20 September 1944, BCA.

[70] Fletcher letters, 30 October 1944, BCA.

[71] Frances Ferguson Sutherland, audio-taped interview with author at Edmonton, Alberta on 10 October 2001.

[72] See E. J. Pampana, "Scientific Progress and the Victims of the War," *Canadian Nurse* 41, no. 1 (January 1945): 45-49. Pampana highlights three technologies as important developments of The Second World War: the very early use of plaster-of-Paris splints, blood transfusion (especially the use of plasma in burn treatments), and the employment of sulphonamides, p. 46. Another article used militarized discourse to refer to the medical personnel who gave plasma in a civilian hospital as "shock troops;" see Katherine Inch, "The Bunyan Bag Treatment for Burns," *Canadian Nurse* 39, no. 3 (March 1943): 194.

[73] Alice Whiteside Gray, "Penicillin," *Canadian Nurse* 40, no. 1 (January 1944): 21.

[74] The secrecy surrounding the development of Penicillin is well-documented but less is known regarding the suppression of research findings on transfusion such as Rawling documented

related to controversies between Wilder Penfield, Frederick Banting, and Hans Selye over publishing research findings on shock. See *Death Their Enemy*: 132-133. The use of drugs as a military strategy was not new, as Daniel Headrick demonstrated in relation to quinine as a tool used by the British for the domination of Africa in *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century* (New York: Oxford University Press, 1981).

[75] "Life-Saving Drugs for the Wounded," *Canadian Nurse* 36, no. 7 (July 1940): 450. Sulphonamides comprised a group of early pharmacological agents that developed in relation to the use of salvarsan in the treatment of syphilis. They were introduced during the late 1920s and 1930s, and began to change both medical therapeutics and nurses' work. The sulphonamide group of agents were relatively effective against streptococci, and therefore, useful in both prevention and treatment of wound infections. British forces carried tablets with them and had been instructed to take one immediately upon being wounded, along with applying their own field dressing. Sulphonamides included sulphanilamide, sulphapyridine, and sulphaguanamide; they were known by trade names such as Prontosil and Neoprontosil. By 1939, their therapeutic ranges remain unclear but their toxic manifestations were well-known. See "Life-Saving Drugs for the Wounded," *Canadian Nurse* 36, no. 7 (July 1940): 450; E. J. Pampana, "Scientific Progress and the Victims of the War," *Canadian Nurse* 41, no. 1 (January 1945): 46; and Perrin H. Long and Eleanor A. Bliss, *The Clinical and Experimental Use of Sulfanilamide, Sulfapyridine and Allied Compounds* (New York: MacMillan, 1939): 11. Gladys Hobby pointed out the importance of sulfonamides during the 1930s as an indicator of shifting concepts of infection and chemotherapy as a cure for bacterial infection. See Gladys L. Hobby, *Penicillin: Meeting the Challenge* (New Haven: Yale University Press, 1985): 31.

[76] Perrin H. Long and Eleanor A. Bliss, *The Clinical and Experimental Use of Sulfanilamide, Sulfapyridine and Allied Compounds* (New York: MacMillan, 1939): 11. There are several good starting points for understanding the social history of Penicillin. Gladys Hobby pointed out the importance of sulfonamides during the 1930s as an indicator of shifting concepts of infection and chemotherapy as a cure for bacterial infection. With Penicillin, drug research also shifted from an 'individual' activity to a collaborative effort of universities, medical centers, government labs, and pharmaceutical industries. See Hobby, *Penicillin: Meeting the Challenge*: 31.

[77] Sheehan, *The Enchanted Ring:* xiiii. Sheehan claimed that only the Manhattan Project equalled the effort and resources poured into the development of penicillin (p. 1). A brief summary of the Canadian development, doses, indications, and issues can be found in Joint Services Penicillin Committee, "Memorandum on Penicillin," *Journal of the Canadian Medical Services* 2, no. 1 (November 1944): 62-68.

[78] Hobby, *Penicillin: Meeting the Challenge*: 145 and 172. The allocation of penicillin was made by War Production Board and by the fall of 1944, Squibb pharmaceuticals was advertising the eminent release of penicillin for civilian use in "Squibb Had Penicillin Ready," *Canadian Nurse*, 40, no. 10 (October 1944): 801.

[79] Hobby, *Penicillin: Meeting the Challenge*: 208-209.

[80] Venereal disease, in particular, was responsible for great numbers of admissions and required extensive treatment from three to four weeks duration—resulting in wastage of human resources. Yet left untreated, syphilis had devastating long-term results for military pension funds as well as for society. When Penicillin proved effective in returning soldiers to active duty within a matter of days, gonorrhea patients were quickly given priority to receive the drug. See David P. Adams, *"The Greatest Good to the Greatest Number": Penicillin Rationing on the American Home Front, 1940-1945* (New York: Peter Lang, 1991): 10-11 and Sheehan, *The Enchanted Ring*: xiii.

[81] Estelle Tritt Aspler, audio-taped interview with author at Westmount, Québec on 13 August 2001.

[82] Doris Taylor Rasberry, audio-taped interview with author at Pointe Claire, Québec on 19 June 2001. Dorothy Surgenor Maddock, audio-taped interview with author at Ottawa, Ontario, 26 June

2001. NS Kellough stated that nurses' skills were their greatest contribution to the war and that physicians expressed definite preferences for nurses to do the treatments and dressings. See Margaret Helena Kellough, interview with Margaret M. Allemang at Toronto, Ontario during April and May 1987, MMA.

[83] Wannop interview.

[84] G. W. L. Nicholson, *Seventy Years of Service*: 185-187. Nicholson described the role of the Mobile research unit and 8th Army Penicillin Team that introduced the antibiotic in field units in Italy at the end of 1943 and early 1944. The first recorded use of penicillin by a RCAMC unit in a forward area was on 11 January 1944 at No. 2 FSU where its use was initially restricted to cases of gas gangrene. By March the supply (and use) of penicillin increased. During the Liri Valley Campaign in June, the shortage of troops related to a high incidence of venereal disease (VD) was so severe that it justified the expense of penicillin for VD cases because of their rapid return to the front lines. Gwladys Aikens wrote about the insufflation of penicillin as a QAIMNS nurse as well. See Gwladys M. Rees Aikens, *Nurses in Battledress: The World War II Story of a Member of the QA Reserves* (Halifax: Cymru Press, 1998).

[85] Helen K. Mussallem, audio-taped interview with author at Ottawa, Ontario on 24 September 2001.

[86] Fletcher letters, 28 October 1943, BCA and in *Military Nurses of Canada*, v. I: 87.

[87] 17 February 1944, No. 1 FSU War Diary, RG 24, C-3, v. 15940, NAC.

[88] "Notes on Penicillin," 20 January 1944, from scrapbook compiled by Frances Ferguson Sutherland, AARN.

[89] Gaëtane Labonté Kerr, audio-taped interview with Lisa Weintraub on 11 April 1985, Oral History Collection, Concordia University, ISN 167796, National Archives of Canada [hereafter as NAC].

[90] Tritt Aspler interview.

[91] Claudia Tennant, in *Nursing Sisters of Canada Commemorative Directory* (Edmonton: Nursing Sisters Association of Canada, 1994): 38-39.

[92] Evelyn Pepper, in *Military Nurses of Canada*, vol. I: 53 and 56.

[93] Lamont Flynn interview.

[94] Jessie (Smith) Jamieson, in *Military Nurses of Canada,* vol. II : 157; Margaret H. Mills, interview with Margaret M. Allemang, 5 April 1991, MMA; Susan Isabel Rowland, interview with Ella Beardmore, 15 May 1988, MMA; and Kellough interview, MMA.

[95] Rita (Murphy) Morin, in *Military Nurses of Canada*, vol. II: 179; Doree interview, RNABC.

[96] Almost all of the interviews included comments on penicillin, its introduction, and the nurses' various experiences with it. See, for example, the interviews with Bayly Tewsley, Nicolson Brown, Cox Walker, Van Scoyoc, and Taylor Rasberry.

[97] Berna Tuckwell Thompson, interview with Ella Beardmore at Scarborough, Ontario on 10 June 1988, MMA and Mary Bray in Jean Portugal, *We Were There*, v. 5: 2238.

[98] Kellough interview, MMA.

[99] Strauss, Fagerhaugh, Suczek, and Wiener, *Social Organization of Medical Work*: 246-251 and 268-272; Jocalyn Lawler, *Behind the Screens: Nursing, Somology, and the Problem of the Body,* North American ed. (Don Mills, Ontario: Benjamin/Cummings Publishing Company, 1993): 44-50 and *The Body in Nursing* (Melbourne, Australia: Churchill Livingstone, 1997). See also the discussion in Sandelowski, *Devices and Desires*: 10-11.

[100] Weir described a whole ward of colostomy cases in Belgium and the need to rotate nurses out of this ward every few days in *Military Nurses of Canada,* vol. I: 245.

[101] See Rawling, *Death Their Enemy*: 150-152 on the Trueta method of wound management. The main issue in treating war wounds was fear of infection and gas gangrene (as was so

prevalent during the Great War) during this period prior to the availability of antibiotics. Trueta's method sought to avoid the closure of wounds that so often provided the medium for bacterial growth by extensive surgical debridement, packing the wound with sulfa powder and tulle gras, and encasing the entire area in a plaster of Paris cast for immobility during evacuation. The goal was to avoid exposing the wound to further dressing changes and risk contamination of the tissue while allowing it to drain freely into the cast material (accounting for foul smelling casts after one or two weeks). These casts were typically left in place until they could be removed under surgical conditions back in England, cleaned and re-dressed in the operating room.

[102] Feasby, *Official History of the Canadian Medical Services,* vol. I: 146; 139-142, 146-148, 155,198, and 313 for incidence statistics and prevention strategies. It was important to identify the causative agent to distinguish between benign tertian or quartan malaria and malignant tertian malaria that required treatment with quinine, although in desperation, commanding officers sometimes ordered all personnel to take quinine regardless of the state of health. Dean Swift, "The Laboratory Diagnosis of Malaria," *Journal of the Canadian Medical Services* 1, no. 5 (September 1944): 573-578; Rawling, *Death Their Enemy*: 177-178; and G.W.L. Nicholson, *Seventy Years of Service*: 164.

[103] Doris V. Carter, *Never Leave Your Head Uncovered: A Canadian Nursing Sister in World War Two* (Waterdown, Ontario: Potlatch Publications, 1999): 68-69.

[104] Doris V. Carter, audio-taped interview with author at Ottawa, Ontario, 22 June 2001. NS Nicolson also confirmed these procedures and roles as part of their experiences in Italy in the Nicholson Brown interview.

[105] Harmer and Henderson, *Textbook of the Principles and Practice of Nursing*: 763-772. Bertha Harmer wrote and revised her basic nursing texts throughout the first decades of the twentieth century. She was an instructor at the Toronto General Hospital School of Nursing as well as schools in the United States, becoming Director of the School for Graduate Nurses at McGill University, Montreal until her death just prior to the publication of this fourth edition. Virginia Henderson completed the revision and noted its conformity to the Curriculum Guide published by the main accrediting body for both Canada and the United States (the National League of Nursing Education) in 1937. See pp. v-vi. For comparison, refer also to one of the earliest published textbooks: Hampton Robb, *Nursing: Its Principles and Practice for Hospital and Private Use*: 327-328.

[106] Harmer and Henderson, *Textbook of the Principles and Practice of Nursing:* 763. See also pp. 765 and 772.

[107] Margaret Roe Dewart, audio-taped interview with author, Edmonton, Alberta on 15 October 2001.

[108] Lamont Flynn interview.

[109] J. A. MacFarland used the term "Plaster War" and described the work of Plaster Teams in "Trends in Military Surgery," *Canadian Nurse* 37, no. 2 (February 1941): 97-99. See also: E. A. MacNaughton, "Early Wound Closure and Treatment in Plaster of Ten Compound Fractures of the Femur from the Normandy Front," *Journal of the Canadian Medical Services* 2, no. 3 (March 1945): 237-247; Rawling, *Death Their Enemy*: 151-152; and Feasby, *Official History of the Canadian Medical Services,* vol. II: 177-180.

[110] Cox Walker interview.

[111] Van Scoyoc interview.

[112] Feasby, *Official History of the Canadian Medical Services*, vol. II: 200-207.

[113] Mary Bray, in *We Were There*, vol. 5: 2238-2239.

[114] Barbara Ross, in *We Were There*, vol. 5: 2252.

[115] Fletcher letters, 25 June 1944, BCA.

[116] Fletcher letter, 20 September 1944, BCA.

[117] Feasby, *Official History of the Canadian Medical Services*, vol. II: 207 and 203-204.

[118] Feasby, *Official History of the Canadian Medical Services*, vol. II: 200.

[119] For a good description, diagrams, and photographs of this system, see E. Gertrude Ferguson, "Continuous Gastric Drainage," *Canadian Nurse* 36, no. 6 (June 1940): 341-344.

[120] Nursing Sisters Tritt, Bayly, and Allemang also mentioned using this system.

[121] This unidentified nurse was quoted in "A Salute to our Nursing Sisters," *Canadian Nurse* 39, no. 12 (December 1943): 796.

[122] Kerr interview, NAC.

[123] Cole Hunter interview.

[124] Grace Paterson, audio-taped interview with Joan Williams, 18 November 1975, ISN 196088, NAC.

[125] Kellough interview, MMA.

[126] Patricia Moll, audio-taped interview with Lisa Weintraub on 5 July 1985, ISN 167813, NAC.

[127] Cox Walker interview; Roe Dewart interview.

[128] Pense interview.

[129] Van Scoyoc, audio-taped interview with Lisa Weintraub on 4 June 1984, ISN 167825, NAC.

[130] McBryde, *A Nurse's War*. 96.

[131] Adams, *"The Greatest Good to the Greatest Number":* 10; see also Bob Beveridge, Anne-Maree Kelly, Drew Richardson, and Richard Wuerz, "Science of Triage," paper presented at the Society for Academic Emergency Medicine conference at San Francisco, California on 25 May 2000, www.saem.org/download/kelly.

[132] Roe Dewart interview.

[133] An excellent illustration of a field medical card is included in David A. Gordon, *The Stretcher Bearers* (Stroud, Ontario: Pacesetter Press, 1995): 68.

[134] Nicolson Brown interview.

[135] Sloan interview.

[136] Jean Dorgan, in *Military Nurses of Canada*, vol. I: 131.

[137] Roe Dewart interview.

[138] MacNalty and Mellor, *Medical Services in War*. 140.

[139] R. I. Harris, "Treatment of War Fractures," *Journal of the Canadian Medical Services* 2, no. 1 (November 1944): 10.

[140] Toman, "'Trained brains are better than trained muscles'": 89-90.

[141] Geertje Boschma traced the development of holism as a concept that evolved through at least three stages during the mid-nineteenth through the twentieth century. Prior to the Second World War, she found that there was a comprehensive approach to nursing care that included physical, social, mental, and teaching aspects. She attributed its origins to the emerging public health and social reform movements of the early 1900s but suggested that aspects also transferred into hospital nursing by mid-century. See "The Meaning of Holism in Nursing: Historical Shifts in Holistic Nursing Ideas," *Public Health Nursing* 11, no. 5 (October 1994): 326-327.

[142] Lily Clegg in *We Were There*, v. 5: 2286.

[143] Van Scoyoc interview.

[144] Cox Walker interview.

[145] Sloan interview.

[146] Lamont Flynn interview.

[147] No. 4 CGH war diary for 30 June 1944, as cited in Nicholson, *Seventy Years*: 209.

[148] Lamont Flynn interview.

[149] Also see: Rawling, *Death Their Enemy*: 152-153.

[150] A tracheotomy is an artificial opening made into the trachea for the purpose of creating an airway for breathing. It was used during wartime, primarily, to preserve the airway in cases of traumatic injuries such as wounds and burns as well as for diphtheria cases where the airway could swell and obstruct itself. The opening was maintained by a metal cannula that remained in place and required close nursing observation as well as suctioning to remove secretions from it. Swallowing was extremely difficult as was verbal communication. NS Sloan also spoke of the challenge in giving "one man with no lower jaw or perhaps no lips or tongue four sulfa tablets crushed and given in water on the tip of a spoon or an eye dropper every four hours." See Sloan in *We Were There*, v. 5: 2282.

[151] A good civilian case study can be found in M. Scott Kelly, "The Nursing Care of Burns," *Canadian Nurse* 36, no. 11 (November 1940): 733-735. In this case, the patient required over a year of treatment and rehabilitation and tannic acid was still the primary immediate measure used.

[152] D. A. Macham, "The Nursing Care of Burns," *Canadian Nurse* 39, no. 2 (February 1943): 110-112; and Kathleen H. Clifford and Katherine Miller, "Nursing Aspects of Pressure Emulsion Dressings for Burns," *Canadian Nurse* 39, no. 1 (January 1943): 26-34.

[153] Clifford and Miller, "Nursing Aspects of Pressure Emulsion Dressings for Burns": 26. This article is interesting for the details of care. The authors described use of sulfathiazole emulsion dressings applied with a pressure bandage over it that was left in place for seven days and was ready for grafting by the fourteenth day. Photographs showed a closed and heated, canvas burn tent in which patients were placed. And finally, there were details for a six week plan of care as used at the Montreal General Hospital.

[154] A good overview of the treatment as developed at the special RCAF hospital wing at East Grinstead can be found in Rita Donovan, *As for the Canadians: The Remarkable Story of the RCAF's "Guinea Pisg" of World War II* (Ottawa: BuschekBooks, 2000): 138-143 and Alfreda F. Dearden, "An Operating Room Set-up for Plastic Surgery," *Canadian Nurse* 29, no. 2 (February 1943): 109-112. NS Dearden served at the Park Prewett Hospital, plastic surgery unit at the time she wrote this article in which she provides detailed descriptions of the technologies in use for grafting. See also, Feasby, *Official History of the Canadian Medical Services,* vol. II: 254-258.

[155] Wannop interview.

[156] See Feasby, *Official History of the Canadian Medical Services*, vol. II: 258.

[157] Joan Doree in *Military Nurses of Canada*, vol. II: 97.

[158] Doree in *Military Nurses of Canada*, vol. II: 97.

[159] Feasby, *Official History of the Canadian Medical Services*, vol. II: 258.

[160] "History of the RCAF Plastic Surgery and Jaw Injury Unit," *Journal of the Canadian Medical Services* 4, no. 1 (November 1946): 91.

[161] Donovan, *As for the Canadians*: 20 and 128. RCAF NS Enid Matheson Faulkner served at East Grinstead and confirmed this doubly-gendered position in which nurses served as the technology (or the therapy) to promote healing in her audio-taped interview with Elizabeth Kirkwood on 22 February 1989, RNABC.

[162] Frances Oakes, audio-taped interview with author at Guelph, Ontario, 15 May 2001.

[163] Ferguson Sutherland interview.

[164] Amy White, letter of 2 April 1944 to her parents from the HMCS Niobe, M. Amy White fonds, MG 30-E508, NAC [hereafter as the White letters]. White's description closely resembles the 'Bunyan Bag' treatment of burns in use at the Royal Victoria Hospital in Montreal. See Katherine

Inch, "The Bunyan Bag Treatment for Burns," *Canadian Nurse* 39, no. 3 (March 1943): 193-196.

[165] Surgenor Maddock interview.

[166] Wannop interview.

[167] Wannop interview.

[168] Roe Dewart interview.

[169] Sir Andrew MacPhail, *The Medical Services: Official History of the Canadian Forces in the Great War, 1914-1919* (Ottawa: King's Printer, 1925): 276.

[170] MacPhail, *The Medical Services:* 277-279.

[171] A. M. Doyle, "Psychiatry with the Canadian Army in Action in the C.M.F.," *Journal of the Canadian Medical Services* 3, no. 2 (January 1946): 100; and Terry Copp and Bill McAndrew, *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939-1945* (Montreal & Kingston: McGill-Queen's University Press, 1990): 43.

[172] Bill McAndrew, "The Soldier and the Battle," in *The Good Fight: Canadians and The Second World War*, eds. J. L. Granatstein and Peter Neary, pp. 124-140 (Mississauga, Ontario: Copp Clark, 1995): 128.

[173] Copp and McAndrew, *Battle Exhaustion:* 8-9 and 39-40. One major change within the RCAMC was the development and incorporation of screening tools for intelligence and mental stability as part of the new PULHEMS system (in 1943). PULHEMS was a medical classification system where recruits were evaluated by their physique, upper limb strength and movement, lower limb strength and movement, hearing, eyes (or visual acuity), mental status, and emotional stability. Recruits received a total score that determined acceptance into the service and any limitations placed on where they could serve. The RCAF had a similar system but it was much more complex with levels of conditions. See a fuller explanation in Jonathan C. Meakins, "'PULHEMS' Profiles for Army Medical Officers," *Journal of the Canadian Medical Services* 1, no. 3 (March 1944): 236-241.

[174] W. R. Feasby in MacNalty and Mellor, *Medical Services in War:* 527.

[175] W. R. Feasby in MacNalty and Mellor, *Medical Services in War:* 526.

[176] W. O. Glidden, "Psychiatry and Post-Discharge Problems," *Journal of the Canadian Medical Services* 1, no. 1 (November 1943): 52-56 and McAndrew, "The Soldier and the Battle": 130-134.

[177] Doree in *Military Nurses of Canada*, vol. II: 95-98; Copp and McAndrew, *Battle Exhaustion*: 25.

[178] Copp and McAndrew, *Battle Exhaustion*: 16-17.

[179] Feasby, *Official History of the Canadian Medical Services*, vol. II: 64

[180] Copp and McAndrew, *Battle Exhaustion*: 69.

[181] A. M. Doyle, "Psychiatry with the Canadian Army": 93 and "Report of the Neuropsychiatrist on the Sicilian Campaign," *Journal of the Canadian Medical Services* 1, no. 2 (January 1944): 106-107.

[182] Copp and McAndrew, *Battle Exhaustion*: 32 and 71.

[183] Doyle, "Psychiatry with the Canadian Army": 97; Feasby, *Official History of the Canadian Medical Services,* vol. II: 64.

[184] Doyle, "Psychiatry with the Canadian Army": 95, 98, and 100.

[185] Doyle, "Psychiatry with the Canadian Army": 97.

[186] G. S. Burton, "Report on No. 1 Canadian Neuropsychiatric Wing," *Journal of the Canadian Medical Services* 2, no. 5 (July 1945): 531-532; Feasby, *Official History of the Canadian Medical Services,* vol. II: 76.

[187] For important new research on the development of 'mental nursing' in Canada, see: Chris

Dooley, "'When Love and Skill Work Together': Work, Skill, and the Occupational Culture of Mental Nurses at the Brandon Hospital for Mental Diseases, 1919-1946," Master's thesis, University of Manitoba, 1998; and Veryl Tipliski, "'Parting at the Crossroads': The Development of Education for Psychiatric Nursing in Three Canadian Provinces, 1909-1955," PhD Dissertation, University of Manitoba, 2002.

[188] John Murray Gibbon and Mary S. Mathewson, *Three Centuries of Canadian Nursing* (Toronto: Macmillan Company, 1947): 388-389 and 416-417. The 1936 CNA Curriculum guide proposed 35-45 hours of Psychology and Mental Hygiene, 35-45 hours of Psychiatry, and 3 months of Psychiatric Nursing in response to increased interest and opportunities in psychiatric nursing during the 1930s. By 1947, however, twenty-one Schools of Nursing included affiliations with mental hospitals; six Ontario Hospitals had their own training schools with 2.5 years of mental nursing and 9 months of general nursing by affiliation; and mental institutions in Manitoba, Alberta, and British Columbia also established their own nurse training schools.

[189] C. M. Crawford, "What about Psychiatric Nursing?" *Canadian Nurse* 40, no. 11 (November 1944): 834.

[190] H. E. MacDermot, *History of the School of Nursing of the Montreal General Hospital* (Montreal: The Alumnae Association, 1940, re-printed 1961): 75 and Valerie Knowles, *Leaving with a Red Rose: A History of the Ottawa Civic Hospital School of Nursing* (Ottawa: Ottawa Civic Hospital School of Nursing Alumnae Association, 1981): 57.

[191] Copp and McAndrew described these therapies further. For a description on the use of diet in psychiatry, for example, see *Battle Exhaustion:* 14 and 24. Increasing doses of insulin were given, to induce a subcoma state, followed by 12 ounces of potatoes and 7 ounces of sugar three hours later—noting that this process resulted in rapid weight gain and improved physical condition.

[192] Aikens also described the use of pentothal with 'shell-shock' patients in *Nurses in Battledress:* 59.

[193] Jean Mary Ciceri, audio-taped interview with Nina Rumen, 13 January 1987, RNABC.

[194] Verna L. White Lister, personal communication with author at Vancouver, B.C. on 18 October 2001; and Lister in *Military Nurses of Canada*, vol. I: 254-256.

[195] Marjorie MacLean Root, audio-taped interview with author at Ottawa, Ontario on 15 June 2001.

[196] Anne Farries, "War Nurse Recalls Second World War Experiences," *Cranbrook Daily Townsman,* 10 November 1992.

[197] Refer to McAndrew, "The Soldier and the Battle" for a good discussion of the social construction and complexity involved for soldiers experiencing the stresses of The Second World War.

[198] Nicolson Brown interview. Nicolson's action is reminiscent of the iconography associated with Florence Nightingale's night rounds during the Crimean War. See Cynthia Enloe, *Maneuvers: The International Politics of Militarizing Women's Lives* (Berkeley: University of California Press, 2000): 198-199.

[199] Ferguson Sutherland interview.

[200] Florence Louise Jamieson, interview with Margaret M. Allemang at Toronto, Ontario on 24 April and 3 May 1987, MMA. Also see Jamieson in *Military Nurses of Canada*, v. III: 108-110.

[201] Bayly Tewsley interview.

[202] Roe Dewart interview.

[203] Rae Fellowes, "Nursing Care of 'Immersion Foot,'" *Canadian Nurse* 39, no. 9 (September 1943): 581-582.

[204] Cole Hunter interview.

[205] Cole Hunter interview.

[206] In addition to references from Chapter 2, see a summary of issues in Patricia E. Roy, J. L. Granatstein, Masako Iino, Hiroko Takamura, "The Hong Kong Disaster," in *The Good Fight: Canadians and The Second World War*, eds. J. L. Granatstein and Peter Neary, pp. 82-96 (Mississauga, Ontario: Copp Clark, 1995).

[207] Kay Christie, audio-taped interview with Joan Williams, 20 November 1975, ISN 196090, NAC; Kay Christie, "Behind Japanese Barbed Wire—a Canadian Nursing Sister in Hong Kong," *Royal Canadian Military Institute Year Book* (Toronto: RCMI, 1979): 11-13; Kathleen G. Christie, "M. & V. for Christmas Dinner," *Canadian Nurse* 63, no. 12 (December 1967): 28-30; Kay Christie, audio-taped interview with Bill McNeil for "Voice of the Pioneer," January 1992, Kay Christie fonds, 94.41, AARN; Jessie G. Morrison, "Kathleen Georgina Christie, 1911-1994: In Memoriam," 91.31, AARN; Bill McNeil, *Voices of a War Remembered: An Oral History of Canadians in The Second World War* (Toronto: Doubleday Canada, 1991): 96-104; Charles G. Roland, "Massacre and Rape in Hong Kong: Two Case Studies Involving Medical Personnel and Patients," *Journal of Contemporary History* 32, no. 1 (1997): 43-61 and *Long Night's Journey into Day: Prisoners of War in Hong Kong and Japan, 1941-1945* (Waterloo, Ontario: Wilfrid Laurier University Press, 2001): 10, 45, and 54.

[208] Christie interview, HCM 28-82.

[209] Christie, "M. & V. for Christmas Dinner": 29.

[210] Christie interview, NAC.

[211] Christie interview, HCM 28-82; Christie interview, NAC; and Christie, "Behind Japanese Barbed Wire: 13.

[212] Christie, "M. & V. for Christmas Dinner": 29.

[213] Christie interview, HCM 28-82.

[214] Christie interview, HCM 28-82.

[215] Some examples include Bullough, "The Lasting Impact of The Second World War on Nursing" and Mary T. Sarnecky, *A History of the U.S. Army Nurse Corps* (Philadelphia: University of Pennsylvania Press, 1999): 398-399.

[216] McPherson, *Bedside Matters*: 187-192, 203-204.

[217] Ethel Johns, "The Shape of Things to Come," *Canadian Nurse* 37, no. 2 (February 1941): 83-84.

[218] Refer to the RNAO Placement Service Advisory Committee Minutes and Reports (1945-46), 96C-1-08 and the RNAO Postwar Planning Committee—Minutes, Reports, and Correspondence (1944-46), 96C-1-09, Archives of Ontario; and Ethel Johns, "Background for Postwar Planning," *Canadian Nurse* 40, no. 3 (March 1944): 161-162.

[219] The files frequently contained supporting documents that indicated how they actually used their credits, and whether or not they completed educational programs. I acknowledge the limitations of working with data based on intended plans, and as one way to assess reliability, I compared my analysis of the NSD to the actual postwar nursing careers of my oral history participants, finding that both sources gave remarkably similar findings.

[220] Victoria T. Grando, "Nurses' Struggle for Economic Equity: 1945-1965," PhD thesis, University of Kansas, March 1994. Grando found similar attitudes on the part of Second World War nurse veterans in the United States. These women were especially adamant regarding their displeasure with hospital nursing because of poor wages and working conditions, and they opted out of nursing rather than revert to prewar incomes and professional opportunities. A 1945 American Nurses Association survey of nurse veterans thus indicated that 69% intended to return to nursing but only 16% of them to prewar positions.

[221] Nicholson noted in his research that the DVA continued to expand hospital services as soldiers returned from overseas units and the peak number of DVA nurses was 1785 during 1947. Not all

of these were former military nurses however and DVA positions downsized as veterans completed rehabilitation programs. Nicholson, *Canada's Nursing Sisters* (Canada: Samuel Stevens Hakkert & Company, 1975): 210.

[222] Dorothy M. (Grainger) Anderson, in *Military Nurses of Canada*, vol. I: 415.

[223] Tritt Aspler interview.

[224] Lyle M. Creelman, "With UNRRA in Germany," *Canadian Nurse* 43, no. 7 (July 1947): 532 and 552-556; "With UNRRA in Germany," *Canadian Nurse* 43, no. 8 (August 1947): 605-610; and "With UNRRA in Germany," *Canadian Nurse* 43, no. 9 (September 1947): 710-712.

[225] Barbara Logan Tunis, *In Caps and Gowns: The Story of the School for Graduate Nurses, McGill University, 1920-1964* (Montreal: McGill University Press, 1966): 81-83 and 126-127.

[226] These are discharge plans as stated to the Veteran's Councillors for the purpose of assessing eligibility benefits and extracted from the Discharge Interview form. Note that the percentages do not accumulate to 100% due to overlapping options wherein nurses might take a course prior to accepting employment, for example.

[227] This remark was taken from restricted military records, NAC. I am required to maintain the anonymity of the person.

[228] Roe Dewart interview.

[229] Cox Walker interview.

[230] C. B. Parker to J. W. Tice, letter of 7 July 1945 and 10 July 1945, HQ file 400-1-1, v. 3365, E-1-b, RG 24, NAC.

[231] "Postwar Planning Activities," *Canadian Nurse* 41, no. 4 (April 1945): 301-302.

[232] Laura Holland, "How Can Nurses Fight for Peace?" *Canadian Nurse* 41, no. 7 (July 1945): 549-551.

[233] H. Evelyn Mallory, "The Time for Action is Now," *Canadian Nurse* 42, no. 3 (March 1946): 201-203.

[234] Cole Hunter interview.

[235] "Opportunities in Nursing in Canada," *Canadian Nurse* 42, no. 6 (June 1946): 494-495.

[236] Report, 1 March 1946, "RNAO Placement Service Advisory Committee Minutes and Reports (1945-46)," 96C-1-08, Archives of Ontario.

[237] Report, 13 September 1946, "RNAO Placement Service Advisory Committee Minutes and Reports (1945-46)," p. 3, 96C-1-08, Archives of Ontario.

[238] Holland, "How Can Nurses Fight for Peace?" 550.

[239] The Committee on Postwar Planning reported seventy-one Nursing Sisters enrolled at nine university schools of nursing in February 1946. See "Notes from the National Office: Committee on Postwar Planning," *Canadian Nurse* 42, no. 2 (February 1946): 150. See also, Tunis, *In Caps and Gowns:* 81-83.

[240] Tritt Aspler interview.

[241] Marion Lindeburgh, "Postwar Planning Committee," *Canadian Nurse* 42, no. 9 (September 1946): 791-792. At McGill University, enrollment doubled to 127 graduate nurses during the 1946-1947 academic year. Of that number, 75% were returning Nursing Sisters. See Tunis, *In Caps and Gowns*: 83.

[242] Mussallem interview.

[243] "Extension of Time Limit for Candidates for University Courses in Nursing," *Canadian Nurse* 42, no. 3 (March 1946): 233-234.

[244] Ethel Johns, "The Home Front," *Canadian Nurse* 37, no. 9 (September 1941): 604 and 605.

[245] "Building for the Future," *Canadian Nurse* 36, no. 7 (July 1940): 415-416; and "Activities of the

School for Graduate Nurses, McGill University," *Canadian Nurse* 39, no. 5 (May 1943): 327-328.

[246] "A Timely and Generous Gift," *Canadian Nurse* 38, no. 8 (August 1942): 546-548.

[247] Marion Lindeburgh, "The Grant from the Federal Government," *Canadian Nurse* 38, no. 9 (September 1942): 607.

[248] Fanny Munroe, "Government Grant Committee," *Canadian Nurse* 42, no. 9 (September 1946): 782-783.

[249] Tritt Aspler interview.

[250] "Enrolment in University Schools of Nursing." *Canadian Nurse* 44, no. 8 (August 1948): 660-661.

[251] Ellen Jean Wheeler Keays, audio-taped interview with Sheila Zerr, 16 August 1994 at White Rock, British Columbia, RNABC.

[252] Taylor Rasberry interview.

[253] Van Scoyoc interview.

[254] Cole Hunter interview.

[255] Oakes interview.

[256] Root MacLean interview.

[257] The precipitating events were documented in two editorials of the *Ottawa Citizen*, 28 February and 4 March 1949. Three volumes of court evidence offer insight to the care received and concerns of these patients; refer to the files on "Judicial Inquiry, vol. I-III," City of Ottawa Archives, MG 38, vol. 36 and to the final report as "Civic Hospital," Minutes of the City Council, 2 August 1949, pp. 662-676, City of Ottawa Archives.

[258] This shortage was not unique to Canada. The American literature reveals similar issues and similar responses from the wider nursing profession. Sociology professor Everett Hughes conducted a study related to the postwar nursing shortage on behalf of the American Nurses Association. It included twenty projects in seventeen states over a period of four years, and found many of the same employment conditions as existed in Canada. He concluded that two major problems were a "combination of responsibility without comparable authority" and the need to "unchain the best educated and experienced nurses from desks and filing cabinets." See Everett C. Hughes, *Twenty Thousand Nurses Tell their Story* (Philadelphia: J. B. Lippincott, 1958): 270 and 272. Grando's socialist feminist analysis of the postwar American nurses' struggle for economic equity also found that they were severely unhappy with working conditions and many opted out of nursing. She suggests that expanded roles did not benefit nurses economically but did enable physicians to increase their incomes because they were freed to see more patients when nurses took over responsibilities. See Grando, "Nurses Struggle for Economic Equity:" 115-116, 156-157, and 220.

[259] MacDermot, *History of the School of Nursing of the Montreal General Hospital*: 77.

[260] Ferguson Sutherland interview.

[261] Dorothy G. Riddell, "Training Nursing Assistants," *Canadian Nurse* 43, no. 11 (November 1947): 851-854.

[262] MacDermot, *History of the School of Nursing of the Montreal General Hospital*: 77-78. The hospital collaborated with four other hospitals to sponsor the Montreal School for Nursing Aides, which moved several times until it was discontinued in 1961.

[263] McPherson, *Bedside Matters*: 222.

[264] Weir, *Survey of Nursing*: 306-307.

[265] Ruby G. Hull, "Recovery," *Canadian Nurse* 41, no. 9 (September 1945): 700-702.

[266] Other authors claimed that wartime nursing shortages required hospitals to centralize Recovery Rooms "to conserve nursing hours and labour" and to group other types of patients,

nurses and equipment for more efficient care giving. See Florence E. Dunn and Miriam G. Shupp, "The Recovery Room: A Wartime Economy," *American Journal of Nursing* 43, no. 3 (March 1943): 279 and Agnes Leon, "Postanesthetic and Postoperative Recovery Units," *American Journal of Nursing* 52, no. 4 (April 1952): 430.

[267] M. Décary, "Hospital Penicillin Treatment Centre," *Canadian Nurse* 43, no. 11 (November 1947): 847-850.

[268] Many of the interviewed Nursing Sisters made reference to specialty units as being linked to their experiences during the war when they had to prioritize patient care and cluster patients according to required skill sets. See interviews with Nursing Sisters Mussallem, Ferguson Sutherland, Maddock, Oakes, and Wannop.

[269] "What You Want to Know about Nursing," monograph (Montreal: Canadian Nurses Association, n.d.): 18, from "RNAO Background/Supplemental Material for CNA Nurse Recruitment, 1944-45," RNAO fonds, 96B-5-20, AO.

[270] Tritt Aspler interview.

[271] A. E. Archer, "Health Insurance," *Journal of the Canadian Medical Services* 1, no. 2 (January 1944): 162.

[272] For a good introduction into the development of the Canadian health care insurance system, refer to: Jacalyn Duffin, "The Guru and the Godfather: Henry Sigerist, Hugh MacLean, and the Politics of Health Care Reform in 1940s Canada," *Canadian Bulletin of Medical History* 9 (1992): 191-218; G. Harvey Agnew, *Canadian Hospitals, 1920-1970: A Dramatic Half Century* (Toronto: University of Toronto Press, 1974); and C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966* (Kingston, Ontario: McGill-Queen's University Press, 1986).

[273] Bullough, "The Lasting Impact of World War II on Nursing": 120.

[274] See McPherson, *Bedside Matters*: 211; Agnes Calliste, "Women of 'Exceptional Merit:' Immigration of Caribbean Nurses to Canada," *Canadian Journal of Women and the Law* 6, no. 1(1993): 85-102 and "Antiracism, Organizing, and Resistance in Nursing: African Canadian Women," *Canadian Review of Sociology and Anthropology* 33, no. 3 (August 1996): 361-390. See also Tania Das Gupta, "Anti-Black Racism in Nursing in Ontario," *Studies in Political Economy* 51 (Fall 1996): 97-116 and Karen Flynn, "Proletarianization, Professionalization, and Caribbean Immigrant Nurses," *Canadian Woman Studies/Les Cahiers de la Femme* 18, no. 1 (1998): 57-60. Also refer to: Florence H. Walker, "Notes from the National Office," *Canadian Nurse* 40, no. 9 (September 1944): 702; and "Notes from the National Office: No Racial Discrimination," *Canadian Nurse* 43, no. 12 (December 1947): 953.

[275] Marion Myers, "Sub-committee on Male Nurses," *Canadian Nurse* 44, no. 6 (June 1948): 470-471.

[276] These measures included: eliminating the marriage bar; introducing part-time work, split shifts, and a shorter work day; reducing the overall number of hours in a work week; introducing nursing assistants into the hospitals; raising salaries; and increasing benefits. The *Canadian Nurse* and CNA reports are full of descriptions related to these changes.

CHAPTER 5

STANDING "THE STRAIN OF PEACE":

COMMUNITY, COMMEMORATION, AND SOCIAL MEMORY

The Nursing Sisters had lived and worked in small, relatively-isolated, and strictly-regimented nurses' residences during their student training days. Those experiences resembled military medical settings to some extent, although the exigencies of war intensified relationships, patriotism, and loyalty to the military system. As we have seen, war brought them together from diverse regions and schools of nursing, but they were military nurses only 'for the duration.' As Nursing Sisters, they developed shared identities as Canadians, as women, as soldiers, and as members of specific military medical units. A return to 'peace,' however, disrupted these newly-created military identities almost as much as war had disrupted their civilian ones. While serving in Italy, NS Marguerite McLimont recognized the need to rebuild war-torn relationships as well as war-torn structures, in a poem entitled, "Prayer on Hearing V-E Day Proclamation." McLimont expressed her anxiety and uncertainty regarding these changes in one particular line: "Lord, give us strength to stand the strain of peace."[1]

In some ways, the postwar professional practice world became another 'no-man's land' where many Nursing Sisters struggled to find a sense of belonging and purpose. Some found themselves suddenly isolated from both the professional and the military world, feeling that they no longer had a place after the armistice. They were no longer soldiers, and some doubted their identity as nurses, questioning their ability to fit back into civilian practice. NS Margaret Van Scoyoc explained: "I think we felt, when you'd been over almost four years, things had changed. And even if there hadn't been a war, things would have changed. And you felt you . . . were curtailed in what you had done. But in some other ways, you weren't as well-educated as the nurses that were [in civilian practice]."[2]

This chapter uses the concepts of community, social memory, and commemoration to examine how military nurses' experiences during the war influenced their identity as Nursing Sisters following the war. Physical and social proximity intersected with gender, to create a community that was initially based on shared spaces and shared experiences. It was most remarkable that many of the Nursing Sisters whom I interviewed for this research continued to identify so strongly as a 'symbolic community' in spite of physical and social distance—even when some had never met previously during the war. Almost sixty years after the end of the war, NS Nicolson could still declare, "I'm Army! . . . You have a loyalty."[3] I argue that this body of Nursing Sisters constituted a symbolic community within which being a military nurse distinguished them from other women and from other nurses, and provided a measure of acceptance and understanding. It represented a social network and created a social memory with associated symbols, rituals, and discourse.

Since the 1980s, our understanding of 'community' has evolved from a spatial concept based on shared place, to a structural concept based on shared social networks, to recent literature that considers community as a mental construct based on shared values, norms, and moral codes which provide a sense of identity.[4] Sociologist and anthropologist, A. P. Cohen, points out that there are over ninety definitions of community in use, but ultimately, it is the meaning (or importance) attributed to a community that comprises its symbolism for the member.[5] Thus, a symbolic community is one in which "members make, or believe they make, a similar sense of things . . . with respect to specific and significant interests . . . ."[6] Community is always relational, with both similarity and difference implied as some things are held in common and some things set a community apart.[7] Benedict Anderson used the term 'imagined' community applied to nations and referring to a capacity for community even though most of the membership "will never know most of their fellow-members, meet them, or even hear of them, yet in the minds of each lives the image of their communion." He suggested community exists regardless of inequality and exploitation because it is conceived as a 'deep, horizontal comradeship.'[8] Charles Wetherell and his colleagues considered community to be a collection of personal relationships

that move beyond kinship, friendship, and neighboring ties while questioning the assumption that such ties are necessarily supportive.[9]

More recently, John Walsh and Steven High contribute a socio-historical perspective to the study of community by pointing to its potential as a concept for historical research that examines how communities emerged, how they worked, and what meanings they held within and without their boundaries. They consider community as a 'social process,' predicated on relationships and change over time, in which both its social and spatial aspects are dynamic and changing.[10] QAIMNS Nursing Sister McBryde wrote that after the war, many British military nurses retired from the profession and buried their war-time memories in domesticity and motherhood.[11] In a similar manner, Canadian military nurses indicated that they were busy 'getting on with life' in the immediate postwar period. Some did not renew their associations with other Nursing Sisters until later in life. Some did not even speak of their experiences publicly or privately until the mid-1990s.[12] As they entered their ninth and tenth decades, however, many nurses expressed an urgency to re-establish community and to re-construct meaning from their previous war experiences. Thus community takes on different meanings in different contexts, and its members attribute less or more importance to identification with it.

Janéa Tallentire examines the construction of a collective social memory, which she defines as "the shared narratives of a community's past."[13] She argues that social memory is an important strategy to ensure community identity and survival. Tallentire points out, however, that *how* memories are selected, agreed upon, and transmitted is often more important than *what* memories are selected.[14] Gender plays a significant role in shaping social memory, particularly that related to women and war. As Cynthia Enloe explains, "Postwar years in all countries are a time of continued gendered war waging. But now the battle is not to take the next hill. It is to capture the collective memory."[15] Literature and social memory of the Second World War have been dominated by male perspectives, while military women have almost disappeared from the scene, typically appearing in the margins and footnotes, if at all. The Nursing Sisters shared

some aspects of this mainstream military memory, but they also created their own 'memory on the margins' that served to sustain identity and meaning.[16]

The emergence of various protest movements during the 1960s-1970s, such as the New Left, antimilitarism, and second-wave feminism—rendered both military history and nursing history less and less popular. Feminist Joan Roberts and nurse Thetis Group point out the long-standing, contested relations between feminists and nurses in general, and particularly between feminists and military nurses. They note that feminists during this period were divided, however, and took stances that reflected "both a negation of militarism and an affirmation of the rights of women in the military."[17] Antimilitarism and second-wave feminism contributed to Nursing Sisters' invisibility and silence within the literature, positioning them as stereotypically female and subordinated, while aligning them with male oppressors within a militaristic system. Postwar military nurses, Nina Rumen and June Parker, referred to the influence of these social movements as contributing to a morale problem among military nurses during the 1960s and 1970s.[18] It is hardly surprising that many Nursing Sisters chose not talk about their experiences outside of their 'safe' community. In addition, the paucity of commemorative material memory such as artifacts, texts, monuments, the naming of public places, art and photography has limited the transmission of a military nursing social memory.[19]

In this thesis, I consider the Nursing Sister community from the perspective of a "social and spatial process,"[20] asking how it emerged, how it worked, how it re-created itself in postwar civilian settings, and what meanings it has held for its members. The community had roots in at least three prior experiences: hospital training school culture, military culture, and the fledgling Overseas Nursing Sisters Clubs (that convened as a national organization in 1932). It reproduced the prevailing gender, race, and class-based discourse related to military nursing, and shaped a social memory that basically conformed to prevailing military social memory. This symbolic community encompassed a diversity of internal sub-groups that were not always cohesive, nor supportive, although internal dissensions remained mostly hidden from public view.

While a large proportion of Nursing Sisters married and left nursing careers behind, others would never fit into women's socially-prescribed roles.[21] They left highly-structured settings where there were few individual decisions to make and privacy was rare, to disperse throughout Canada where they often found themselves to be the only ex-military nurses in the area. Some of them 'just got on with life' and never spoke of their experiences to family, friends, or co-workers, like NS Pauline Cox who decided not to reveal her military service to co-workers, in case they questioned her professional qualifications. NS Pauline Lamont became immersed in raising a family, and in following her husband's career, with no further involvement in the community until almost fifty years later.[22]

It is not clear what this community may have meant for military nurses who did not stay connected to it, either by choice or by circumstance. But a substantial number of them sought out other individual Nursing Sisters and either maintained or re-built close relationships that endured over the rest of their lives. According to a 1958 Nursing Sisters Association of Canada membership list, approximately 670 of them were still 'members in good standing' at least a decade after the end of the war.[23] The Nursing Sister community and its social memory have been constructed primarily by those who needed it, and found meaning in it.

The Emerging Community

Previous chapters have explored intersecting variables that brought the Nursing Sisters together as a distinct homosocial group that was isolated geographically, socially, and professionally from prewar relationships and identities. They frequently referred to a special camaraderie and closeness, as well as intense relationships that lasted a lifetime—relationships never again experienced in civilian nursing. NS Van Scoyoc explained that it was hard to compare these relationships to anything they experienced before or after the war: "Because the spirit was so different . . . . [W]e just seemed to be like one big family. . . . That was one thing that we missed so much when we came back to civilian life. . . . Right from the time you went in as a

recruit, you had that until the very end . . . all these friendships have lasted over the years, which is a great plus for us. . . . Comradeship--it was the most wonderful thing."[24]

Camaraderie was not unique to Nursing Sisters, however. Other soldiers and veterans also shared experiences, joined veterans' associations, and referred to themselves as 'war buddies.' For example, Karen Davis' research on women who joined the Women's Division of the Royal Canadian Navy during the 1940s and 1950s found that shared military experiences were highlights that extended into their civilian lives.[25] Jan Bassett notes that the Australian Nursing Sisters joined organizations such as the "Returned Army Sisters' Association" after the First World War and the "Returned Sailors, Soldiers, and Airmen's Imperial League of Australia" after the Second World War.[26] And both Brenda McBryde and Diane Fessler mentioned comradeship and reunions among their respective British and American nurse colleagues.[27] But we know little concerning the nature of these various associations and reunions, or what they ultimately meant to their members.[28]

One of the roots for intense and enduring relationships among Nursing Sisters arose from their prior experiences in nurse training school communities. Early Canadian schools of nursing were established during the mid- to late-nineteenth century, as a source of inexpensive labour in exchange for marketable skills and enhanced occupational status. Kathryn McPherson has provided an excellent analysis of the student nurse work culture during the period prior to the Second World War, with its dual focus on shaping character, as well as subsequent nursing practice.[29] The number of schools increased rapidly during the first half of the twentieth-century, due to the rise in hospital care, although the size of these schools varied considerably. In Ontario, for example, there were sixty-eight training schools in 1939-1940. Kenora General Hospital reported eleven students while the five largest hospitals reported between 186-277 students each.[30] Regardless of school size, however, students were effectively removed from their families and often from their home communities as well, because training schools required them to live in residence with very little time off-duty. This policy ensured plenty of opportunity for

the inculcation of feminine values, norms, and moral codes during the three years of training—and nurses' training constituted the students' first homosocial, professional community.

Graduate nurses typically retained close relations with their training schools through membership in their respective alumnae associations. These associations served several purposes, providing a small measure of job security for nurses, as well as participation in social, educational, political, historical, and economic activities.[31] Nurses worked primarily in private practice after graduation, and they depended on referrals to patients who needed nursing care from hospitals and physicians. Most hospitals preferred to recommend their own graduates through registries that they maintained, or through the local alumnae association. Alumnae associations also provided limited economic assistance when work was scarce, or when a nurse became unable to work for a period related to illness.

Thus, civilian nurses were already socialized as members of distinct nursing communities. They typically developed a strong sense of identification with, and pride in, their training schools while students who trained together often remained lifelong friends. It is not clear that nurses actually were more 'bonded' than other cohorts, such as physicians who also trained together and shared patient-related 'life-and-death' events. But many of the interviewed Nursing Sisters perceived their training school relationships to have been particularly significant and enduring. NS Betty Nicolson attended the sixtieth anniversary of her graduation from the Winnipeg General Hospital (class of 1940) where she was reunited with nine other classmates. She said, "I think the nursing profession is more bonded than any other profession." And NS Lois Bayly planned to attend the sixty-fifth reunion of her class at Montreal General Hospital in 2002 along with her friend. As she explained, "Ida Johnson and I are the two oldest ones that attend. We graduated in 1937 and we've gone back every five years pretty well."[32]

Isolation and mutual dependency supported the development of identity as a community. When they enlisted as soldiers then, the Nursing Sisters experienced a second environment that isolated them professionally and socially while inculcating values, beliefs, and norms specific to the military. Military service disrupted previous personal relationships, controlled most of their

activities, and deliberately fostered camaraderie—much as it did for all soldiers as a basis for survival under adverse conditions in the field.[33] NS Jean MacBain described military nursing as an "unnatural way of life away from home and families and old friends [that] resulted in strong friendships which have lasted through the years. Something which we as nursing sisters learned was that we always had to be optimistic and cheerful. The patients had many problems so it was up to us to make them as comfortable as possible in as cheerful a manner as possible."[34] NS Norma Fieldhouse pointed out another advantage to the military environment, referring to her "very, very pleasant social life" which was "a real contrast to civilian life because all the men you knew were overseas." She felt that this attractive lifestyle was partially responsible for the continued enthusiasm for military nursing when the armed forces called for volunteers to serve in the Pacific campaign: "[W]hen word came that there would probably be an offensive in the Pacific, we all raced to get our names on the dotted line."[35]



Photograph 7. "Nurses posing next to a tent," North Africa. PA 213782, photographer unknown. Department of National Defence, National Archives of Canada.

The Nursing Sisters left families, friends, and work colleagues when they enlisted, to be transported further than most of them had ever traveled before. In active theatres, they were totally dependent on the military in the midst of hostilities. NS Lettie Turner said they formed a bond because "they were scared of the same things, facing the same things."[36] NS Constance Bond attributed close relationships to being isolated on the continent.[37] NS Pauline Lamont explained: "Anybody that was overseas never, ever, came back the same."[38] And NS Doris Carter knew that "once I left England, I would have no civilian friends; they would all be from the fighting forces of various countries. It would take me three years to become socialized into my new way of life. And it would not be until I was on a troop ship leaving England for Canada in 1945 that I would realize how much I had changed during the preceding five years."[39]

Military nursing constituted a second female community with similarities to the civilian profession, but it was uniquely embedded within a large, dominant, male community of military men. Gender boundaries shifted within military and medical settings to accommodate the Nursing Sisters, but as we have seen, these shifts were understood to be temporary and contingent on distance from the civilian settings, and they were relatively non-threatening to previously-existing roles and relationships. Change was proportional to the distance from Canada, and it was most flexible in shared communal spaces that were socially and geographically isolated. Various stakeholders assumed that nurses, like other women, would desire a return to 'normalcy' in the postwar era.

Many Nursing Sisters used the image of a 'family' to describe their military experience. NS Nicolson put it this way: "We were devoid of family connections. We were there with these people. So of course, they became our family at the time. . . . We would have done anything for each other. . . . Our whole attitude had changed. It was different altogether, military nurses."[40] And they did look after one another, as NS Elizabeth Dean illustrated. She was a dietician at Sydney, Nova Scotia and roomed at one point with a nurse who did not spend all of her nights in barracks. Dean covered for her, saying:

> I was called in also to [pause] in other words, 'tell on her' because they figured she was going down to the ships and spending her night on the ships. And I did know that I lived

> right beside the fire escape and I used to let her in every morning, and so on. But they accused her of this. And I would say, "Oh, no. Her home is Glace Bay so she's just gone home, and probably missed the train." Because in those days (from Sydney to Glace Bay, there was a train). . . . But my roommate wasn't going home to Glace Bay![41]

Like real-life sisters, NS Margaret Van Scoyoc described conditions in Normandy where nurses would lie in the dark at night, telling personal stories because they had no radios, lights, or other entertainment. Some were homesick, and delayed or lost mail exacerbated the loneliness.[42] For some nurses, military nursing was a 'coming of age' experience and as NS Gaëtane LaBonté said, she "grew up during the war."[43] In South Africa, a group of ten Nursing Sisters posted to Baragwaneth became a little "island of Canada" unto themselves.[44]

Closeness, or community, did not develop because the military nurses had known each other previously from training schools or work environments. With the early change in military policy to integrate personnel from 187 different hospital training schools within medical units, Nursing Sisters did not necessarily know the medical officers and nurses prior to their postings, although some nurses from the larger teaching hospitals claimed to have recognized practitioners who affiliated at their hospitals for part of their training.[45] But many nurses developed equally close, or closer, relationships with other Nursing Sisters than they had within the civilian nursing culture. NS Pauline Cox referred to one Nursing Sister as a "Very, very fine girl. Like I say, we celebrated our 60th anniversary since the day we met in Halifax when we were going overseas! I never had met Ethel because she was at the Vic and I was at the General. And we've been in touch ever since. Now, we aren't able to visit. I am always in touch with her. I phone every week or she phones me."[46] NS Harriet Sloan recalled mutual support within military medical units: "I think we were very conscious of one another's losses. When someone's boyfriend was killed, some dear relative, when a husband died—it was awful. There was compassion for one another. . . . Everyone knew. Everyone would express their sympathy. . . . People tried to make it as easy for you as possible under the circumstances, and we all would get tired and grumpy."[47]

These relations extended into their postwar lives as NS Frances Oakes illustrated in speaking of a special friend who is dead. Oakes became godmother to her friend's children and as she said, "they call me every Saturday or Sunday. I miss her very much. We got along very

well. We didn't know each other. We met on the boat going over. And we got along fine."[48] Sometimes there was too much closeness, however. NS Doris Carter noted there was little or no privacy, especially while living under canvas: "[Y]our tent was never quiet. You could hear everybody talking and they could hear you. You never had any secrets. Everybody could hear."[49]

The development of community depended partially on when a nurse enlisted and where she was posted. The armed forces accepted younger nurses during the last years of the war, and this created a noticeable generation gap related to age and experience. NS Beatrice Cole explained that camaraderie was stronger among the older nurses and the physicians, while younger nurses could be more easily intimidated by their inexperience and by rank.[50] In a similar manner, Nursing Sisters who served overseas were more dependent on intra-unit relationships, and increasingly so, as they moved further forward to the front lines.

The case of NS Kay Christie and May Waters is unique, as community became a physical and psychological tool for survival in the prisoner of war (POW) and internment camps. Christie expressed a sense of betrayal regarding her secret posting and the manner in which she was forced to decide about it: "Not knowing where I was going . . . I felt numb. I felt like Little Red Riding Hood. Take these goodies to your grandmother who lives across the forest. But go straight there and don't talk to strangers. This is just what I felt like."[51]

On the one hand, POW camps were communities of fear, whose membership also included the Japanese army. Christie described witnessing unspeakable tortures and deaths, noting that the Japanese soldiers didn't discriminate between guilt and innocence among POWs. For example, when the Japanese guards thought a mass escape was being planned, they sought a man named "Anderson" as one of the leaders. According to Christie: "They didn't know which Anderson so they took [killed] all six Andersons that were in the camp. That's the way things were done."[52]

On the other hand, while the POW community faced constant danger and de-moralization, it also called forth remarkable innovation and cooperation. Community became a necessary tool of survival as well as a mental construct that gave meaning to the situation.

Christie's interviews and writings describe how adversity and deprivation forged bonds between nurses and patients, between nurses and civilian internees, and among nurses. POWs used whatever assets they had developed to endure the months and years of idleness. They taught one another bridge, new languages, and other skills. Bridge became an obsession with Christie who said it helped her to forget all about the surroundings, hunger, lack of privacy, uncertainty about the future, and what was going on around her.[53]

Community, as a POW survival strategy, sometimes elicited incredible commitments. Rumors of prisoner and internee exchanges circulated periodically within Stanley Camp. But in the fall of 1943, Christie and Waters learned that they were indeed going to be included in an American exchange. Since there had been almost no communication between the camp and the outside world, the other POWs were desperate to let their families know they were alive. Christie described a formidable process by which she delivered news of their survival to the outside world after she had been liberated:

> When word first got around the camp . . . every time you were out walking, you'd have somebody say, 'When you get out, would you write to so and so." And they would give me these great addresses in Britain, and Australia was just as bad, and when I'd go back to my room I'd write this down and who it was that had asked me. Then every time I would meet any of those people in the camp, I would repeat the name and address she or he had given me to write to when I got home. But I had quite a list. And I had the Brigade casualty list too, written but also memorized. So when we were down by the shore and were waiting, always in alphabetical order, to be searched before we went on ship, I suddenly remembered about these lists of names. You know, you were warned what would happen to you if you were caught with anything that you shouldn't have, and as I say, we had seen enough—that helped you to obey the rules. And so I took out the pages from that book and just ripped them into shreds and threw them. So when we finally got on the *Teia Maru* [the Japanese exchange ship] and were handed this roll of toilet paper, the first thing I did was, I went in and I sat down and wrote out all those names and addresses again on this orange toilet paper. . . . But when I got on the *Grypsholm* [a Swedish-American liner], then I began writing letters. I mailed some from South Africa when we stopped there; I mailed some more from Rio de Janeiro when we stopped there. And then the rest I mailed from home. Anybody I didn't hear from in a month or so then, I wrote again because I knew that mail was being lost.[54]

It was at least two decades before she spoke or wrote about this undertaking, but when she did, Christie balanced her memories with humour and accounts of "many friendships formed in those difficult days which not only have lasted but have become more firmly cemented as the years go by."[55] Although Christie stayed in the military after her repatriation, with postings to

Chorley Park Military Hospital and a Retraining Centre, she claimed that she could never quite 'fit in' with the evolving military nursing community again. She found military nurses in Canada during the last years of the war to be much younger in years and in experience, while feeling that she had less in common with them. Christie also noted that she had become less willing to accommodate to a rigid military system after her years as a POW.[56] When she did leave the military, she dedicated a major part of the rest of her life to working with veterans' organizations, and as an advocate for veterans. For example, she became a key witness at a Canadian Pension Commission compensation hearing in the case of Bud Sweet, her patient at the Bowen Road Hospital. As Christie reported, "I went to bat for Sweet."[57]

How Community Worked: Conflicts and Diversity

The Nursing Sister community has portrayed itself publicly as one united, harmonious group. But in spite of closeness and camaraderie, there were also multiple differences, conflicts, and fractures within the community, whether or not they were perceived by the individual members.[58] It is more difficult to examine these conflicts because the nurses involved left few records of resistance and dissent to contrast with conventional accounts of a unified sisterhood. Reading 'against the grain' of existing sources and listening carefully to nurses' voices, however, reveal that communities are not always supportive, unified, or egalitarian. But they constitute symbolic communities when what they hold in common is valued more than what is different within them. Examination of the Nursing Sisters as a community supports Cohen's findings that simplicity, egalitarianism, and conformity are three of the myths regarding community.[59]

The only two book-length memoirs that have been published do provide evidence of differences and conflict.[60] Both have been written by Nursing Sisters who are considered to be somewhat 'on the margins' of the community by the nurses interviewed for this study. Doris Carter's memoir has received limited recognition, while Mary White's memoir has been generally considered atypical of most nurses' experiences. Their references to such aspects of community

life as alcohol use and abuse, sexuality, and power struggles within the medical units have been perceived by many military nurses as transgressing internal, private boundaries of acceptability. For the most part, the interviewed nurses denied having similar experiences to Carter or White. They seldom mentioned White's book and when they did, it was usually to distance themselves from her account. Both Carter and White indicated personal feelings of being 'outsiders' to the community although they maintained their official membership in the postwar organization, and 'paid their dues'.[61] Their memoirs make an important contribution, which I use later in this chapter to counterbalance the more numerous narratives that emphasize camaraderie and harmonious relationships.

The first, and most obvious, commonality that shaped the Nursing Sisters community was their Canadian identity. With few exceptions, the Canadian military nurses served as part of Canadian forces' units, unlike their situation during the First World War. Their written accounts and interviews are unanimously proud of this national identity, even though many of the Nursing Sisters denied 'patriotism' as a primary motivation for serving. But Canadian identity could be problematic and equated with 'colonial' in Great Britain where they sometimes encountered derogatory treatment and remarks from British Nursing Sisters and Matrons because of it. In many ways, the Canadian profession had achieved more control over nursing practice, and Canadian military nurses had achieved officer rank long before the British nurses had.[62] These achievements only served to exacerbate relations between the regular British forces and the 'territorial forces,' as the Dominion military services were called. As the only Canadian nurses serving in Hong Kong, for example, Christie and Waters encountered discrimination from British Nursing Sisters, and especially from the Matron who referred to them as "bloody colonials".[63] According to Christie, the Matron's objections to the 'colonials' stemmed from not understanding their language ("I can't make out a word they're saying"), their 'nicer uniforms' and higher rate of pay, the attention and 'fuss' they attracted, and their officer status.[64]

The designation 'colonial' was perceived by Canadian Nursing Sisters as pejorative and as positioning them inferior to British nurses. Commenting on attitudes portrayed by both patients

and non-patients toward Canadian military nurses, NS Claire Murray wrote: "[The British] did not really expect to find us civilized. . . . [One patient] was very uneasy, though his injuries were not severe. . . . He was afraid of us, being 'colonials.'"[65] She concluded from her experiences, that nursing was not considered a respectable occupation by the British. NS Bond was with No. 2 Casualty Clearing Station that landed concurrently with a British medical unit at Courseulles, France soon after the Normandy Invasion. As she stated, "When we were landing we were on landing barges and one of our nurses started to step onto shore. There were British nurses with us. The British Matron prevented us from landing on the barge until all of her nurses landed first. She pulled the Canadian nurses back and said, 'We are the senior service.' So we joined No. 77 British General Hospital under canvas, just for one day, and the next day, July 12th, we rejoined our unit."[66] Although Canadian nurses did work in British military hospitals occasionally, it was only for brief periods and on an emergency basis. They clearly identified themselves as Canadians and typically exerted great effort to make sure the Italians, French, Dutch, Belgians, Japanese, and South Africans understood that difference.

In spite of sharing a common Canadian identity, there were differences among Nursing Sisters based on regional origins and language which sometimes proved contentious. Initially, military medical units recruited personnel that were accustomed to working together (such as No. 15 Canadian General Hospital mobilized from the Toronto General Hospital and No. 5 Canadian General Hospital mobilized from the Winnipeg General Hospital in 1939). The attempt to create an all-French speaking medical unit did not materialize, partially due to the abandonment of the Army's original plan for an all-French brigade by the summer of 1940. There was little need for such a unit if it was not feasible for the casualties to also be segregated by language.[67] Whenever small working units were required as in small forward field units or on hospital ships, however, these postings were planned to place 'compatible' nurses together because of the limited working and social spaces.[68] In general, the RCAMC followed a policy of mixing personnel from a variety of regions and training schools within medical units, and as we have seen, that

policy change had benefits for the armed forces.[69] But it also exposed fractures within the community that were related to region and language.

The civilian nursing workforce was dominated by the large teaching hospitals of Eastern Canada which had been established well before those in Western Canada. Graduates of these training schools dominated the profession's leadership numerically, as they also dominated the armed forces nursing services. NS Estelle Tritt, a graduate of the Reddy Memorial Hospital in Montreal, was posted to two units that had distinct regional compositions: one originated in Saskatchewan and one in Nova Scotia.[70] She described the units as competitive with an "intense rivalry and dislike" between them. NS Helen Mussallem enlisted from Vancouver, and as she said, "Coming from the west (the far west in Vancouver), we thought that people in the East . . . (the Sisters) were a little snobbish, you know. And they did things this way and that way."[71] NS Margaret Fletcher was a Westerner serving in England with No. 7 Canadian General Hospital, which originated in Halifax, Nova Scotia. She wrote: "I'm still taking a dim view of a lot of things-- & the more I see of some people, the more respect I have for training schools in the west. Apparently people in the east get well in spite of the staff. All the ex #5 [referring to nurses who had served with No. 5 Canadian General Hospital prior to being transferred to No. 7 Canadian General Hospital] are very browned off." In a later letter, she called the situation 'not conducive to good work.'[72] The boundaries between work and social activities were so porous that differences based on regionality were experienced in both domains. Matron Dorothy Macham decided to avoid revealing her Eastern origins when she arrived at No. 8 Canadian General Hospital that mobilized initially at Regina, Saskatchewan: "I began by saying I was from Corn Hill—this is actually the small community where I was born, near Barrie, but no one knew whether it was in Saskatchewan or Ontario."[73]

In addition to an East-West division, there was also a French-English division in some units. As noted previously, there was only a tiny percentage of unilingual francophone Nursing Sisters (0.3%), while 85.5% were unilingual Anglophones and 99.7% spoke English as either their first or second language. English clearly dominated the functioning of medical units with few

exceptions, but linguistic and cultural differences could also generate inequalities and anti-French behaviours. NS Margaret Roe came from Winnipeg where, as she said, "St. Boniface was a French city there, right across from Winnipeg and some of the French girls worked in our front office and at the telephone exchange; and we use to go to parties with them—in a group, you know. We never (Manitobans, Westerners), didn't think of them one way or another. They were just the French people from St. Boniface." Roe remarked that some Ontario nurses, however, "had a different outlook on French Canadians than we did . . . . [T]hey were calling them 'frogs'. . . . I said, 'What's that?' And they said, 'Don't you know what a frog is?' And I said, 'No.' . . . . And I was quite shocked."[74]

The *Canadian Nurse* published a revealing letter from Suzanne Giroux, Matron of No. 17 Canadian General Hospital, a French-speaking medical unit in England. She described the group's 'good fortune' as a recipient of attention from an organization formed to help 'foreign groups to know England':

> [W]e have been given very special attention and received a big box of books, all of them so interesting. They describe English life, English children, English schools, artists, musicians—a perfect choice. Beautiful original coloured prints (the kind you always want to buy and can never afford) were lent to us . . . Now, if we can get a good piano, they will send us musicians and brilliant speakers. Well! It is very nice to be French-speaking in England.[75]

It is difficult to assess Giroux's intended meaning or how her letter came to be published in the predominantly English publication. It would also have been extremely difficult to maintain French-Canadian cultural identity within such an overwhelmingly dominant Anglophone community. Relationships between the cultural groups were not always smooth, as illustrated in the case of NS Morrison and her twin sister who were Anglophone nurses with the RCAMC. After Morrison completed her one-year contract with the South African Military Nursing Service, she returned to Canada for a posting to England where she re-united with her twin sister, who was serving with a French-Canadian unit. Her sister felt very isolated within the unit because the francophone nurses refused to speak English to her. The twins requested and received permission to room together at Leavesden Military hospital.[76]

In addition to dissension based on region, language, or culture, the Nursing Sisters community was made up of women from both working-class and middle-class backgrounds. This difference often played out in subtle ways such as the use of personal and family resources to become a military nurse as we saw previously, to get one of the highly-desired postings overseas, or to circumvent some of the military policies. NS Carter's interview and memoir are full of anecdotes related to the myriad ways she used her class privilege within the military—from changing uniform regulations to suit herself, to her use of family connections to obtain her discharge. Carter explained that she had been unhappy with the way Army-issued uniforms fit, but her Matron informed her: "'You will wear the same as everyone else, whether it fits or not!' Traditionally there were only two sizes in the Army—too big and too small." She waited until she got to England where she then had "a greatcoat and a 'walking out' suit tailored, quietly and discreetly, as the Army seemed a place where things were done that way!" She also had a special blazer made for her informal wear, a silk tie with the Medical Corps colours in stripes, and specially-made uniform shirts to replace the 'Boys' Department' shirts that had been issued in Canada. Acknowledging that her new clothes were made from the darker fabric used for naval uniforms, she wrote: "The Matron was becoming more and more flexible about my uniforms being somewhat different from those of the others."[77] NS Carter also used family connections and influence to obtain her discharge in spite of being posted to a rehabilitation unit in Canada at the end of the war. When she returned to Canada, her discharge was continually delayed until she spent a weekend off at Ottawa where she visited her sister's mother-in-law, Lady Kingsmill. Lady Kingsmill was the widow of a World War I First Admiral of the Canadian Navy. She arranged a meeting between Carter and a General, who subsequently phoned the Québec Army Headquarters at Longueil and requested her immediate discharge. Carter wrote: "It was a wonderful feeling to know I would be out of the Army soon, but I never dreamt it would happen the next day!"[78]

Class could manifest itself in a variety of ways. I suggest that long-standing training school rivalries, contentious relationships between Matrons and Nursing Sisters, and differences

in educational backgrounds held the potential to obscure class as a contested arena among Nursing Sisters. Nurse training schools could represent class differences as much as inter-school rivalries. While 70.4% of the military nurses graduated from at least different 174 hospitals and the vast majority of nurses therefore represented relatively small schools of nursing, 16.6% of the nurses in my sample graduated from three large and well-known hospital training schools: the Montreal General Hospital, the Royal Victoria Hospital, and the Toronto General Hospital. These schools of nursing were among the oldest and most prestigious training schools but they also sustained a history of inter-school rivalry.[79] Because of their size and reputation, these hospitals received the largest number of applications for nurses' training and could be more selective in their admissions. It was also common practice to require applicants to submit reference letters.[80] In one of several examples, NS Carter referred to one of her postings where a group of seven Royal Victoria graduates (including her) felt outnumbered by the Montreal General graduates who were "running" the unit according to their way of doing things. They managed to wrangle a meeting with Matron-in-Chief Smellie during a visit to the unit, and requested their transfers out of the unit.

The rank structure of military medical units subjected Nursing Sisters to their own administrative officers of Matrons, Principal Matrons, and the Matron-in-Chief. While most accounts portray these nursing leaders as well-liked and even admired, there are glimpses of situations that were less congenial, such as the relations between Matron Gladys Sharpe and her nurses that I have already described.[81] In another example, NS Fletcher expressed her open resentment of Matron Edna Rossiter's Royal Red Cross award in 1944:

> All the B.C. crowd are very amused at Rossiter's New Year's Honors R.R.C., & none of the girls who went to Italy or Africa even mentioned. Medals in this war are pretty phoney [sic]. The Boys who have to wear the 1939-43 medals call them the "spam" medal; obtained for slicing more tins of spam than anyone else—and they have been in <u>action</u> for years. This "stay at home" army who say they want to come over, but prefer crowns [the designations used for all ranks above Nursing Sister] to reverting to Nursing Sister, amuse us all--& then they get medals for it!!![82]

Fletcher's letter also differentiated between nurses who had served overseas and those who did not. Although Fletcher was posted to England and eventually to the continent, ironically, she also

resented the publicity attracted by the 'girls' who went to Sicily in 1943. In one letter, she reprimanded her family for expressing concerns over the nurses' hardships while also revealing rivalries associated with serving at the front:

> Glad you think that the girls in Sicily are having a hard time—they don't seem to think so—are working in palacial [sic] surroundings overlooking the straits of Messina, & are back in veils & starched collars again. Don't bother feeling sorry for them—they are just gloating about it all. One of the #7 girls got tight the other night & informed us that if we had been any damn good they would have taken us too—so you see, life has its little difficulties.[83]

Educational background constituted another area of contention. Nurses, as the largest professional group in the Nursing Sister rank, were overwhelmingly trained in hospital apprenticeship programs whereas the majority of physiotherapy aides, occupational therapists, and some dieticians were university graduates.[84] NS Dean was a Dietician and she explained the relationships between nurses and dieticians as sometimes difficult:

> [B]ack in those days, nurses did not go to university and they were very jealous. Let's face it. They really were. And consequently, I never talked about having been at university--ever. I mean, they might find out. But in order to be on friendly terms with them, I didn't tell them. Now is that naughty? I just felt it was important because after all I needed their assistance to make sure the food was properly served, or [that] I knew about a special diet immediately, or something like that . . . . So when you say, did I run in to problems? I never did because I purposely never mentioned having been at university.[85]

NS Mussallem also witnessed a similar attitude toward physiotherapists and dieticians. As she explained, "Some of the Sisters thought the physios and dieticians had greater respect. . . . [T]hey were all graduates of universities and the nurses were not--or weren't at that time. And there was all of that bit of, what would you call it? Not resentment, but friction shall I say. They were university graduates."[86]

The Nursing Sister community, then, was not necessarily simple, egalitarian, conforming, nor supportive for all members. It was initially based on shared spaces and shared experiences as Canadians, as women, as nurses, and as soldiers. But it continued to exist, in spite of diversity and dissension, partially because it was embedded within such a large and dominant male military community, and partially because it was so isolated from nurses' previous relationships. After the war, many Nursing Sisters sought to transform these temporary

relationships into a symbolic community wherein they maintained their identity as military nurses, participated in meaningful public service activities, and created a social memory of Nursing Sisters. Others Nursing Sisters did not.

Postwar Disruptions and Community

The European war ended with abruptness, following an intensive build-up of Allied troops for the Normandy Invasion and, surprisingly, a rapid withdrawal of German troops. Demobilization, the process of closing units and releasing military personnel from the armed forces, proceeded cautiously for at least two reasons. First, there was still a war in the Pacific region, and a request for volunteers from the Canadian forces for that theatre. Second, the Canadian government was acutely aware of social, economic, and political effects related to a rapid return of a large numbers of demobilized soldiers, based on its previous experience after the First World War and recent unemployment during the Great Depression. As a result, the military developed a discharge priority system based on 'points' accumulated in the service.[87] Troops were held in repatriation units located in England, where a variety of rehabilitation assessments were conducted, while waiting for their return to Canada. The medical units closed more slowly than combat units since they were still needed for the care of recovering patients and subsequent evacuation, first to England and then to Canada.[88] As noted previously, one-third of the Nursing Sisters volunteered for the Pacific campaign. Some of them, like NS Mussallem, were already in Vancouver for staging when suddenly and unexpectedly the atomic bombs brought about a swift end to the war.[89]

Almost half of the Nursing Sisters had served between 3-6 years. Many of them described this period as exciting, challenging, and rewarding. Without any hesitation, all of the Nursing Sisters interviewed for this thesis, counted their military service as a highlight of their lives. Many, like Margaret Allemang, Frances Ferguson Sutherland, and Helen Mussallem said the experience changed their lives completely—providing education and opportunities never

before anticipated.[90] At the discharge interviews conducted by DVA counsilors many more nurses expressed a desire to remain in the military than there were positions available in the postwar forces.[91] NS Lamont felt 'protected' within the RCAMC, 'focused on one common goal,' and 'central' to main activities of the war. As she said, "You still were on that high roll of adventure. . . . Sure we had a hard life, but we were in the middle of it. It's better to be in the middle of things. It takes more courage to be on the outside and look in, and your imagination is far worse than the real thing. . . ."[92] Although NS Carter took matters into her own hands and obtained her discharge through personal connections when she returned to Canada, she also wrote: "You were leaving good friends you had been with for a long while . . . ; it was like losing your family. Being sent out into civilian life, into a crowd of strangers, or even people you knew but hadn't seen in a long while, was frightening, as was the expectation of freedom. We hadn't made our own decisions since going into the Army!"[93]

With the sudden cessation of war, nurses lost both their legitimacy as military nurses and their status as military officers, along with the associated rights and privileges, including the right to wear the Nursing Sister uniform. After years of having their lives planned and orchestrated for them, they were now expected to 'get on with life.' But the civilian world was no longer familiar, nor necessarily desirable. Many of them spoke and wrote about being restless or having a tough time after the war—personally and professionally. NS Mabel Glew recalled her difficulty decades later when she wrote, "I'd been four years over there—and it was a different life entirely. You came back here and you'd be amazed how hard it was to get back. They (the people at home) didn't know anything about war. . . . They didn't realize what we had been through. I was a nervous wreck when I got back."[94]

Similarly, few nurses knew or understand changes within civilian contexts, as NS Van Scoyoc explained, "My family knows very little about my life experiences overseas, and I know not too much about what went on in Canada while I was away. Sort of a blank period."[95] As NS Anne Gair wrote, "I felt lonely and found I missed my Army friends very much and I missed the active life I had had."[96] NS Margaret Mills said she "felt very flat. There was nothing more to see

or do. The excitement had all gone."[97] NS Ruth Littlejohn felt "scattered," and "at loose ends," with no sense of place.[98] NS Louise Jamieson returned to very different family circumstances than she had left on enlistment. Her mother and grandparents had died, her brother was killed during the war, and her father had moved to a different house. In her search for a place to belong and perhaps a place to escape, she tried outpost nursing, considered joining the United Nations Relief and Rehabilitation Administration, applied to the World Health Organization, and went to India for two years.[99]

Not all of the changes were external ones. Nurses frequently talked about being personally transformed by their war experiences. NS Margaret Fletcher tried to prepare her family prior to her discharge regarding some of the changes they might expect in her:

> You see we live in the midst of people who live high & sleep in slit trenches-- & coming home to a family that is too prim & proper would be an awful shock. No—I haven't taken to 'wine, men & song', but have learned to make the most of short opportunities. It will be difficult to settle down to an ordered life, where thing are planned-- & everyone in uniform doesn't accept you as a long lost friend at sight. It really will be a trifle lonesome for a while—no doubt.[100]

NS Van Scoyoc said she became too independent to fit her former life again. Her family thought she was "ahead of her time" regarding the choice to remain unmarried, but as she explained: "If I could have found someone that would have allowed me to do what I wanted to do, then probably I would have married. But I never met that individual."[101] NS Potts expressed regrets about *not* having married saying: "I would probably have married, if I hadn't gone to the war. . . . I felt I had to go on and do more and more. . . . One man that I knew very well was killed in Israel. . . . [H]e was a very fine person too. But, as you go on in years, it doesn't mean anything anymore, you look back and say, 'ah, I could have been married and had children by now.' I don't think of that any more at all."[102] On the other hand, NS Bower expressed regrets about *having married* during the war, suggesting that if there had been counseling available, she would not have made poor choices that led to a 'marriage breakup' and a difficult life trying to support three small children on her own: "I believe that at that time, I was just so homesick and the invasion had been on for

quite some time. And the buzz bombs were going . . . ; and all the frustrations of the war. I think that if I had had counseling, I would never have married."

The first troops to return to Canada received a warm welcome and public attention. But many Nursing Sisters were discharged later and under different circumstances, as their work with casualties extended into the months and year following the armistice. Instead of relaxing on the homeward voyage, they often worked by caring for returning casualties or for war brides and their children. NS Bond, along with many others nurses, resented the imposition and their own inferior accommodations. She recalled: "We came back with a group of English war brides and their babies who were in first and second class and we were in steerage."[103] NS Lamont accompanied a group of thirty war brides and twelve children under five years old, from England to Halifax, with the assistance of another Nursing Sister and a Red Cross worker. Lamont described her awful experience where the Red Cross woman went to bed for two weeks and "never lifted a finger" while the ship encountered a North Atlantic storm so severe that Lamont feared that they were "doomed." She said, "Those poor women and the babies! And somebody asked if I was seasick, and I said, 'I guess I must have been the first day, but we didn't have time. We were so busy all the time.' So we got to Halifax and I remember how tired I was." While the war brides were warmly welcomed, the Nursing Sisters were neither welcomed nor acknowledged. As Lamont explained further, "Here was a big banner (Welcome to Canada) for the war brides. And there was hot coffee and donuts, and they got a wonderful welcome. We were left on the dock with our luggage there. Nobody said 'boo' to us. Until these two or three boys (soldiers) came and said, 'What can we do for you sisters?' And they helped us—took our luggage, took us to the train."[104] NS Van Scoyoc had a similar experience and felt it had been "very odd" that they didn't get the same kind of welcome that earlier troops had received on their return. She thought, "Maybe the public was tired of it."[105]

Nursing Sisters were not necessarily released immediately on their return to Canada. Some of them were posted to military hospitals and rehabilitation centers across Canada, to cover the interim period until the Department of Veterans Affairs hospitals could accommodate all

of the soldiers who continued to need medical care. Others applied to remain in the permanent forces, transferred to Department of Veterans Affairs hospitals as civil servants, or used this interim period to plan for the rest of their lives.

Some nurses sought postwar experiences which offered opportunities for travel, adventure, and autonomous roles similar to those they had experienced in the military while others wanted to leave the military life behind them. NS Eileen MacGregor found that on return from overseas, she had to relinquish much of her autonomy while the work was "tedious and menial."[106] NS Elizabeth Pense had been a member of the Permanent Forces prior to the war and ultimately, served a total of twenty-one years in the armed forces. With her permanent force status and years of service, Pense explained that the military took measures after the war to constrain her potential authority and privilege by posting her where she would pose little threat to the male hierarchy. She said, "They didn't quite know what to do with me, because I was the only overseas sister there. But they were going to make sure I wasn't throwing my weight around, so after the first few months, I was put in charge of the isolation hospital, and I loved that because I was all by myself and had the running of the place."[107] NS Roe didn't feel ready to make decisions on her future at discharge, but after a brief interval, she did re-enlist for one-and-a-half years in the Permanent Force. The experience turned out to not be the same, however, and she soon felt postwar military nursing was a "dead-end" for her. NS Allemang knew right away that she was ready to get out of the Air Force: "I wasn't finding it too much to my liking. . . . I think I was tired of the life and I decided if I never went to another party, it would be too soon."[108] And NS Fletcher told her family, "Have the crystal pool all clear & a red evening dress ready. I'm aiming to forget khaki."[109]

As general public support for the military waned throughout North America during the immediate postwar decades, there was an overall reduction of military infrastructure along with unification of the Canadian Forces. Military nurses of this era were somewhat less positive about their experiences than either the First or Second World War nurses had been. When NS Roe re-enlisted shortly after the war, she only stayed in briefly, calling it a 'dead end.' NS Nina Rumen

trained at the end of the war, and served in the military for twenty-three years. She reflected on this period as one of low morale and disillusionment for both the military and military nursing, explaining that nurses lost a great deal of autonomy and confidence following the war.[110] NS June Parker recalled that there was "an awful lot of climbing on each other's back, wanting promotions. . . . [T]here were things that happened in the forces that made me really angry. But you can't do anything about it."[111]

The postwar civilian profession was desperate for nurses and expected the Nursing Sisters to help fill the void. At the same time, the armed forces no longer required their services. Nor did they perceive nurses as having any rehabilitation needs, since they were already fully trained and there were abundant employment and educational opportunities for them. But many Nursing Sisters expected some form of welcome, some recognition, time to make the transition back to the civilian context, and a place to debrief and be understood—possibly even to receive some counseling. Their community had been dispersed and they had become invisible in the postwar world. As NS Lamont summarized, "I don't think they knew what to make of us, to tell you the truth. . . . We didn't talk about it. Nobody was interested. . . . I'm not blaming them--they just couldn't connect. So they really couldn't visualize what went on over there. . . . I never opened my mouth until 1994—literally. . . . [But] the minute we got with war buddies, oh boy."[112]

Shaping a Symbolic Community

The Nursing Sisters Association of Canada was one of the logical places where Nursing Sisters sought support from their "war buddies" during the postwar transition period. In April 1920, Nursing Sisters in Edmonton had formed a club for military nurses who had served overseas, in order to "continue a fellowship which was peculiar to those who served overseas during the Great War, and to help one another should the occasion arise."[113] Similar clubs emerged across Canada by 1927. During the International Congress of Nurses at Montreal (1929), the clubs organized nationally as the "All Canada Nursing Sisters Association." Re-

named the Overseas Nursing Sisters Association, this national body met biennially, concurrent with the Canadian Nurses Association. Primary concerns at the first meeting in 1932, included nurses' employment, medical and hospital care, and assistance to individual members—reflecting both the dearth of nursing employment during the Depression, and the absence of social welfare programs.

During the Second World War, the Overseas Nursing Sisters Association was active in fund raising for the war effort and in continuing support for serving military nurses, as well as relief support for British civilian nurses. Membership was restricted to Canadian military nurses who had served outside of Canada or Britain, and prospective members were interviewed by a selection committee. By 1936, membership included Nursing Sisters of the Allied forces as well.[114] Somewhere between 1944 and 1946, the organization dropped the requirement for overseas service and changed the name to "Nursing Sisters Association of Canada" while extending membership to "all Nursing Sisters honourably discharged from the three military services."[115] It was not until 1960, however, that dieticians, physiotherapist aides, occupational therapists, and home sisters who had served as Nursing Sisters became eligible for membership.[116] The Nursing Sisters Association of Canada affiliated officially with the Royal Canadian Legion in 1944, beginning a long association that would prove instrumental in shaping the commemoration of military nurses. A 1958 membership list included sixteen local units, noting that three other units had recently closed. The thirty-fifth, and final, biennial meeting was held in 2000 at Toronto where the last directory was distributed. It still listed eleven active units with a total of 636 members, and included many military nurses who had enlisted since the Second World War. Several local units continue to meet, with Lt. Colonel (retired) Harriet Sloan as the national contact person for the organization. As NS Bayly explained: "All my years, I belonged to the Nursing Sisters Association. . . . And I have enjoyed that so much. But now, it's getting to be too big a job. . . . Well, we still meet in Ottawa . . . but we won't get together like when we first started."[117]

Many of the returning Nursing Sisters looked to this organization, and to the first generation of military nurses, as one way to remain connected to each another. They had first been welcomed into military nursing through the Overseas Nursing Sisters Association of Canada when some of the World War I nurses assumed 'big sister' roles for the new recruits at the beginning of the war. NS Cole was surprised when the RCAMC phoned her (a new graduate) for an appointment to the nursing service. She didn't learn until later that one of her patients had interceded on her behalf. As she explained, "It wasn't until after I . . . came back and got in contact with Captain Nursing Sister MacDonald. She had given me her handbag which I carried with me all the time I was over there (the Nursing Sisters had a navy blue leather handbag). . . . I said to her, 'You know I have often wondered how it was I got into the military. And I wondered if you might have recommended me?' And she smiled and said, 'Yes dear, yes I'm the one. And I hope that you enjoyed the experience.'"[118]

As the Second World War ended and nurses returned to Canada, the now re-named Nursing Sisters Association of Canada held local 'Welcome Home' parties and sent letters of invitation to join the association to 2455 discharged nurses.[119] There was no explanation provided for this number, but it is reasonable to infer from the eligibility criteria during this period, that the number of invitations represented only those nurses who had served overseas. The association differentiated between overseas service and service in Canada, as well as between nurses and non-nurse members of the Nursing Sister rank at this time. This membership policy privileged some Nursing Sisters over others initially.

Several local units extended free memberships for the first year, and hosted returning nurses as speakers for their meetings. The Hamilton Unit, for example, was looking for new leadership and expressed their situation in the *Canadian Nurse:* "[T]he present executive have carried on for many years, the unit having few members. With new and younger nurses joining the unit it is planned to pass the reins of office on to them at the annual meeting."[120] As NS Jessie Morrison wrote regarding her introduction to the Edmonton Unit, "They opened ranks and received us warmly . . . . I believe ten of us joined that night."[121] Over the next six decades, this

organization was instrumental for demobilized nurses who desired to remain 'one of the girls,' and for shaping the social memory of Canadian military nurses. It became a primary structure through which members communicated with one another, and organized to represent the interests of military nursing to the public. Thirty-five years after they first landed in England, journalist Lotta Dempsey described the organization as a "sisterhood, forged in on-the-spot blood, sweat and tears" where "there's really no space for outsiders. Even husbands."[122] And for the seventieth anniversary of the Nursing Sisters Association in 1990, NS Margaret Dewart and Jessie Morrison declared that, "The original objective, to strengthen, not weaken the bonds that have made us one mind and spirit, has been carried on."[123]

For those Nursing Sisters who did not remain in active nursing practice, the association served to link them to both the ex-military and professional nursing communities through biennial meetings, newsletters, directories, and fund-raising activities. They used these gatherings for social networking, as well as for activism in support of veterans' benefits, relief to countries affected by the war, political activism, and the advancement of military nursing. NS Kay Poulton noted that "the friends I made are still my friends and even though we're scattered all over the country, we all try to keep in touch with each other."[124] The network was so extensive that, according to NS Van Scoyoc, "There isn't a city or part of the country that I could visit, that I wouldn't know someone whom I could just phone and just say, 'I'm here. Let's get together.'"[125] For a portion of the group, this community became an important social support network within a larger society where military nurses were no longer visible, or needed. As NS Nicolson explained: "We never talked about our wartime experience. . . . Just when we were together with veterans and our pals; and we would visit each other regularly, and we always had that close bond, that fellowship. Always. Still to this day."[126] Newsletters, published activities of local units, and directories (local and national) became important tools that kept these Nursing Sisters connected to one another. There are many personal references to the value that Nursing Sisters placed on these communication tools in their interviews and anthologies. The Ottawa unit continues to distribute a newsletter with the annual Nurses' Week luncheon in May, and the

Remembrance Day luncheon in November, as for example, do other units in Toronto, Edmonton, and Vancouver.

Local units reported periodically on their activities to the wider nursing body through the *Canadian Nurse*, although fewer and fewer of these reports were published by the end of the 1940s. They informed the community, regarding the 'comings' and 'goings' of individual members, as well as activities and deaths. A survey of these reports indicates that units organized for the stated dual purposes of 'fellowship' and 'service.'[127] They hosted returning nurses, held bridge parties (as well as teas and picnics), visited veterans in DVA hospitals, sent relief packages overseas, met for annual Vesper Services in May and Remembrance Day dinners in November, volunteered together for Red Cross projects, collected and mailed uniforms to British and European nurses, raised funds for the "rehabilitation of nurses in devastated countries," participated in wreath-laying ceremonies at cenotaphs, and more. The Toronto unit organized as a group to join the Blue Cross Hospital Plan sponsored by the Ontario Hospital Service Association, thus assisting their membership to obtain hospital insurance.[128]

Local and national directories provided another important link. My earliest reference is a 1958 membership directory that includes the names of Nursing Sisters from sixteen units. It gives the dates of unit organizations, a brief history, a list of presidents, and important information for veterans regarding rights and benefits related to health care. At least 670 Second World War nurses were included in that edition. The directory listed each Nursing Sister's rank, decorations, address, service branch, and dates of service as well as an entry called 'occupational code'—although I have not been able to completely decipher the code.[129] A combined commemorative issue and national directory was published for the fiftieth anniversary of D-Day (June 1994), and the final national directory was published in May 2000, commemorating the eightieth anniversary of the Nursing Sisters Association of Canada.

These organizational structures served to keep the community informed and connected, but they also helped to shape a social memory, revealed through what was included and excluded from these reports, newsletters, and directories—as well as whose voices were

included or excluded. The social memory revealed in these sources, portrays Nursing Sisters as a benevolent community whose members worked and socialized together on behalf of war's casualties—primarily, for the improvement of care and benefits for veterans, and relief aid for nurses and nursing education in Europe. During the 1960s and 1970s, the association engaged in limited political activism as it mounted a letter-writing campaign to protest "the change of the flag and proposed demotion of medals conferred for military service", and presented a brief to the Parliamentary Committee on Veterans Affairs requesting that a Nursing Sister be appointed to the Pensions Commission.[130]

Cohen argues that symbolic communities increase in importance as actual geo-social boundaries are undermined, blurred, or otherwise weakened—as the Nursing Sisters' boundaries were after the war.[131] They no longer shared physical spaces as they dispersed throughout Canada and indeed, internationally. They seldom shared social spaces unless they attended commemorative occasions or the biennial meetings. The *Canadian Nurse* published less and less on their activities, except for annual Remembrance Day features. For those who chose to maintain an identity as military nurses, the Nursing Sisters Association proved to be a key resource. It provided an organizational structure for social and charitable activities, for peer support, for limited political activism by one group of military women, and for communication between members. Through its 'official' status as the voice for military nurses, leaders of the association exerted substantial influence over the way in which the Second World War Nursing Sisters were commemorated, and thereby, the social memory created.

Commemoration and Social Memory

Nursing Sisters had always existed in relation to groups of military men: medical officers, medical orderlies, and casualties. When these men no longer needed their skills, however, military nurses all but disappeared from the armed forces and from social memory related to the Second World War. In order to maintain visibility and create a social memory, the Nursing Sisters

Association collaborated with the Canadian Nurses Association in decisions about how to commemorate their wartime service. They also continued their association with military men, and shaped their own social memory congruent with the dominant postwar military discourse, in order to enhance military nurses' visibility. And as historians Jay Winter and Jonathan Vance point out, the construction of both commemoration and memory is as much about forgetting, as it is about remembering.[132]

Commemoration, social memory, and the creation of a symbolic community are interrelated processes. By commemoration, a group or society recalls an event or person(s) using specific images and discourse that have been consciously selected, usually to attribute respect or honour for that event or person(s). Commemoration can take the form of rituals such as celebrations, pilgrimages, and religious ceremonies. It includes symbols such as awards and medals, as well as material expressions such as monuments, buildings and architectural features, the naming of topographical features, and a variety of artifacts. Commemoration both reflects and shapes the shared values, beliefs, meanings, and moral codes of a symbolic community. As the Nursing Sisters' decisions about commemoration will illustrate, the process may be contested and negotiated by persons holding less power.

Social memory, or a 'shared narrative,' is constructed both within a community and outside it—that is, the symbolic community has both a private and a public face. There are discourses that the community desires to reinforce in the public arena, as well as a shared private memory exclusively for members. The bonds of sisterhood have been relatively effective in protecting private memories from becoming public ones. Both are shaped by interaction among members who seek to contest, validate, or corroborate past events and interpretations of those events. Among the various documentaries, interviews, and written anecdotes of Nursing Sisters, there are stories and themes that emerge repeatedly. The language and discourse are remarkably consistent, regardless of the setting as some experiences have been well-polished in the telling. One such story involves a nurse who was in the lower bunk of a transport craft that crossed the English Channel at night and hit an object, causing a bucket of water on the floor to

spill. The nurse is purported to have felt the water and yelled out, "Girls, we will have to swim for it."[133] NS Christie was interviewed several times, and left several written accounts of her POW experience. Although these records were created over a period from 1967 to 1992, the events and language used to describe them are consistent.[134] In a similar manner, the Nursing Sisters typically describe their patients as being "very brave" and "wonderful boys", their medical orderlies as very helpful and supportive, and the medical officers as collegial.

One of the ways to examine social memory is to consider what a community commemorates and how it does so, as well as what it chooses not to commemorate.[135] Jay Winter suggests that the proliferation of images, metaphors, and discourses related to bereavement after the First World War did not reoccur after the Second World War.[136] While the First World War Nursing Sisters were never the subjects of commemoration or material memory to the extent that military men were, the social memory created around their experiences certainly exceeded that of the Second World War military nurses. Indeed, the women interviewed for this research confirmed Winter's finding that there was a 'profound silence' after the second war. He pointed out the inadequacy of those earlier 'languages of mourning' for survivors of the second war: "After Hiroshima and Auschwitz, the earlier commemorative effort simply could not be duplicated. . . . The Second World War helped to put an end to the rich set of traditional languages of commemoration and mourning which flourished after the Great War."[137]

The first generation of Nursing Sisters had been the primary focus of social memory associated with military nursing, partially because they were part of the interwar commemoration process. As Kathryn McPherson points out, ordinary women were not typically portrayed in public statues and monuments, partially because ordinary women did not die as a direct result of military involvement.[138] But forty-six Canadian Nursing Sisters did die during the First World War and the public was particularly enraged over the bombing of hospitals in France and the sinking of hospital ships that caused the deaths of twenty-one of them.[139] Their nursing colleagues raised the funds to commission the Canadian Nurses Association War Memorial, and they negotiated its location in the Hall of Honour of the Centre block of Ottawa's Parliament Buildings by 1926. This

memorial has remained the only nursing symbol of its kind in Canada, and one of two such commemorations in the Hall of Honour.[140] The National War Memorial unveiled at Ottawa in 1939 included two Nursing Sisters among the twenty-two figures portrayed. Both memorials became the subject of further debates during the 1940s, related to decisions about the commemoration of Second World War nurses.

Three individual First World War nurses were honoured respectively in the naming of a hospital wing, a hospital, and a mountain in their memory. Collectively, the First World War nurses are memorialized in at least four, stained glass memorial windows in churches or chapels,[141] as well as several other commemorative portrayals. One that has often been overlooked due to its lack of accessibility is a massive war art panel titled "Third Canadian Stationary Hospital, France" by Gerald E. Moira.[142] Another often-overlooked portrayal consists of a multi-volume set of "Books of Remembrance" that is kept in the Memorial Chamber of the Peace Tower on Parliament Hill, which includes Canadian Nursing Sisters who died during both wars.[143] The city of Saskatoon (Saskatchewan) is the site of an unusual commemoration in the form of a living memorial where trees were consecrated in 1923 to those who had died during the war.[144]

By contrast, the second generation of military nurses remained relatively silent and invisible in social memory, whether it was because few people were interested in their experiences after the war, or because there were no adequate means to express their collective experience. There are no statues, hospital wings, nor public buildings named in their honour, not even a memorial tree. Those who died during the war have been included in the Books of Remembrance, and a recently-erected "Manitoulin Women's Memorial" cenotaph includes one portion dedicated to the "Canadian Nursing Sisters".[145] The Royal Canadian Military Institute at Toronto named a meeting room in honour of NS Kay Christie while the Canadian Nurses Association named their national library for NS Helen K. Mussallem.[146] On a far less public level, Second World War Nursing Sister images are represented by an obscure oil painting that was created as the basis for a Victory Bond poster, one panel in a recently-dedicated memorial

window at Hart House in Toronto,[147] one of seven figures on the Canadian Volunteer Service Medal, and one song that none of the Nursing Sisters seem to have ever heard.[148] On an individual level, some Nursing Sisters also received recognition for their contributions through military awards and decorations.

Two little-known portrayals of Nursing Sisters appeared during and just after the war. In the spring of 1944, during the build up to D-Day, the *Canadian Nurse* published a small reproduction of a Victory Bond poster that bore the image of a Nursing Sister. It is difficult to know how this poster was actually distributed due to lack of sources at present, but its embedded discourse around women, femininity, military service, and safety certainly had an appeal for fund-raising purposes. This poster portrays the head and shoulders of an innocent, young military nurse wearing a billowing white veil and blue silk uniform, with an intense look of concern on her face (Figure 6). The simple caption read, "Now, more than ever . . . Buy Victory Bonds." When the poster appeared in the *Canadian Nurse*, the accompanying script targeted nurses on several levels. Not only were Nursing Sisters portrayed as serving in danger from the enemy "on land and sea and in the air" but civilian nurses were reminded that they served in safety. Nurses were urged to invest in Victory Bonds based on their recent experience during the Depression, now that there was "time to tuck away a dollar or two for a rainy day when jobs might be harder to find." They were to sacrifice and invest toward a future home with 'your own fireside' where "there is no need for you to outstay your welcome." But most of all, they were to build up a savings account to furnish a home because, "[w]hen the war is over and *he* comes back from overseas a new life will begin for many young Canadian nurses. There will be a house to build, gay curtains, cups and saucers, pots and pans to buy, all the things that go to make a home. It won't be as easy then to build up the savings account that every young couple ought to have. *Buy victory bonds!* [emphasis in the original]."[149]

At least three, inter-related messages come through clearly in the poster: the safety-danger discourse, a reminder of nurses' precarious economic situation, and most predominantly, a highly-heterosexist discourse on femininity. It was assumed that the unmarried woman would

be a burden to others and unable to provide for her own needs. It was equally assumed that marriage would bring not only a man, but also material goods with which to create the 'good life.'

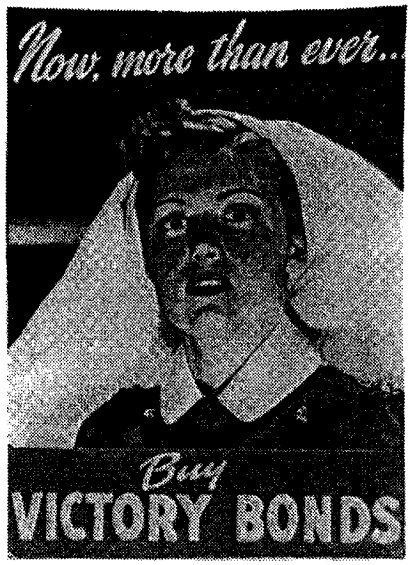


Figure 5. Victory Bond Poster. "Our Canadian nursing sisters who are serving overseas are in danger from enemy action on land and sea and in the air. . . . . When the war is over and *he* comes back from overseas a new life will begin for many young Canadian nurses. There will be a house to build, gay curtains, cups and saucers, pots and pans to buy, all the things that go to make a home. It won't be as easy then to build up the savings account that every young couple ought to have. *Buy victory bonds!*"[150]

In a second portrayal, John Murray Gibbon wrote the lyrics for a song about Nursing Sisters that was published in 1946. Gibbon is remembered best within the nursing profession as a co-author of *Three Centuries of Canadian Nursing* (1947).[151] He was a journalist and novelist, but unknown to most of the nursing profession, he was also the "foremost authority on folk music in Canada."[152] This dual identity may explain why he published a whole set of songs about Canadian nurses—of which, one commemorated Nursing Sisters in general (Appendix 15).[153] Gibbon's image of the military nurse, however, bore little resemblance to most real Nursing Sisters. His nurse was a 'Fairy Queen'—someone ethereal, flitting around the tent of a casualty clearing station, or sitting by the soldier's bed. She relieved pain with soothing hands and drugs,

and 'wafted' care away. The Gibbon nurse must not have worn heavy Army boots or the same Khaki shirt for days on end without an adequate water supply to launder it. She must not have been busy evacuating hundreds of casualties in a brief time period while preparing for the next arrivals, if she had time to sit at the bedside. She was portrayed as someone who could flit around the tent rather than as a competent and highly-skilled professional. Her patients found her 'irresistible' as she was first and foremost highly feminine.

These were the portrayals of military nurses available to the general public and to the nursing profession during and immediately after the war. But the Nursing Sisters Association assumed that when the official accounts of the war were written, these histories would necessarily include the Nursing Sisters. At their 1954 annual meeting, the association vetoed a proposal to commission a military nursing history, noting that "there would undoubtedly be historical material re the services of nursing sisters included in histories presently being compiled which would be adequate for all general purposes. The membership generally felt that the costs of publication and the purchasing cost for individuals would be prohibitive, if such an account were written exclusively for the nursing services.[154]

By 1972, realizing that their own history was passing them by, the Nursing Sisters Association reconsidered its previous decision, and commissioned its own organizational history by military historian Colonel G. W. L. Nicholson.[155] With four chapters on the Second World War nurses, Nicholson's history has remained the primary source of information about Canadian Nursing Sisters. While many of them commend the book for its military aspects, individual Nursing Sisters find that it doesn't necessarily reflect their own experiences. NS Patricia Moll, for example, had collected "a great deal of material" from the Québec units for Nicholson's research, including diaries, photos, and papers. But she felt that the majority of this material, which represented rank-and-file nurses, remained unused: "He only used incidentals from the lot we contributed."[156] Everyday nursing practice and rank-and-file nurses are barely visible in this account.

This situation is remarkably similar to the Australian, British, and American scenarios. Bassett referred to the Australian Nursing Sisters as having been either "ignored or sanctified" in historical accounts.[157] British NS McBryde's memoir and her anthology of the recollections of other British Nursing Sisters were published thirty-four and forty years after the war, in an attempt to correct the absence of Second World War British military nurses. And more than fifty years after the war, Fessler was told by the American military nurses she interviewed, "how proud they were to know that the nurses of World War II were going to be remembered. They'd felt neglected as the years passed by."[158]

Partially because of the lack of interest exhibited by women's groups and feminists, military nursing leaders found it necessary to shape their social memory congruent with mainstream military discourse, and to share in traditional forms of military commemoration. One strategic alliance was formed in 1944, when the Nursing Sisters Association of Canada officially affiliated with the Canadian Legion. NS Pauline Lamont recalled that the Legion hosted her only official 'welcome home' reception at the end of the war: "I remember, it was at the legion (that was the only time I was at the legion). I think I was the only female from Port Elgin that had been overseas, so they gave me a little do."[159] As members of the Veterans Association of Canada, the Nursing Sisters continue to participate in Remembrance Day activities at local and national cenotaphs in their regions; they serve as ceremonial sentries, march as part of veterans' parades, attend vespers and church services as veteran representatives, and make presentations at schools; and during more recent years, they have served on a variety of veterans' committees. Reports from local units of the Nursing Sisters Association of Canada, published in the *Canadian Nurse* during the immediate postwar decades, focus primarily on accounts of these activities.[160]

Beginning with the thirtieth anniversary of the D-Day landings (1974) and the thirtieth anniversary (1975) of the end of the Italian campaign, Nursing Sisters have participated in numerous commemoration trips or 'pilgrimages' to various battle sites.[161] For example, NS Jean MacAulay was a delegate on the pilgrimage to commemorate the fifty-fifth anniversary of D-Day; NS Shirley Kelly went on the official pilgrimage to Hong Kong; NS Mary Hutton went to France as

part of the entourage to repatriate the remains of Canada's unknown soldier; and NS Lois Bayly Tewsley represented nurses on a recent trip to Juno Beach as part of the fund-raising campaign to build a Canadian memorial there.[162] There has been renewed public interest expressed in the Second World War as fiftieth anniversaries were commemorated during the 1990s. More recently, mainstream military historians have demonstrated considerable urgency to enlarge museums and military collections as the sixtieth anniversaries approach and Second World War veterans decrease in number. This urgency has resulted in the production of two Canadian Nursing Sisters documentaries and one feature film with a supporting Canadian Nursing Sister character, as well as a perennial interest in veterans associated with Remembrance Day, or Remembrance Week, activities.[163] These forms of social memory have been created in conjunction with the wider veterans' associations and as such, they tend to represent male perspectives associated with specific campaigns or battles such as the D-Day landings, Sicily, or the fall of Hong Kong.

Social memory of the Second World War Nursing Sisters, in general, has remained sparse but their social memory within the nursing community is somewhat stronger because of the manner in which that memory was shaped. The Nursing Sisters left little 'material' memory, partially because they had fewer resources with which to create it, but also because they made different decisions regarding what to commemorate, and how to commemorate it. Public structures typically required large financial investments and considerable political influence—neither readily available within the nursing profession.

Their first deliberations concerned modifications to the Canadian Nurses' Memorial to reflect the second war's veterans, but that was quickly prohibited. Immediately after the end of war, the Canadian Nurses Association's executive appointed a War Memorial Committee to consider how to commemorate not only those Nursing Sisters who died during the Second World War, but "all Canadian nurses who had served in the armed forces." The Toronto Unit of the Nursing Sisters Association of Canada suggested the establishment of a Nursing Sisters' clubhouse. The War Memorial Committee initially felt that the existing Nurses' Memorial in the

Hall of Honour would be appropriate and no further memorial necessary, if there was an addition that contained the names of nurses who died, along with the total number of nurses who had served in the armed forces during the second war.[164]

The War Memorial committee next reported during the 1948 CNA biennial meeting. During the interim, their request for permission to add a carved plaque in tribute to the nurses of The Second World War below the central figure of the Hall of Honour memorial had been denied by the Minister of Public Works. They were told that any addition of that nature would "detract from its chaste dignity" and destroy its original intent. They then proposed simply engraving dates (signifying each war period) on each side of the central figure but "[i]n view of the present unsettled state of world affairs, this committee recommends that this project be abandoned . . . and all moneys concentrated on the living memorial."[165] Perhaps the ominous uncertainty that accompanied emergence of the Cold War period left this committee pondering where the next set of dates could be engraved—as indeed military nurses were called upon again during the Korean War.

Through fund-raising endeavors, donations, and bequeaths from members' estates, the Nursing Sisters Association did accumulate considerable assets with time. They chose, however, to invest these funds in less visible and often non-material ways that did not necessarily leave traces in their public social memory. After negotiations with the Minister of Public Works failed, the War Memorial Committee suggested a different type of tribute that would recognize members of the nursing profession in 'war-torn countries' and have 'lasting value.'[166] The Nursing Sisters Association established a Rehabilitation Fund in support of nurses in 'devastated countries,' from which they forwarded monies to various overseas relief efforts and the Geneva Red Cross for nurses' convalescent care in Switzerland. Together with the Canadian Nurses Association, they also created educational scholarships and loans which were available to military nurses initially, and later, to all Canadian nurses.[167]

The "living memorial" that was finally approved by the committee and by CNA consisted of professional literature and educational materials to re-establish nursing resources in countries

where they had been disrupted by war activities. Provincial quotas were apportioned and by fall of 1947, the committee had raised $22, 701.58 for this living memorial. The *Canadian Nurse* donated fifty complimentary subscriptions of one year each that the War Memorial Committee renewed for three additional years. With the donated money, the committee purchased and shipped libraries (comprised of fifty nursing textbooks each) to twenty countries: Austria, Belgium, Bulgaria, China, Czechoslovakia, Denmark, Finland, France, Germany, Greece, Holland, Hungary, Italy, Japan, Korea, Norway, Philippines, Poland, Romania, and Yugoslavia.[168]

In light of the substantial funds that nurses were able to raise for these living memorials, it would be inadequate and unconvincing to suggest that lack of money was the main barrier to more visible material commemorations such as those of male war veterans. Instead, decisions made by the Canadian Nurses Association and the Nursing Sisters Association of Canada were consistent with prevailing discourse among international nursing organizations: giving service to others. A growing internationalism among women had emerged during the second half of the nineteenth century, taking root within groups that were striving for the professional recognition of British nurses during the early 1900s. There was an overlap in the leadership of these two movements, women's internationalism and nursing professionalization, partially due to a perception that they held common interests as women. This internationalism was built on an understanding of gender as a bond that superceded national and cultural boundaries. Within the nursing profession, it was best exemplified by the International Council of Nurses, established in 1899.[169]

Several historians have built variously on the concept of nursing internationalism in relation to issues of race, class, and colonialism in their examinations of the International Council of Nurses over different periods.[170] From their research, it is clear that the International Council of Nurses maintained a curious tension between 'intense nationalism' (following the principle of one professional organization per country as the basis for membership) and nursing internationalism, wherein professional identity was supposed to transcend national identities. Ethel Gordon Fenwick (founder of the British Nurses Association and the key instigator for the International

Council of Nurses) was quoted as having said "there is no nationality in nursing."[171] This uneasy tension between nationalism and internationalism became particularly problematic during periods of war when nurses responded to calls for military nursing service.

Early leaders of International Council of Nurses, like other women's organizations of the period, often espoused pacifist ideologies although according to Tomes, "Officially, the ICN never advocated a pacifist position in relation to war," and pacifism was a minority perspective.[172] Indeed, as Tomes and Penny Starns argue, the British nursing profession used military service as a key strategy to eventually gain state registration and professional status.[173] When the Canadian Nurses Association made a recommendation in 1937 that the International Council of Nurses "sponsor and support measures for the promotion of world peace and control of armaments," it was contested. Canadian nurse Grace Fairley had to withdraw the recommendation.[174] According to Joan Lynaugh, a New Internationalism emerged following the Second World War, that took an even more activist stance in support of peace efforts and international relief work.[175]

This was the larger context within which Canadian military and civilian nurses found themselves following the Second World War. There was less societal inclination to commemorate the war than there had been after the Great War, and there was a professional culture of internationalism. Relief efforts also served to reinforce a pre-existing nursing work culture of self-sacrifice and altruism.[176] Therefore, commemoration through living memorials, in the form of libraries and material relief to other nurses, was congruent with prevailing nursing ideologies among the profession's leaders.

A second way that the Canadian profession chose to commemorate the Nursing Sisters was to provide financial resources to members within their community, through an educational scholarship named after Matron-in-Chief Agnes Neill, the senior Nursing Sister officer at the end of the war.[177] Neill bequeathed $1000 to the NSAC on her death in 1950, "to benefit nurses who have served or are serving in the RCAMS [Royal Canadian Army Medical Service]." Neill's two sisters matched that amount and individual NSAC units raised an additional $5000, for a total of at least $7000 to establish the Agnes C. Neill Memorial Fund. Initially, terms stipulated that

monies were to be used for further education, hospital care for veteran nurses, and for life membership grants. CNA agreed to administer the fund and the first award went to The Second World War NS Janet Wallace at the June 1960 biennial meeting in Halifax. The criteria varied over the years as fewer Nursing Sisters applied. In 1970 it became a bursary awarded by the Canadian Nurses' Foundation as the Agnes Campbell Neill Memorial Award, for which all Canadian nurses were eligible. The scholarship award was a product of the nursing elite—donated by one of the profession's leaders and administered by other leaders. While many Nursing Sisters did take postgraduate courses after the war, a relatively small proportion of these were rank-and-file nurses.

Decisions regarding the Canadian Nurses Association's War Memorial, the living memorials, and the Agnes Neill award were initiatives taken by the nurses themselves to commemorate their colleagues. One form of public recognition was the awarding of war medals, a type of commemoration that they shared with military men. But nurses shared only in campaign awards and stars, as well as length of service awards: the Canadian Volunteer Service Medal, the Defence Medal, the War Medal 1939-45, the 1939-45 Star, and the campaign stars for Italy, France and Germany, and the Pacific. Instead of the Decorations that men received, Nursing Sisters were eligible for two specially-created awards. The Royal Red Cross, First Class was instituted in 1883, and designated for trained nurses. The Associate Royal Red Cross was instituted in 1915, and designated for either trained or assistant nurses. These decorations were to be awarded for "exceptional devotion and competency in the performance of actual nursing duties, over a continuous and long period" or "some very exceptional act of bravery and devotion at her post of duty."[178] During the Second World War, 71 Nursing Sisters received the Royal Red Cross, 4 received Bars to Royal Red Cross, 311 received the Associate Royal Red Cross, and more than 100 nurses were 'Mentioned in Despatches.'[179] One Nursing Sister, RCN Dietician Margaret Brooke, received the Order of the British Empire for heroism in trying to save the life of Nursing Sister Agnes Wilkie when the *SS Caribou* was sunk by a German submarine.[180] The nurses frequently indicated that they didn't know how or why nurses were selected to receive the

awards. NS Dorothy Macham received the Associate Royal Red Cross decoration while in Italy: "I had no idea what this was for. It must have come up in the rations that day. . . . I never knew why."[181] But in actual practice, overseas Matrons typically received the Royal Red Cross and Assistant Matrons received the Associate Royal Red Cross because of perceived leadership roles.

Beyond these official forms of commemoration and social memory, the Second World War Nursing Sisters do have personal private 'memories' often supplemented by diaries or notes, which they have kept over the years. Only two nurses have published their memoirs, while military nurses' diaries remain private, for the most part. They also have personal items such as entire or partial uniforms, awards and commissions, poetry written by or about military nurses, playbills and luncheon menus, a few photographs, and occasionally, a piece of equipment such as a canvas basin or field dressing. At least one Nursing Sister came home with a German sword while another kept a piece of shrapnel.[182]

The examination of material memory and commemoration has been useful to illuminate this community's self-perception, as well as its social memory. The Nursing Sister community has portrayed itself, and been portrayed variously by others. During the immediate postwar period, the nursing profession portrayed Nursing Sisters as leaders. They were featured in the "Nurses to Know" section of the *Canadian Nurse* with descriptions of their military awards and decorations as well as their immediate civilian appointments or educational achievements. Within a few years, they became merely "Interesting People" and then disappeared into civilian life except for the annual November issues.

More interest developed during the late 1980s and 1990s within the profession and to a very small extent within women's history as feminists sought to recover women from obscurity. These interests have resulted in oral history collections and preservation efforts such as the Concordia University Oral History Project at Montreal in the mid-1880s and a collection on "Nurses and Their Work" at the Provincial Archives of Manitoba.[183] Within nursing, the renewed interest at the provincial level was instrumental in the creation of oral history projects, especially

in British Columbia and Ontario.[184] These collections, anthologies, and historical documentaries tend to portray Nursing Sisters as heroines, as angels of mercy, and as patriots deserving of equal honour and military awards as the men received. They make a valuable contribution toward the creation of sources and for military nursing social memory although their relative inaccessibility is a limiting factor.

The symbolic community has constructed a discourse around Nursing Sisters as professional change agents, reluctant warriors and heroines, and sometimes as feminists who broke gender barriers.[185] It has sustained the discourse on nursing as vocation and religious calling, without raising contradictions between caring for life and taking life during wars. The symbolic community has avoided revelations of rivalries or dissensions among Nursing Sisters, while generally ignoring myriad forms of danger, risk, and unpleasantness other than one heroic death attributed to enemy action.[186] It has avoided any hint of sexuality other than within married, heterosexual relationships, as well as any age other than young. The symbolic community has also downplayed power inequalities--portraying men and women, physicians and nurses as equals in the armed forces. The military has been portrayed as breaking down gender stereotypes and providing new opportunities for women, rather than as a system that reinforced gendered roles like military nursing. For the most part, this was a social memory that the Nursing Sisters helped to shape through its leaders, associations, and decisions regarding commemoration.

Summary

During the Second World War, civilian nurses joined the Canadian armed forces and created a distinctly female community embedded within the larger male military system. This community was legitimated by the military's need for nurses' skills, and identity as a Nursing Sisters was based initially on shared physical and social spaces. But their position within military medical units was understood to be temporary, gendered, and contingent on a state of war.

Removed from their prewar social and professional networks, military nurses forged a different set of relationships that, ultimately, shifted their experience as a community from shared physical settings to a mental construct that has endured across time and space for many of them. But the abrupt cessation of war disrupted and dispersed the Nursing Sisters.

Suddenly released from settings where most of their decisions were made for them, many Nursing Sisters struggled to relocate themselves in civilian settings. They sought to re-create some of the lost relationships and camaraderie, in the form of a symbolic community that served as a supportive resource, a repository of meaning, and an extended sisterhood. To do so, it was necessary to shape a unified public image and a social memory that was congruent with prevailing forms of male commemoration. They have been partially successful in maintaining a small presence within veterans' groups, military museums, and historical records. But a paucity of material memory has resulted in a parallel loss within the wider Canadian social memory as the Second World War Nursing Sisters die. NS Jessie Morrison reminded her audience of this paradox and reinforced the discourse of 'service' as part of military nurses' social memory in a 1974 address:

> The branches of the tree are becoming bare: Hopefully there won't be a new crop of leaves. By the terms of our membership this necessitates war—and we don't want that. . . . We hope that when all the leaves have fallen there will be something of substance left behind for the enrichment of future generations. We hope they might read our records and learn from them that life's greatest rewards are found in giving service to others.[187]

This symbolic community served best as a resource for its members and a place where Nursing Sisters made, or believe they made, a similar sense of things.

Endnotes

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[1] "Prayer on Hearing V-E Day Proclamation," Marguerite McLimont, NS at Bologna, Italy in May 1945. As read by Florence Louise Jamieson in her interview with Margaret M. Allemang at Toronto, Ontario on 24 May and 3 June 1987, Oral History Collection, Margaret M. Allemang Centre for the History of Nursing at Toronto [hereafter as MMA].

[2] Margaret Van Scoyoc, audio-taped interview with author at Kingston, Ontario on 13 June 2001.

[3] Constance Betty Nicolson Brown, audio-taped interview with author at Ottawa, Ontario on 3 June 2001.

[4] These concepts have been derived from literature on community and social memory that includes: Barry Wellman and Barry Leighton, "Networks, Neighborhoods, and Communities: Approaches to the Study of the Community Question," *Urban Affairs Quarterly* 14, no. 3 (March 1979): 363-390; Benedict Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism*, rev. ed. (New York: Verso, 1991); A. P. Cohen, *The Symbolic Construction of Community* (New York: Tavistock Publications, 1985); Charles Wetherell, Andrejs Plakans, and Barry Wellman, "Social Networks, Kinship, and Community in Eastern Europe," *The Journal of Interdisciplinary History* 24, no. 4 (Spring 1994): 639-663.

[5] Cohen, *Symbolic Construction of Community*: 12.

[6] Cohen, *Symbolic Construction of Community*: 16.

[7] Cohen, *Symbolic Construction of Community*: 9 and 12-13.

[8] Anderson, *Imagined Communities*: 6-7.

[9] Wetherell, Plakans, and Wellman, "Social Networks": 646.

[10] John C Walsh and Steven High, "Rethinking the Concept of Community," *Histoire sociale/Social History* 32, no. 64 (November 1999): 256 and 261-262

[11] Brenda McBryde, *Quiet Heroines: Nurses of the Second World War* (Saffron Walden, Essex: Cakebreads Publications, 1989): 230.

[12] Pauline Lamont Flynn, audio-taped interview with author at Ottawa, Ontario on 3 April 2001; Nicolson Brown interview.

[13] Jenéa Tallentire, "Strategies of Memory: History, Social Memory, and the Community," *Histoire sociale/Social History* 67 (Spring 2001): 198.

[14] Tallentire, "Strategies of Memory": 197-212.

[15] Cynthia Enloe, *Maneuvers: The International Politics of Militarizing Women's Lives* (Berkeley: University of California Press, 2000): 218.

[16] Tallentire, "Strategies of Memory": 202-203 and 206.

[17] Joan I. Roberts and Thetis M. Group, *Feminism and Nursing: An Historical Perspective on Power, Status, and Political Activism in the Nursing Profession* (Westport, Connecticut: Praeger, 1995): 147. For fuller discussion, refer to pp. 133-140. Cynthia Enloe called it paradoxical that some women claimed female military roles as a form of feminist liberation—given the degree of subordination and manipulation experienced in the system. See, *Does Khaki become You? The Militarisation of Women's Lives* (Boston: South End Press, 1983): 100.

[18] Nina Rumen, personal communication with author at Vancouver, British Columbia on 18 October 2001; and E. June Parker, audio-taped interview with author at Ottawa, Ontario on 23 November 2001.

[19] Josep R. Llobera, "The Role of Historical Memory in Catalan National Identity," *Social Anthropology* 6, no. 3 (1998): 333 as cited in Tallentire, "Strategies of Memory": 203.

[20] See Walsh and High, "Rethinking the Concept of Community": 256 and 261-262; and Tallentire, "Strategies of Memory: 197 and 199.

[21] Betty Nicolson explained that all but two of her friends, married and raised families instead of returning to a nursing career. She added, "But we never talked about our wartime experience." Nicolson Brown interview.

[22] Pauline Cox Walker, audio-taped interview with author at Kingston, Ontario on 13 June 2001; and Lamont Flynn interview. NS Cox and Lamont have been referenced in previous discussions on the postwar 'silence' among Nursing Sisters, in Chapter 3.

[23] Lt. Colonel/NS (retired) Harriet J. T. Sloan of Ottawa graciously provided a copy of the "Nursing Sisters Association of Canada: Membership Directory, 1958" for this research.

[24] Van Scoyoc interview.

[25] See Karen D. Davis, "Women Join the Navy, 1942-1946 and 1951-1954: Social/Historical Processes and Their Decision to Join," Second Inter-University Colloquium of Sociology Students, McGill University, 26-28 March 1993: 83-92. Amidst the large body of biography and autobiography written by or about male combat units, there are stories regarding the importance of relationships for men but no studies that examine them as a community or communities. One American Internet site notes: "For almost 50 years, World War II has remained a painful memory or a puzzling mystery in the back of most Americans' minds; however, with the release of such movies as "Saving Private Ryan" and "The Thin Red Line," World War II veterans have begun to share their long-buried stories. And none too soon--it is estimated that over 100 World War II veterans are dying daily." See www.members.aol.com/ksurn/page5/index.htm and www.history.navy.mil/faqs/faq87-3b.htm. In a similar manner, the Veterans Affairs Canada/ Anciens Combattants Canada Internet site posts personal anecdotes of World War II men and women at www.vac-acc.gc.ca/general/sub.cfm?source=feature/week2001/recollect/oralhis and www.vac-acc.gc.ca/general/sub.cfm?source=history/secondwar/diary/grandmother.

[26] Jan Bassett, *Guns and Brooches: Australian Army Nursing from the Boer War to the Gulf War* (New York: Oxford University Press, 1992): 95.

[27] McBryde, *Quiet Heroines:* 231 and Diane Burke Fessler, *No Time for Fear: Voices of American Military Nurses in World War II* (East Lansing: Michigan State University Press, 1996): 3.

[28] Mary T. Sarnecky's extensive history of the United States Army Nurse Corps (USANC) did not examine this aspect. See, *A History of the U.S. Army Nurse Corps* (Philadelphia: University of Pennsylvania Press, 1999).

[29] Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996): 25-47. The Canadian and American nursing workforces were remarkably similar in development during these early years. Indeed nurses had a great deal of mobility across national borders and many Canadian nurses became early leaders within the American profession. For a comparison with American training school culture, see Barbara Melosh, *"The Physician's Hand": Work, Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982), and Susan M. Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (New York: Cambridge University Press, 1987) and "A Legitimate Relationship: Nursing, Hospitals, and Science in the Twentieth Century" in *The American General Hospital: Communities and Social Contexts,* eds. Diana Elizabeth Long and Janet Golden, pp. 135-156 (Ithaca: Cornell University Press, 1989).

[30] The number of students reported by the Registered Nurses' Association of Ontario for the largest hospitals included: Victoria Hospital in London, 186; Ottawa Civic Hospital, 189; St. Michael's Hospital in Toronto, 197; Hamilton General, 204; and Toronto General, 277. See "Where Our Ontario Graduates Come From," brochure produced by the, 96B-1-09, RNAO fonds, Archives of Ontario [hereafter as AO].

[31] McPherson, *Bedside Matters*: 64-66 and 147-150. See also the institutional histories of almost any of the hospital schools or biographies of nurse leaders such as: Valerie Knowles, *Leaving with a Red Rose: A History of the Ottawa Civic Hospital School of Nursing* (Ottawa: Deneau Publisher, 1981): 184-196; H. E. MacDermot, *History of the School of Nursing of the Montreal*

General Hospital (Montreal: The Alumnae Association, 1940): 114-121; and Natalie Riegler, *Jean I. Gunn: Nursing Leader* (Markham, Ontario: Associated Medial Services and the Hannah Institute for the History of Medicine, 1997): 51-56.

[32] Nicolson Brown interview. See also Lois Bayly Tewsley, audio-taped interview with author at Ottawa, Ontario on 11 June 2001.

[33] The military, in general, was deliberately insulated from the 'real world,' and constituted a secure haven in overseas settings. See Enloe: *Maneuvers*: 46 and 72.

[34] Jean MacBain MacAulay in *The Military Nurses of Canada: Recollections of Canadian Military Nurses*, vol. II, ed. E. A. Landells (White Rock, B.C.: Co-publishing, 1999): 112 [hereafter cited as *Military Nurses of Canada*].

[35] Norma Fieldhouse, interview with Margaret M. Allemang at Toronto, Ontario on 16 February 1988, MMA.

[36] Lettie Turner, video-taped interview for "Nurses on the Battlefield," producers Lori Kuffner and Barbara Campbell for Cooper Rock Pictures, 2001.

[37] Constance Bond Young, interview with Ella Beardmore at Omeemee, Ontario on 4 July 1989, MMA.

[38] Lamont Flynn interview.

[39] Doris V. Carter, *Never Leave Your Head Uncovered: A Canadian Nursing Sister in World War Two* (Waterdown, Ontario: Potlatch Publications, 1999): 53-54.

[40] For other interviews where the family image is dominant, see: Dorothy A. Macham, interview with Norma Fieldhouse at Toronto, Ontario on 10 February 1988, MMA; Eva Wannop, audio-taped interview with author at Toronto, Ontario on 25 April 2001; Frances Ferguson Sutherland, audio-taped interview with author at Edmonton, Alberta on 10 October 2001.

[41] Elizabeth Dean Doe, audio-taped interview with author at Ottawa, Ontario on 30 June 2001.

[42] Margaret Van Scoyoc, audio-taped interview with Lisa Weintraub, 4 June 1984, ISN 167825, Concordia University fonds, Oral History Project, NAC.

[43] Gaëtane LaBonté Kerr, interview with Lisa Weintraub, 11 April 1985, ISN 167796, Concordia University fonds, Oral History Project, NAC.

[44] Isabel Morrison Fraser, audio-taped interview with author at Ottawa, Ontario on 27 November 2001.

[45] Patricia Moll, audio-taped interview with Lisa Weintraub on 5 July 1985, ISN 167813, Concordia University fonds, Oral History Project, National Archives of Canada [hereafter as NAC].

[46] Cox Walker interview.

[47] Harriet J. T. Sloan, audio-taped interview with author at Ottawa, Ontario, 14 March 2001.

[48] Frances Oakes, audio-taped interview with author at Guelph, Ontario on 15 May 2001.

[49] Doris V. Carter, audio-taped interview with author at Ottawa, Ontario on 22 June 2001.

[50] Beatrice Cole Hunter, audio-taped interview with author at Edmonton, Alberta on 13 October 2001.

[51] Kay Christie, audio-taped interview with Joan Williams, 20 November 1975, ISN 196090, NAC.

[52] Kathleen G. Christie, "Experiences as a Prisoner-of-War, World War 2," interview with Charles G. Roland on 8 December 1982, HCM 28-82, Oral History Archives, Hannah Chair for the History of Medicine, McMaster University, Hamilton, Ontario [hereafter as HCM 28-82].

[53] Christie interview, NAC.

[54] Christie interview, HCM 28-82.

[55] Kathleen G. Christie, "M. & V. for Christmas Dinner," *Canadian Nurse* 63, no. 12 (December 1967): 30.

[56] Kay Christie, interview with Margaret M. Allemang at Toronto, Ontario on 5 April 1992, MMA.

[57] Christie interview, HCM 28-82.

[58] See Cohen, *Symbolic Construction of Community*: 13 for further analysis of perception and boundaries.

[59] Cohen, *Symbolic Construction of Community*: 28, 33, and 36.

[60] Carter, *Never Leave Your Head Uncovered* and Mary M. White, *Hello War, Goodbye Sanity* (Canada: Mary M. White, 1992).

[61] Carter interview; and Mary M. Bower White, audio-taped interview with author at Surrey, British Columbia on 20 October 2001.

[62] Historian Penny Starns argues that British nursing, both civilian and military, was in a state of chaos at the beginning of the Second World War, and that the profession used military service as a professionalizing strategy. For good overviews of Starns argument, see her introductory remarks in *Nurses at War: Women on the Frontline, 1939-45* (Stroud, Gloucestershire: Sutton Publishing, 2000): xii-xvii and 12-15.

[63] Kay Christie, "Behind Japanese Barbed Wire—A Canadian Nursing Sister in Hong Kong," *Royal Canadian Military Institute Year Book* ((Toronto: RCMI, 1979): 13. Additional explanations are found in Kay Christie, interview with Margaret M. Allemang at Toronto, Ontario on 5 April 1992, MMA and the Christie interview, HCM 28-82.

[64] The Queen Alexandra Imperial Military Nursing Service and the Territorial Auxiliary Nursing Service were granted 'emergency' commissions with equivalent rank in 1941 but did not become "Nursing Officers" until 1942. Arthur Salusbury MacNalty and W. Franklin Mellor, eds., *Medical Services in War: The Principal Medical Lessons of the Second World War Based on the Official Medical Histories of the United Kingdom, Canada, Australia, New Zealand and India* (London: H.M.S.O., 1968): 77-78 and Juliet Piggott, *Queen Alexandra's Royal Army Nursing Corps* (London: Leo Cooper, 1975): 73.

[65] Claire (Murray) Bowman in *Military Nurses of Canada*, vol. I: 319.

[66] Bond Young interview, MMA.

[67] See a general discussion of the tactical decisions to abandon the plan for a French brigade in C. P. Stacey, *Official History of the Canadian Army in the Second World War*, vol. I: *Six Years of War—the Army in Canada, Britain and the Pacific* (Ottawa: Queen's Printer, 1955): 44-45. Nicholson mentions No. 17 CGH as one unit originally intended to be a French-speaking unit, but he notes that it was not possible to admit casualties based on the criterion of language. See *Canada's Nursing Sisters*: 130-131. It is likely that the military found it more advantageous to mix staffing and create a more flexible work force.

[68] Bond Young interview, MMA.

[69] Refer to the previous discussions in Chapters 3 and 4, for the benefits of mixed staffing.

[70] Estell Tritt Aspler, audio-taped interview with author at Westmount, Québec on 13 August 2001.

[71] Helen K. Mussallem, audio-taped interview with author at Ottawa, Ontario on 24 September 2001.

[72] Margaret Fletcher, letters of 10 September and 28 October 1943 to her family, Margaret Fletcher fonds: 1933-1945, SC042, University of Victoria Archives and Special Collections, British Columbia Archives [hereafter as the Fletcher letters, BCA].

[73] Dorothy A. Macham in *Military Nurses of Canada*, vol. I: 311.

[74] Margaret Roe Dewart, audio-taped interview with author at Edmonton, Alberta on 15 October 2001. The epithet "frog" was a common expression in English Canada; it symbolized French-English tensions and anti-French prejudice.

[75] Suzanne Giroux to Eileen Flanagan in "Overseas Mail," *Canadian Nurse* 39, no. 5 (May 1943):

344.

[76] Morrison Fraser interview.

[77] Carter, *Never Leave Your Head Uncovered*: 7 and 41.

[78] Carter, *Never Leave Your Head Uncovered*: 150. See also pp. 149-151.

[79] See for example, Carter, *Never Leave Your Head Uncovered*: 5.

[80] For more discussion on nurse training schools and the admission process, see: McPherson, *Bedside Matters*: 12, 15-18, and 30; Knowles, *Leaving with a Red Rose*: 22; and John Murray Gibbon and Mary S. Mathewson, *Three Centuries of Canadian Nursing* (Toronto: Macmillan Company of Canada, 1947): 156.

[81] See Chapter 3. Matron Sharpe was resented by some of the Nursing Sisters who felt that she treated them more like student nurses than as graduate nurses who had been working independently prior to the war.

[82] Fletcher letter, 12 January 1944, BCA.

[83] Fletcher letter, 7 September 1943, BCA.

[84] See G. W. L. Nicholson, *Canada's Nursing Sisters* (Canada: Samuel Stevens Hakkert & Company, 1975): 199-205. Whether or not these other professional women were graduates of university degree programs, or had earned university certificates in their specialty, depended on when they graduated. University programs in physiotherapy, occupational therapy, household science, and household economics were evolving during the interwar years. In the NSD, for example, there were thirty-four physiotherapy aides (the official designation by the armed forces during the war). They graduated between 1918 and 1944, and at least five of them specified their educational preparation as diplomas or certificates with three of these earned in hospitals. There were twenty-two Dieticians, graduating between 1930 and 1944. Eight dieticians (36%) graduated from hospital or agricultural school courses, with certificates in dietetics. Finally, there were fifteen occupational therapists. They graduated between 1932 and 1945: one from a three-year program at Boston University, and the other fourteen from the University of Toronto. The armed forces resolved most qualification issues by requiring professional women to be 'members in good standing with their professional associations,' thereby avoid credentialing problems. The requirement for dieticians was upgraded in October 1943, from a diploma to a degree. For fuller analysis of the professional development of dieticians and physiotherapists, see: Ruby Heap, "From the Science of Housekeeping to the Science of Nutrition: Pioneers in Canadian Nutrition and Dietetics at the University of Toronto's Faculty of Household Science, 1900-1950," in *Challenging Professions: Historical and Contemporary Perspectives on Women's Professional Work*, eds. Elizabeth Smyth, Sandra Acker, Paula Bourne, and Alison Prentice, pp. 141-170 (Toronto: University of Toronto Press, 1999) and "Training Women for a New 'Women's Profession': Physiotherapy Education at the University of Toronto, 1917-40," *History of Education Quarterly* 35, no. 2 (1995): 135-158.

[85] Dean Doe interview.

[86] Mussallem interview.

[87] C. P. Stacey, *Official History of the Canadian Army in the Second World War*, vol. 1: *Six Years of War: The Army in Canada, Britain and the Pacific* (Ottawa: Queen's Printer, 1955): 432.

[88] By 15 May 1946, the last Canadian medical units in Europe were closed down. W. R. Feasby, ed., *Official History of the Canadian Medical Services, 1939-1945,* vol. I*: Organization and Campaigns* (Ottawa: Queen's Printer, 1956): 302-303.

[89] Mussallem interview.

[90] Allemang, Ferguson Sutherland, and Mussallem interviews.

[91] A summary of the discharge interview was included in almost all of the personnel records sampled for the NSD. NS Margaret Van Scoyoc spoke at length, regarding the desire of many of

her colleagues to remain in the armed forces, in her interview.

[92] Lamont Flynn interview.

[93] Carter, *Never Leave Your Head Uncovered*: 142.

[94] Mabel (Glew) Tweddell in *Military Nurses of Canada*, vol. I: 194-195.

[95] Van Scoyoc interview, NAC.

[96] Anne A. (Gair) Evans in *Military Nurses of Canada*, vol. I: 348.

[97] Margaret H. Mills, interview with Margaret M. Allemang at Toronto, Ontario on 5 April 1991, MMA.

[98] Ruth Littlejohn McIlrath, audio-taped interview with Nina Rumen on 20 October 1987 and 23 November 1988, Oral History Collection, Registered Nurses Association of British Columbia Library [hereafter cited as RNABC]. Linda Beeber found that World War I Red Cross nurses had similar experiences of not belonging or feeling lost after the war in her qualitative analysis based published memoirs, published accounts in the professional literature, and taped interviews. See "To be one of the Boys: Aftershocks of the World War I Nursing Experience," *Advances in Nursing Science* 12, no. 4 (1990): 32- 43.

[99] Jamieson interview, MMA.

[100] Fletcher letter, 21 January 1945, BCA. Fletcher's subtext here, referring to making the most of "short opportunities" is revealing when linked to other remarks from her letters. In Chapter 3, for example, I cited a reference to "borrowing" relationships while overseas where "no one has been burned," as well as her warning to family members that some behaviours occurred overseas that would be considered unacceptable at home.

[101] Van Scoyoc interview, NAC.

[102] Dorothy Agnes Potts, interview with Margaret M. Allemang at Toronto, Ontario on 30 September 1987, MMA.

[103] Bond Young interview. NS Carter also spoke of this discrimination, writing the Prime Minister Mackenzie had promised all Nursing Sisters first-class accommodations on the return trip home but that the War Brides were placed there and Nursing Sisters went to the lower decks. See *Never Leave Your Head Uncovered*: 143 and 145-146.

[104] Lamont Flynn interview.

[105] Van Scoyoc interview, NAC.

[106] Eleanor (Jones) MacGregor, "Defending the Empire," unpublished paper in possession of author.

[107] Elizabeth B. Pense Neil, interview with Norma Fieldhouse at Kingston, Ontario in March 1987, MMA.

[108] Margaret M. Allemang, audio-taped interview with author at Toronto, Ontario on 26 April 2001.

[109] Fletcher letter, 29 April 1945, BCA.

[110] Nina Rumen, personal communication with author at Vancouver, B. C. on 18 October 2001.

[111] NS June Parker began her military career as a radar technician for the RCAF Women's Division during the war. She trained as a nurse after the war and enlisted as a RCAF Nursing Sister in 1959, retiring in 1974. Parker described her first posting as the worst time of her career—twelve months of isolation in Goose Bay, Labrador. For her second posting, she was sent to a Naval hospital against her wishes where she was told, "June, you will conform or else." E. June Parker, audio-taped interview with author at Ottawa, Ontario on 23 November 2001.

[112] Lamont Flynn interview.

[113] Margaret Dewart and Jessie Morrison, "Formation of the First Unit – Edmonton, 1920," *Nursing Sisters Association of Canada: Commemorative Issue & National Directory* (Edmonton: Nursing

Sisters Association of Canada, 1990): 81.

[114] Morrison, "Address to Royal Alexandra Hospital Nurses Alumnae" and n.a., "The Nursing Sisters Association of Canada, 1920-1966," Agnes MacLeod Scrapbook, AARN; Dewart and Morrison, "Formation of the First Unit": 81-82; and Nicholson, *Canada's Nursing Sisters*: 106-112.

[115] Nicholson, *Canada's Nursing Sisters*: 109.

[116] Nicholson, *Canada's Nursing Sisters*: 224.

[117] Bayly Tewsley interview.

[118] Cole Hunter interview.

[119] Nicholson, *Canada's Nursing Sisters*: 223.

[120] "Nursing Sister' Association of Canada," *Canadian Nurse* 43, no. 1 (January 1947): 71.

[121] Jessie Morrison, "Address to Royal Alexandra Hospital Nurses Alumnae—Edmonton, December 9, 1974," Jessie Morrison fonds, 87.4, 91.30 and 92.10, Alberta Association of Registered Nurses Museum and Archives [hereafter as AARN].

[122] Lotta Dempsey, "Canadian Nurses Will Recall War Years," *Toronto Globe and Mail,* 21 June 1975.

[123] Dewart and Morrison, "Formation of the First Unit": 82.

[124] Kay Poulton, in Bill McNeil, *Voices of a War Remembered: An Oral History of Canadians in World War Two* (Toronto: Doubleday Canada, 1991): 91.

[125] Van Scoyoc interview.

[126] Nicolson Brown interview.

[127] For examples of these reports during the immediate postwar years, see: "Overseas Nursing Sisters Association," *Canadian Nurse* 36, no. 1 (January 1940): 32; "Nursing Sisters Association of Canada," *Canadian Nurse* 42, no. 1 (January 1946): 80 and 82; "Nursing Sisters Association of Canada," *Canadian Nurse* 42, no. 3 (March 1946): 246; "Nursing Sisters Association of Canada," *Canadian Nurse* 42, no. 4 (April 1946): 342; "Nursing Sisters Association of Canada," *Canadian Nurse* 43, no. 1 (January 1947): 71-72; and "Nursing Sisters Association of Canada," *Canadian Nurse* 43, no. 9 (September 1947): 728-729. See also: Morrison, "Address to Royal Alexandra Hospital Nurses Alumnae."

[128] "Nursing Sisters Association of Canada," *Canadian Nurse* 42, no. 3 (March 1946): 246.

[129] Lt. Colonel/NS (retired) Harriet J. T. Sloan of Ottawa graciously provided a copy of the "Nursing Sisters Association of Canada: Membership Directory, 1958" for this research.

[130] Morrison, "Address to Royal Alexandra Hospital Nurses Alumnae."

[131] Cohen, *Symbolic Construction of Community*: 50.

[132] Jonathan Vance, *Death So Noble: Memory, Meaning, and the First World War* (Vancouver: University of British Columbia Press, 1997): 260. Jay Winter used similar concepts in *Sites of Memory, Sites of Mourning: The Great War in European Cultural History* (New York: Cambridge University Press, 1995): 34 and 224.

[133] This story appears frequently in many sources such as the accounts in Landells, Military Nurses of Canada. I cite it here, from Elizabeth (Andreas) McIntosh in *Nursing Sisters Association of Canada: Commemorative Issue & National Directory*: 29.

[134] See the various interviews by Joan Williams, Charles Roland, Bill McNeil, and Margaret Allemang as well as Christie's publications.

[135] Janéa Tallentire, distinguishes material memory as the "tangible basis of community identity," from social memory as "the mental constructs" of community identity. See, "Strategies of Memory": 211.

[136] Historians Jonathan Winter and Jonathan Vance each studied the First World War related to memory and commemoration in their respective European and Canadian contexts. Both authors demonstrated the development of extensive cultural and material memory that emerged after the Great War. Both explored ways in which meaning both shaped and was shaped by particular forms of memory. Politically, the interwar years were largely occupied (if not consumed) by the construction of these various meanings.

[137] Winter, *Sites of Memory, Sites of Mourning*: 9.

[138] Kathryn McPherson, "Carving out a Past: The Canadian Nurses' Association War Memorial," *Histoire sociale/Social History* 29, no. 58 (November 1996): 418-419. McPherson provides a provocative and insightful analysis of the Nursing Sisters' Memorial, pointing out contradictions in imagery as well as the contested process of negotiating its location.

[139] Nicholson, *Canada's Nursing Sisters*: 94-96 and 98.

[140] McPherson, "Carving Out a Past": 429. See also Nicholson, *Canada's Nursing Sisters*: 103-106 for decisions and negotiations related to the Nursing Sisters' Memorial and on the Internet at http://www.vac-acc.gc.ca/general/sub.cfm?source=memorials/memcan/memnurse. A smaller sculpture, created by Beatrice Catherine Lennie, was installed at the Shaughnessy Military Hospital at Vancouver, British Columbia in 1940. It depicts a World War I Nursing Sister, with an inscription that reads simply, "Canadian Medical Corps." See: "Lennie Sculpture 1940," Commemorative card produced by the British Columbia History of Nursing Professional Practice Group, 1999.

[141] A wing of the Shaughnessy Military Hospital was named the Jean Matheson Memorial Pavilion; a military hospital on Prince Edward Island was re-named the Rena McLean Memorial Hospital; and Mount Wake, British Columbia was named in commemoration of NS Gladys Maude Wake. See: Nicholson, *Canada's Nursing Sisters*: 112 and Marjorie Barron Norris, *Sister Heroines: The Roseate Glow of Wartime Nursing, 1914-1918* (Calgary: Bunker to Bunker Publishing, 2002): 146-147. For memorial windows, refer to: "The Nurse Memorial Window, Canadian Memorial Church, The United Church of Canada," commemorative card of the B. C. History of Nursing Professional Practice Group, Vancouver, 1989; "Christ Church Cathedral Anglican Church of Canada," commemorative card of the B. C. History of Nursing Professional Practice Group, Vancouver, 1997; Nicholson, *Canada's Nursing Sisters*: 112. The 1921 Lens window at Kingston's Memorial Hall (Ontario) was dedicated to the fourteen nurses who died in the sinking of the *Llandovery Castle*. Another window depicting a First World War nurse was donated by nursing veterans of the First World War to the Canadian Memorial Church at Vancouver, British Columbia in 1928. Major J. Mathews donated a memorial window to Vancouver's Christ Church Cathedral in 1950 as a tribute to his wife, a First World War Nursing Sister. A fourth window was installed in Pemberton Chapel at the Royal Jubilee Hospital School of Nursing in Victoria, British Columbia during 1984 as a joint effort of the Victoria Nursing Sisters unit and Veterans Affairs Canada. Internet sites: www.rjhnursingalum.com/chapel_3.html and www.city.kingston.on.ca/visitors/memhall/index.asp; http://www.bcnursinghistory.ca/cards.html

[142] For the art panels, see the cover of Nicholson's history, *Canada's Nursing Sisters,* as well as, the Canadian War Museum's War Art Collection in Ottawa.

[143] The book of World War I veterans was not completed until 1942. The names are inscribed in elaborate calligraphy and in order that all of the names may be viewed once a year, pages in the Books of Remembrance are turned daily in an elaborate "Turning of the Page Ceremony" precisely at 1100. See: www.vac-acc.gc.ca/general/sub.cfm?source=collections/books

[144] Called the "Next-Of-Kin Memorial Avenue" at Woodlawn Cemetery, trees could be planted there for each individual with a plaque at its base giving the details about the individual that the tree memorialized. One bears a simple plaque that reads: "In Grateful Tribute to the memory of the 14 nursing Sisters who furished [sic] on the Llandovery Castle - A NURSE." See: www.city.saskatoon.sk.ca/org/parks/cemetery/memorial/memorial.htm

[145] "Manitoulin District Cenotaph and Veterans Memorial Gardens," Royal Canadian Legion, branches 177 and 514, Little Current, Ontario.

[146] This library closed at the end of the 1990s with the transferral of material to the National Archives of Canada, the Canadian Museum of Civilization, and the National War Museum.

[147] A memorial window located at the Soldier's Tower, Hart House (University of Toronto) was dedicated in November 1995. One panel of the window contains an image of a Nursing Sister who represents 'all' serving women. See: www.alumni.utoronto.ca/groups/tower.htm

[148] There is a good description and image of the Volunteer Service Medal on the Internet at http://www.vac-acc.gc.ca/general/sub.cfm?source=collections/cmdp/mainmenu/group04/cvsm. Alex McLaren did the oil painting as a composite from photographs of three Nursing Sisters. It was used as the basis for a War Finance Committee's Victory Bond poster in the series titled "Now, more than ever..." See "Canadian Nurse," C-143234, Accession 1992-364-1, Documentary Art Department, NAC. NS Frances Copeman recalled having her photograph taken as one of the models for this portrait, in Jean E. Portugal, *We Were There: The Navy, the Army, and the RCAF: A Record for Canada*, v. 5 (Shelburne, Ontario: The Battered Silicon Dispatch Box, 1998): 2257-2258. Song lyrics for "Our Canadian Nursing Sister" were written by John Murray Gibbon and arranged by Harold Eustace Key (Toronto, Canada: Gordon V. Thompson, 1946).

[149] "Why Buy Victory Bonds?" *Canadian Nurse* 40, no. 4 (April 1944): 258. Also see the promotional article, Margaret E. Kerr, "That Men May Serve," *Canadian Nurse* 40, no. 10 (October 1944): 758.

[150] "Why Buy Victory Bonds?" *Canadian Nurse* 40, no. 4 (April 1944): 258.

[151] *Three Centuries of Canadian Nursing* was the first and only Canadian history of nursing until the mid-1990s. The other author was Mary Mathewson, Assistant Director for the School for Graduate Nurses at McGill University and Director of Nursing at the Montreal General Hospital during the 1940s. See John Murray Gibbon and Mary S. Mathewson, *Three Centuries of Canadian Nursing* (Toronto: Macmillan Company of Canada, 1947).

[152] Gibbons biography appears on the jacket cover for *Three Centuries of Canadian Nursing*. See also: Donald J. C. Phillipson, "John Murray Gibbon," in *The Canadian Encyclopedia*, Year 2000 ed., ed. James H. Marsh: 976.

[153] John Murray Gibbon, "Our Canadian Nursing Sister," arranged by Harold Eustace Key (Toronto, Canada: Gordon V. Thompson, 1946).

[154] Cited from minutes of the 14th biennial meeting, 19 June 1954 by Nicholson, *Canada's Nursing Sisters*: 223-224.

[155] Nicholson's received $10,000 for this history, published in 1975 as *Canada's Nursing Sisters*.

[156] Moll interview, NAC.

[157] Bassett, *Guns and Brooches*: 1.

[158] Fessler, *No Time for Fear*: 2.

[159] Lamont Flynn interview.

[160] For examples of these reports during the immediate postwar years, see: "Overseas Nursing Sisters Association," *Canadian Nurse* 36, no. 1 (January 1940): 32; "Nursing Sisters Association of Canada," *Canadian Nurse* 42, no. 1 (January 1946): 80 and 82; "Nursing Sisters Association of Canada," *Canadian Nurse* 42, no. 3 (March 1946): 246; "Nursing Sisters Association of Canada," *Canadian Nurse* 42, no. 4 (April 1946): 342; "Nursing Sisters Association of Canada," *Canadian Nurse* 43, no. 1 (January 1947): 71-72; and "Nursing Sisters Association of Canada," *Canadian Nurse* 43, no. 9 (September 1947): 728-729. See also: Morrison, "Address to Royal Alexandra Hospital Nurses Alumnae."

[161] Nicholson, *Canada's Nursing Sisters*: 226.

[162] "55th Anniversary of D-Day and the Battle of Normandy Campaign: A Delegation to

Remember," www.vac-acc.gc.ca/general/sub.cfm?source=feature/normandy/norm_bios. Also refer to reports filed with the NSAC from Shirley Kelly, "My Pilgrimage to Hong Kong, Nov. 28 – Dec. 7, 2000" and Mary Hutton, "Pilgrimage to Repatriate and Inter the Unknown Soldier, 23-28 May 2000." See also, minutes of the NSAC, Ottawa unit, 11 May 2001 and Sarah Staples, "Nurse Returns to Dieppe to Mark 60th Anniversary," *Ottawa Citizen*, 10 August 2002.

[163] Two documentaries have been produced since the mid-1990s: "Angels of Mercy: The Story of Nursing Sisters from World Wars I & II," Sound Venture Productions, Ottawa, 1994 and "Nurses on the Battlefield," Cooper Rock Pictures, 2001. *The English Patient* was a full-length, feature film produced by Miramax Films and Tiger Moth Productions (1996) that included a Second World War Canadian Nursing Sister as one of the main characters. Each November there are special interviews conducted with veterans and frequently there is a Nursing Sister included in the groups. One example is the "Remembrance Day Town Hall," with Peter Mansbridge at Vimy House in Ottawa on 11 November 2000 produced by the Canadian Broadcasting Corporation.

[164] Ethel Cryderman, "War Memorial Committee," *Canadian Nurse* 42, no. 9 (September 1946): 792 and Margaret E. Kerr, "War Memorial Committee," *Canadian Nurse* 44, no. 6 (June 1948): 480.

[165] Kerr, "War Memorial Committee:" 481.

[166] Ethel Cryderman, "War Memorial Committee," *Canadian Nurse* 42, no. 9 (September 1946): 792 and Margaret E. Kerr, "War Memorial Committee," *Canadian Nurse* 44, no. 6 (June 1948): 480.

[167] "The Nursing Sisters Association of Canada, 1920-1966," AARN.

[168] Kerr, "War Memorial Committee": 480.

[169] A consortium of authors recently published a remarkable history of the International Council of Nurses (ICN) based on a century of organizational existence. One of the analytical themes was the ICN's role as an international community or as the authors called it, a 'nursing state.' See Barbara L. Brush and Joan E. Lynaugh, eds., *Nurses of All Nations: A History of the International Council of Nurses, 1899-1999* (Philadelphia: Lippincott, 1999): xiv.

[170] These historians contributed pertinent individual chapters to the collective history *Nurses of All Nations*: Nancy J. Tomes with Geertje Boschma, "Above All Other Things—Unity," pp. 1-38; Anne Marie Rafferty with Geertje Boschma, "The Essential Idea," pp. 39-70; Meryn Stuart, "Seeking Stability in the Midst of Change," pp. 71-110; and Joan E. Lynaugh, "From Chaos to Transformation," pp. 111-147.

[171] Rafferty with Boschma, "The Essential Idea": 44. The authors provided an excellent analysis of the ICN as an imagined community, of colonialism within the organization, and the tension between nationalism and the 'nursing state' as part of their discussions. See pp. 41and 45-56 in particular.

[172] Tomes, "The Essential Idea": 44.

[173] Starns, *Nurses at War:* xiii and xv-xvi.

[174] Lynaugh, "From Chaos to Transformation": 113-114.

[175] Lynaugh, "From Chaos to Transformation": 120.

[176] While this image is part of conventional wisdom associated with nurses and their training, the discourse is clear in examples of training school admission processes. See: Knowles, *Leaving with a Red Rose*; and MacDermot, *History of the School of Nursing of the Montreal General Hospital.* Also refer to McPherson, *Bedside Matters*: 27-31; and Meryn Stuart, "War and Peace: Professional Identities and Nurses' Training, 1914-1930," in *Challenging Professions: Historical and Contemporary Perspectives on Women's Professional Work*, eds. Elizabeth Smyth, Sandra Acker, Paula Bourne, and Alison Prentice (Toronto: University of Toronto Press, 1999): 171-172.

[177] Nicholson, *Canada's Nursing Sisters*: 224-226; Morrison, "Address to Royal Alexandra

Hospital Nurses Alumnae": 7; and "The Nursing Sisters Association of Canada, 1920-1966": 3.

[178] www.vac-acc.gc.ca/general/sub.cfm?source=collections/cmdp/mainmenu/group01

[179] Nicholson, *Canada's Nursing Sisters*: 208; Bassett, *Guns and Brooches*: 176; and Elizabeth M. Norman, *We Band of Angels*: T*he Untold Story of American Nurses Trapped on Bataan by the Japanese* (New York: Random House, 1999): 235-238.

[180] Nicholson, *Canada's Nursing Sisters*: 203.

[181] Macham interview, MMA and in *Military Nurses of Canada*, vol. I: 309.

[182] Lamont Flynn interview; Roe Dewart interview.

[183] The project at Concordia involved interviews of women and war work, and were deposited with the National Archives of Canada. I have used several interviews that were conducted with Nursing Sisters: Patricia Moll, interview with Lisa Weintraub on 5 July 1985, ISN 167813; Margaret Van Scoyoc, interview with Lisa Weintraub, 4 June 1984, ISN 167825; and Gaëtane LaBonté Kerr, interview with Lisa Weintraub, 11 April 1985, ISN 167796. Concordia University Oral History Project, Concordia University fonds, National Archives of Canada. The Provincial Archives of Manitoba holds the collection of oral histories with nurses conducted by Kathryn McPherson, entitled "Nurses and Their Work," Oral History Collection.

[184] The British Columbia History of Nursing Professional Practice Group and the Margaret M. Allemang Centre for the History of Nursing are to be commended for their foresight and leading endeavours in oral history collections related to the Nursing Sisters. As well, Edith Landells has made a valuable contribution through her three-volume set of military nurses' recollections that she published independently between 1995 and 1999. Landells maintains an Internet site related to these volumes and works actively to disseminate the material to educational institutions throughout Canada. See: http://www.addison.bc.ca/military_nurses. From the mid-1980s to early 1990s, Margaret M. Allemang organized and oversaw the creation of an oral history collection, conducting many of the interviews herself. Fourteen of them were Second World War Nursing Sisters: Kathleen G. Christie, audio-taped interview with Margaret Allemang on 5 April 1992 and 3 June 1992; Norma Fieldhouse, audio-taped interview with Margaret Allemang on 16 Feb 1988; Florence Louise Jamieson, audio-taped interview with Margaret Allemang on 24 April and 3 May 1987; Margaret Helena Kellough, audio-taped interview with Margaret Allemang on April and May 1987; Dorothy A. Macham, audio-taped interview with Norma Fieldhouse on 10 February 1988; Margaret H. Mills, audio-taped interview with Margaret Allemang on 5 April 1991; Elizabeth Pense Neil, audio-taped interview with Norma Fieldhouse in March 1987; Elizabeth Harpham Orford, audio-taped interview with Margaret Allemang on 9 October 1991 and 26 January 1993; Dorothy Agnes Potts, audio-taped interview with Margaret Allemang on 30 September 1987; Helen Morton Rendall, audio-taped interview with Margaret Allemang on 14 and 21 March 1986; Susan Isabel Rowland, audio-taped interview with Ella Beardmore on 15 May 1988; Berna Thompson Tuckwell, audio-taped interview with Ella Beardmore on 10 June 1988; Eva R. Wannop, audio-taped interview with Margaret Allemang on 28 August 1991; Constance Bond Young audio-taped interview with Ella Beardmore on 4 July 1989. These interviews or transcripts are held at the Margaret M. Allemang Centre for the History of Nursing, Oral History Collection at Toronto, Ontario.

[185] For a few of the many existing examples, see: Earl McRae, "Nursing Sister Agnes Wilkie Represented the Best of Canadian Womanhood," *Ottawa Sun* (10 March 2002): 5; David Stonehouse, "Horrors of War, Triumphs of Spirit," *Ottawa Citizen* (19 March 2001): A3; "Welcome—Nursing Sisters of Canada," *Alberta Association Of Registered Nurses* 50, no. 5 (May 1994): 12; Bev Wake, "Valiant Nurse gets Posthumous Medal," *Ottawa Citizen* (23 August 2001); Heather Topliss, "Remembering Contributions of Nurses during WWII," *Alberta RN* 55, no. 4 (July/August 1999): 12-13; "Salute World War II Nursing Sisters," Wal-Mart flyer supplement to the *Ottawa Citizen* (November 2001): 22-A. Wal-Mart distributed this flyer as part of its involvement in the Juno Beach commemorative project to more than 8 million households across

Canada according to its Internet site: www.junobeach.org/press_releases/pr_010206-e.html.

[186] These findings are similar to a study of American newsreels and 'outtakes' used to recruit nurses and nursing students in the United States, that were kept from public view during 1942-1944. Susan Stevens analyzed these sources for images of military nurses, finding public relations material was censored, biased, and "orchestrated to promote a competent, attractive, intelligent, courageous, and patriotic image of nurses." The newsreels told only part of the story—nurses as comrades, heroic, and having fun. Outtakes that were "unflattering, demonstrated danger, routine, or unpleasant work were studiously avoided." See, "Sale of the Century: Images of Nursing in the Movietonews during World War II," *Advances in Nursing Science* 12, no. 4 (1990): 45 and 48-50.

[187] Morrison, "Address to Royal Alexandra Hospital Nurses Alumnae": 8.

CONCLUSION

In order to fulfill social obligations to provide nursing care for sick and wounded soldiers during the Second World War, the Canadian armed forces looked to the civilian nursing profession to "fill the ranks" beside an almost non-existent, permanent force military nursing service. It was far more expedient to rely on the civilian profession to train and credential nurses, economizing on the cost of that training and on the expense of maintaining nurses during peace time. On one hand, civilian nurses "saved" the military by their overwhelming rush to enlist and by their willingness to deliver nursing care to the frontlines. On the other hand, the military also "saved" hundreds of nurses who sought regular, full-time, decently-paid work.

This thesis makes an important and unique contribution to nursing history, women's history, military history, and the history of medical technology through the use of previously unexplored sources to examine how war, gender, and medical technology intersected to shape civilian nurses as military nurses. Two new sets of data were created to this end: a set of oral history interviews, and an extensive demographic database from military personnel files. Both sources are extremely rich and provide excellent material for analysis. The interviews were focused specifically on nursing practice through the lens of medical technology, enabling me to shift the attention toward nurses as workers, and toward war as nurses' work. I sought rank-and-file nurses wherever possible, rather than leaders of the profession. When interviewing leaders, however, I focused on the period during which they had been rank-and-file nurses, serving in the armed forces. The demographic database enabled me to examine a much larger sample of Nursing Sisters from the perspective of multiple variables, and to gain a fuller appreciation for rank-and-file Nursing Sisters who "did their bit" and "got on with life". It provided an excellent counterbalance to the oral histories which constitute a much smaller sample, and represent a necessarily limited and self-selected group of Nursing Sisters. Several of these nurses moved

into postwar leadership positions, either with the nursing profession or within the symbolic community.

Several themes emerge in this thesis. They may be broadly grouped in relation to gender, technology, class, and community. In reality, these themes are interconnected and need to be understood in relation to each other. They address military nurses' multiple identities as women, as soldiers, as professionals, and as Canadians. The prevailing theme that runs through the thesis is the role that gender played in shaping all aspects of military nursing during the Second World War. One cannot miss the obvious construction of the Nursing Sisters cohort as a unique, all-female, military workforce or the deliberate choices whereby the armed forces constructed nursing as female and combat as male.

Gender was a pervasive, mediating variable throughout the military nursing experience. It shaped who could serve as nurses, where they served and under what conditions, the duration of that service, what roles they could assume, and the expectations that both the military and Canadian society held with respect to nurses' postwar futures. The transformation of civilian nurses into military nurses required a series of careful negotiations. It was necessary to negotiate the number of Nursing Sisters and how they were selected, in order to balance military and civilian needs. Without due consideration of civilian hospital staffing, the armed forces would stand to lose public support and access to those nurses. It was necessary to select only the right kind of nurses who would conform to military discipline and who could be shaped as "officers" and as "ladies", that is, as respectable professional women working within a dominantly male domain. But it was also necessary to shape military nursing in accordance with a dominant public discourse that required women in the military to be protected, and their aspirations to be temporary.

Once enlisted, gender continued to shape nurses' social, professional, and technological boundaries. As women serving in the military, it became very clear in this thesis that nurses were more constrained by their gender than by their abilities. They were less afraid to "bend" gendered roles than either civilian or military hierarchies were. Indeed, nurses learned to play the role as

"one of the boys", earning the right to wear khaki, scramble up the side of battleships, and have "war buddies" while also using their femininity to advantage. And while the military recognized nurses' value to the care of soldiers, there was a great deal of ambivalence related to their presence in theatres of war. The prevailing discourse on masculinity and femininity shaped women as needing the protection of men. They were to be protected at all costs from a variety of dangers and from death—even if that meant creating an official silence around their presence and exposure to these situations. Little consideration was given to the Nursing Sisters themselves—their desires to serve ever closer to the frontlines of both war and medical technology, their acceptance of adverse working conditions and military discipline, or their long-term career goals. After all, even Matron-in-Chief Smellie had given the public her assurance of nurses' safety.

As nurses serving in the military, Nursing Sisters found that their practice was always constructed in relation to the availability of men: medical officers and medical orderlies. Nursing Sisters capably incorporated roles and responsibilities of either group whenever those men were unavailable, or whenever expanded roles reinforced nurses' value to the larger system. In a similar manner to social relationships in the armed forces, there was more role flexibility and autonomy the closer nurses served to the frontlines where patient acuity was higher, skilled personnel fewer, and risk-taking more acceptable. But these roles were just as temporary as the social boundaries were, and once nurses left the military system (or left forward areas), their expanded roles and responsibilities did not necessarily transfer with them. The degree to which boundaries were de-stabilized by wartime conditions was contingent on the relative closeness to military fronts and to technological frontiers. Gender bending was acceptable during the war because it was context-dependent and understood to be temporary by those in power. The contingent and temporary nature of war work was also acceptable to the majority of Nursing Sisters, for whom their career was a relatively short-lived stage of life prior to marriage, as it was for most nurses of this period. For the most part, they returned to traditionally gendered roles as

wives and mothers after the war, although we don't know what choices they might have made if the civilian practice options had been less constraining.

The Second World War constituted less of a technological "watershed" experience for nurses, and there was more continuity with significant changes that had already taken place in civilian hospitals prior to 1939. Although new medical technologies were introduced during the war, and Nursing Sisters were heavily involved with some of the more dramatic innovations (such as blood transfusions and penicillin), I have shown that technology was not a new component of nurses' practice. Civilian nurses were experiencing a variety of technological role transitions during the 1930s, such as giving intramuscular injections and intravenous fluids, taking blood, suture removal, pouring anaesthetics, taking blood pressure readings, and serving as first surgical assistants. The Nursing Sisters did demonstrate that many more of the newly-developing wartime technologies could readily be transferred to nurses, and that nurses incorporated their own nursing perspectives as actors in the shaping of shared technologies. These perspectives became absorbed into medical discourse for the most part. The medical profession retained conceptual and legal control over the introduction and delegation of technology in patient care. Furthermore, many military nurses capitalized on their position as essential personnel to gain additional technological skills and expanded nursing practice roles. This thesis illustrates the importance of gender as a variable of analysis for technology theory.

The military made key decisions to move medical personnel to the casualties rather than risk long evacuations of casualties to the personnel, as technological changes in transportation, communication, and weaponry influenced where the delivery of medical and nursing care took place. Although the military was ambivalent about nurses serving in active theatres of war and attempted to replace nurses by training medical orderlies for specific technological skills to be used on the frontlines, it found that nurses could not be replaced effectively by lesser-trained personnel. This need for nursing skills created occupational space for women in the military, while also creating a measure of tolerance for their occasional indiscretions, to which the military turned a "blind eye."

After the war, however, there was little opportunity to use these newly-acquired skills, and many Nursing Sisters were reluctant to resume previous roles and the practice constraints of hospital nursing. Conventional hospital nursing roles were no longer satisfying for these nurses because hospitals were unable (or unwilling) to capitalize on their demonstrated abilities with expanded technological roles or their increased autonomy. Instead, hospitals continued to rely heavily on student labour as novice caregivers, with only limited concessions for "specially-trained" graduate nurses. For these Nursing Sisters, the end of war also brought an abrupt end to meaningful work in direct patient care. Many military nurses clearly resisted a return to their pre-war practice roles by using veterans' credits and benefits—not only for advanced nursing education that took them away from direct hospital nursing practice, but also for establishing small business ventures and re-training for career changes.

Contrary to what has been suggested in the literature, the enlistment of Nursing Sisters was not responsible for the Canadian nursing shortage that emerged during the early 1940s. Instead, their absence from the workforce merely exacerbated the underlying working conditions that made hospital nursing unsatisfying and unattractive.[1] By the 1950s and 1960s, hospitals were forced to introduce reforms that addressed the composition of the workforce by removing barriers of race, ethnicity, gender, and marital status. During the 1970s, further reforms shifted the delivery of nursing care from a student workforce to a graduate nurse workforce.[2]

Both during and after the war, universities benefited greatly from more stable funding for nursing programs, as military nurses used their veterans' credits for further education. These courses were slow to develop into university nursing degree programs,[3] as the nursing profession did not make substantial shifts toward university education as basic preparation for practice until the late 1960s and 1970s. Public health nursing was a popular choice of practice settings for military nurses who brought their wartime skills and knowledge with them, as well as their postwar university courses. Other specialty areas, such as psychiatric and industrial (or occupational health) nursing, were also more attractive to Nursing Sisters than hospital nursing.

Much of the nursing historiography includes debates on the quest for professional status, the process of professionalization, and the class position of nursing. Class and professional status were confirmed through deliberate decisions made within the armed forces regarding officer rank for all Nursing Sisters, and the manner in which military nurses were shaped as both officers and ladies according to embedded class and gender discourse. This thesis illustrates the importance of understanding how the concept of profession shifts over time, and how we must consider professional status within specific historical contexts. Professional status of the Second World War Nursing Sisters was reinforced on at least three levels. First, the 1932 Weir Report had already concluded that nursing should be regarded as a profession.[4] Second, the 1941 Canadian census classified registered nurses as professionals. And third, the armed forces reaffirmed nurses' professional status through the granting of officer rank to all Nursing Sisters.

The incorporation of nurses into the Canadian military eliminated many of the previous issues that had arisen during the First World War in regards to untrained, partially-trained, and volunteer nurses who were outside of military control while assuring the armed forces of the availability and flexibility of nursing care. Granting nurses officer rank imposed definite behavioural expectations while it also enhanced nurses' social and professional standing for the duration of the war. The activities of both individuals and groups of Nursing Sisters appeared in society columns and newspaper features. They were regularly considered as "interesting people" for the *Canadian Nurse* column of the same title. And among their peers, Nursing Sisters frequently were perceived to have elite status, especially if they had served "at the front." In addition, officer rank shifted traditional professional boundaries between nurses and physicians temporarily. War was understood to be an extra-ordinary state that justified the risks associated in shifting class and professional boundaries—but only within situations that were both temporary and distant from civilian settings. The military could be more flexible when there was little threat that equality would remain as permanent change. The extent to which military service de-stabilized these relationships was also contingent on where, when, and what was at stake.

Although nurses came into the military from a range of working- and middle-class backgrounds, my research has raised the importance of shared spaces and shared experiences in creating identity as a community. Based on their common wartime identities and roles, Nursing Sisters came to see themselves as comrades, as patriotic citizens, and as united to "win the war" while they often overlooked their individual differences, dissensions, and ambivalences regarding caring roles within a military system. At the same time, it has been equally valuable to uncover situations where language, culture, ethnicity, religion, regional origins, age, class, and education have exposed fractures within the nursing profession. This thesis then, also makes a contribution toward the deconstruction of the category "nurse", as well as the category of "military nurse", in these respects.

When peace disrupted their newly-created military identities, the Nursing Sisters lost their legitimacy as members of the armed forces along with the associated benefits of officers' status. They dispersed throughout Canada as many of them struggled to find a new sense of belonging within civilian settings. Many of them sought to recreate similar relationships and to commemorate their experiences as military nurses within a symbolic community. This community became an important resource for many of its members, as well as a repository of meaning and social memory. Among the Nursing Sisters, there still remains a strong code of silence about danger, risk, indiscretions, personal relationships, conflicts, and dissonances. Few military nurses were willing to talk about negative experiences, or to criticize either the armed forces or the medical officers with whom they worked. But there was often non-verbal language in the interviews, and subtext in the narratives and letters, that point to less collegial and less congenial relationships.

This thesis has led to many unexpected findings, especially from the demographic analyses. For example, nurses were much older and much more experienced than the literature implied. They were overwhelmingly English-speaking with strong British origins—indeed some 40% were first-generation Canadians. They came from more than 180 schools of nursing rather than from a few large teaching hospitals. This thesis also provides a glimpse into the sometimes

tenuous relationships between British and Canadian military nurses, especially with respect to the colonial status attributed to Canadian Nursing Sisters. Very little comparative literature exists on military nurses; while this thesis has not attempted to make a comparative international study, it does raise questions regarding the specificities of the Canadian nursing experience.

Although I have built a database containing information on approximately 26% of the Nursing Sisters, we still know relatively little about them demographically. Further analysis of the database may reveal a greater variation among Nursing Sisters along class lines: such as who received promotions and awards, who capitalized on military service through their postwar career options; and how class intersected with choice of training schools. It would be also be valuable to expand the database with additional records from the personnel files. There are significant gaps regarding nurses who served in the Royal Canadian Air Force and Royal Canadian Navy, as well as Nursing Sisters who served exclusively in Canada. There is an especially noticeable silence related to RCN Nursing Sisters, as I have been unable to identify an adequate body of primary sources relevant to study them further. It would also be extremely valuable to locate Matron-in-Chief Smellie's personal papers, if they still exist.

One important issue raised by this thesis concerns the degree to which military nurses increasingly identified themselves as soldiers, and war as nurses' work. Both civilians and Nursing Sisters assumed that military nurses went to war under the protection of the Geneva Convention that guaranteed their status as non-combatants and assumed the neutrality of medical services. They were not to be held as prisoners of war.[5] But military nurses increasingly perceived themselves as Canadians and as soldiers, and therefore, not neutral. They considered their work to consist of "winning the war" through the salvage of damaged men. They increasingly accepted risks and dangers associated with being soldiers such as becoming casualties and prisoners of war, especially following events in Hong Kong and the Mediterranean. Some of the Nursing Sisters expressed the futility of repairing men and returning them to the battlefield. Other nurses differentiated the "enemy", from individual prisoners of war who became their patients. Most Nursing Sisters viewed war as a terrific waste of human lives and resources

on both sides of the conflict. Further research is needed to understand this militarization process, and how nurses reconciled such dissonances.

For some of the Nursing Sisters, the opportunity to participate in oral history interviews has provided another opportunity to review memories and bring some closure to their wartime nursing experience. Several Nursing Sisters expressed it best when they described 'seeing the wards' exactly as they were during the war, and 'being there now' as they told me about their patients.[6] As NS Pauline Lamont reminded me, no one ever returned from the war the same. NS Norah Mallandaine kept her Army belt that had been "autographed" by her patients. She described it as: "A precious mememto [sic] which I still have is my army belt which many of my patients signed. On occasion I take it out and try to put faces to those names."[7] For my part, I have attempted in this thesis to understand the Second World War through the eyes and experiences of the Canadian Nursing Sisters themselves, as one way to balance traditional accounts of war in terms of political and military strategy.

Endnotes

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[1] See Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996): 207-208, and 210-215.

[2] McPherson, *Bedside Matters*: 257-259.

[3] Meryn Stuart makes this observation about public health nursing courses and Canadian universities in relation to the First World War Nursing Sisters in "War and Peace: Professional Identities and Nurses' Training, 1914-1930," in *Challenging Professions: Historical and Contemporary Perspectives on Women's Professional Work*, eds. Elizabeth Smyth, Sandra Acker, Paula Bourne, and Alison Prentice, pp. 171-193 (Toronto: University of Toronto Press, 1999): 172.

[4] George M. Weir, *Survey of Nursing Education in Canada* (Toronto: University of Toronto Press, 1932): 50-65.

[5] "RCAMC Nursing Sisters on Duty in Hong Kong," *Canadian Nurse* 38, no. 1 (January 1942): 32.

[6] Some examples of Nursing Sisters who were able to visualize wartime experiences in these ways, include: Harriet J. T. Sloan, audio-taped interview with author at Ottawa, Ontario on 14 March 2001; Constance Betty Nicolson Brown, audio-taped interview with author at Ottawa, Ontario on 3 June 2001; Pauline Lamont Flynn, audio-taped interview with author at Ottawa, Ontario on 3 April 2001; and Lois Bayly Tewsley, audio-taped interview with author at Ottawa, Ontario on 11 June 2001.

[7] Norah (Mallandaine) Noiles, in *The Military Nurses of Canada: Recollections of Canadian Military Nurses*, vol. II, ed. E. A. Landells (White Rock, B. C.: Co-Publishing, 1995-1999): 147.

APPENDIX 1: ETHICS APPROVAL



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Cabinet du vice-recteur à la recherche — Office of the Vice-Rector, Research

SOCIAL SCIENCES AND HUMANITIES RESEARCH ETHICS BOARD

CERTIFICATION OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Social Sciences and Humanities Research Ethics Board (REB) has examined the application for ethical approval for the research project Medical Technology, Gender, and War: The Canadian Nursing Sisters of World War II (File 12-00-03) submitted by Cynthia Toman and supervised by Ruby Heap and Meryn Stuart. The members of the REB found that the research project met appropriate ethical standards as outlined in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards, and accordingly gave the research project a Category Ia (Approval). This certification is valid for one year from the date indicated below.

Lise Frigault
Protocol officer for ethics in research,
for the Chair of the Social Sciences and Humanities REB
Tim Aubry

January 31st, 2001
Date

FILE 12-00-03

550, rue Cumberland C.P. 450, Succ. A
Ottawa (Ontario) K1N 6N5 Canada

550 Cumberland St., P.O. Box 450, Stn. A
Ottawa, Ontario K1N 6N5 Canada

Université d'Ottawa • University of Ottawa

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SOCIAL SCIENCES AND HUMANITIES RESEARCH ETHICS BOARD

CERTIFICATION OF ETHICS APPROVAL

This is to certify that the University of Ottawa Social Sciences and Humanities Research Ethics Board (REB) has examined the application for extension of the ethics approval for the research project *Medical technology, gender, and war: The Canadian Nursing Sisters of World War II (File 12-00-03)* submitted by Cynthia Toman, and supervised by Ruby Heap of the Department of History, and Meryn Stuart of the School of Nursing. This project received initial ethics approval in January 2001 as meeting appropriate ethical standards, as set out in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards. The University of Ottawa REB members accordingly grant it an extension of ethics approval. This certification is valid for one year from the date indicated below.

Lise Frigault
Education officer for ethics in research
For Julie Dompierre,
Chair, Social Sciences and Humanities REB

January 23, 2002
Date

FILE NUMBER: 12-00-03

550, rue Cumberland
Ottawa (Ontario) K1N 6N5 Canada

550 Cumberland Street
Ottawa, Ontario K1N 6N5 Canada

(613) 562-5270 • Téléc./Fax (613) 562-5271

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Cabinet du vice-recteur à la recherche
Office of the Vice-Rector, Research

SOCIAL SCIENCES AND HUMANITIES RESEARCH ETHICS BOARD

CERTIFICATION OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Social Sciences and Humanities Research Ethics Board (REB) has examined the application for extension of ethics approval for the research project **Medical Technology, Gender and War: The Canadian Nursing Sisters of World War II (File 12-00-03)** submitted by Cynthia Toman, and supervised by professors Ruby Heap and Meryn Stuart. This project received initial ethics approval in January of 2001 by the Social Sciences and Humanities REB as meeting appropriate ethical standards set out in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards. An extension was given to the project in January 2002. This second ethics renewal certification is valid for one year from the date indicated below.

Catherine Paquet
Protocol Officer for Ethics in Research
For the Chair of the Social Sciences and Humanities REB
Christine Dallaire

January 16, 2003
Date

550, rue Cumberland
Ottawa (Ontario) K1N 6N5 Canada

550 Cumberland Street
Ottawa, Ontario K1N 6N5 Canada

APPENDIX 2: INFORMATION LETTER FOR ORAL HISTORY PARTICIPANTS

January 2001

Information Letter for Participants

Title: Medical Technology, Gender, and War: The Canadian Nursing Sisters of World War II

This research project has been designed in partial fulfillment of the requirements for the Doctor of Philosophy degree in History at the University of Ottawa. Cynthia Toman is investigating the process by which nurses assumed roles and responsibilities related to medical technologies which emerged during the war and how these influenced nursing practice. You are invited to participate in the study as a Nursing Sister who served in the Canadian Armed Forces between 1939 and 1946. Your participation is valued as you contribute a better understanding of the work that nurses did and continue to do. At the same time, your experiences will contribute unique nursing perspectives to Canadian history, women's history, and military history.

You will be expected to participate in a minimum of one audio-taped interview with Cynthia. You may choose the time and place at your convenience as well as the number of interviews you want to do. Each interview will last approximately one hour, but no longer than one-and-a-half hours unless you desire to continue longer. If you wish, a second or third interview may be arranged either to continue the discussion or to clarify aspects of your experience. You may look over the interview questions ahead of time. At any time during the interviews, you may decline to answer a question, change the subject matter, or request the tape recorder to be turned off. As well, you may contact Cynthia at any time to clarify information or express any concerns regarding the research.

Participation is voluntary and you may choose to discontinue the interview or withdraw from the study at any time, without penalty of any kind. There may be potential benefits and risks to you by participating in this study. Potential benefits include the opportunity to share from your personal experiences and to contribute to historical knowledge. Potential risks include fatigue during the interview or uncomfortable memories you may recall. Opportunity for rest during the session will be provided as required. If you recall experiences that are stressful during the interview, you may change the subject matter, stop the interview, or decline to answer.

Between twenty and thirty Nursing Sisters will be interviewed for this study. Once the interviews are completed, they will be transcribed for analysis and used to write my dissertation. Cynthia will present the findings at nursing and history conferences as well as publish articles in professional journals. Ultimately, the goal is to publish a book that will share your experiences

with other persons who are interested in Canadian history, military history, women's history, and nursing history. In order to make that history more authentic and to acknowledge your role as a Nursing Sister, permission is requested to use your name when quoting you or your stories. If there is any particular part of your interview for which you do not want to be identified by name or by identifying characteristics, your request will be honored and that specific material will be used anonymously (with all identifying material removed).

All tapes, transcriptions, and notes will be kept in locked files at Cynthia's office and will be available only to Cynthia and her supervisors (Dr. Meryn Stuart and Dr Ruby Heap) for five years following the completion of the project. Then they will be offered for deposit, first to the Margaret M. Allemang Centre for the History of Nursing archives and second, to the National Archives as part of their oral history collection. If not accepted by either organization, the tapes and transcripts will be destroyed by shredding at the University of Ottawa. At the end of the study, once analysis is complete, you may have a summary of the research and findings by mail if you wish one and provide your address on the consent form.

Thank you for considering participation in this research. Your contributions are very valuable and appreciated. You may contact Cynthia or Dr. Stuart with questions about the study at the phone numbers given below. You may also refer any concerns regarding the ethics of this research to the Protocol Officer for the Ethics in Research at (613) 562-5800, ext. 1787. Any information requests or complaints about the ethical conduct of this project may be addressed to the Protocol Officer for Ethics in Research at the phone number below.

Contacts:

Cynthia Toman,	Dr. Meryn Stuart, PhD	**For Ethical questions only:**
PhD candidate	Faculty of Health Sciences	Protocol Officer for Ethics in
2391 Ogilvie Road	School of Nursing,	Research,
Gloucester, Ontario	University of Ottawa	Room 246, Tabaret Hall
K1J 7N4	451 Smyth Road	University of Ottawa
(613) 748-7960	Ottawa, Ontario K1N 8M5	(613) 562-5800, ext. 1787
	(613) 562-5800, ext. 8435	

APPENDIX 3: CONSENT FORM

Medical Technology, Gender, and War: The Canadian Nursing Sisters of World War II

Investigator: Cynthia Toman
Supervisors: Dr. Meryn Stuart and Dr. Ruby Heap
Institution: University of Ottawa, Departments of Nursing and History
Phone: (613) 748-7960
Email: ctoman@attglobal.net

I, _____, have read the Letter of Information and wish to participate in the research conducted by Cynthia Toman of the History Department at the University of Ottawa, on the history of the Canadian Nursing Sisters of World War II. This project is supervised by Drs. Meryn Stuart and Ruby Heap. The purpose of the research is to examine how the war influenced nurses, the nursing profession, and nursing care related to new or changing medical technologies that emerged. My involvement will consist of participation in a minimum of one audio-taped interview in English, with Cynthia. I may choose the time, place, and number of interviews. Each interview will last approximately one hour, but no longer than one-and-a-half hours unless I choose to continue longer. I will be asked about my nursing experiences during the war. I understand that transcripts of the tapes will be made for study purposes, and that I may review my transcript if I wish. I understand that specific parts of the interview will be removed or used anonymously upon my request. These tapes and transcripts will be retained by Cynthia in a locked file of her office, accessible only to her and her supervisors for five years following the completion of the project. Then they will be offered for deposit, first to the Margaret M. Allemang Centre for the History of Nursing archives and second, to the National Archives as part of their oral history collection. If not accepted by either organization, the tapes and transcripts will be destroyed by shredding at the University of Ottawa.

I understand that I might become fatigued or recall uncomfortable memories. I have been assured by the investigator that at any time during the interviews, I may decline to answer a question, change the subject matter, or request the tape recorder to be turned off. I understand that participation is voluntary and at any time during the research, I may withdraw my consent without penalty of any kind.

I understand that reports, presentations, and publications may result from the research and that my name will be used in quotes attributed to me from this study with the exception of any portions for which I have requested anonymity. One copy of this signed consent will be provided to me and one copy will be kept by Cynthia. I may address any complaints about the ethical

conduct of this project to the Protocol Officer for Ethics in Research, Room 246, Tabaret Hall of the University of Ottawa or (613) 562-5800, extension 1787. If I have questions about the conduct of the research project, I may contact Cynthia or her supervisors at the phone numbers or addresses given below.

____ I wish to receive a summary of the findings from this research.

My mailing address is: _____

_____

Investigator's signature: _____ Date: _____

Participant's signature: _____ Date: _____

Contacts:

Cynthia Toman,
PhD candidate
2391 Ogilvie Road
Gloucester, Ontario
K1J 7N4
(613) 748-7960

Dr. Meryn Stuart, PhD
Faculty of Health Sciences
School of Nursing
451 Smyth Road
University of Ottawa
Ottawa, Ontario K1N 8M5
(613) 562-5800, ext. 8435

For Ethical questions only:

Protocol Officer for Ethics in Research
University of Ottawa
Room 246, Tabaret Hall
(613) 562-5800, ext. 1787

APPENDIX 4: INTERVIEW QUESTIONS

1. Briefly describe your background and nurse's training. (Prompts: birth place and date, father's occupation, education, School of Nursing)

2. Briefly describe your nursing career path. (Prompts: work opportunities, enlistment, postwar education, marriage or partnerships, military or civilian career postwar)

3. Briefly describe your enlistment and postings as a Nursing Sister. (Prompt: Why did you join the Armed Forces?)

4. How would you compare nursing care given in Canadian civilian hospitals to nursing care in military settings during The Second World War?

5. What types of medical problems or injuries did your patients experience? (Prompts: most frequent, exceptional cases, particular challenges, most time-consuming, most difficult)

6. What new or different medical treatments did you carry out?

7. How did you learn to carry out these procedures? (Prompt: how did nurses modify or change these procedures because of wartime conditions? How did nurses improvise when necessary?)

8. Describe any procedures or equipment that nurses tried out but rejected. (Prompt: who decided to accept or reject them? How did nurses influence these decisions? Was there any resistance?)

9. Describe relationships among the different members of the medical staff related to roles and responsibilities. (Prompts: other nurses, orderlies, nursing assistants, physiotherapists, dieticians, physicians)

10. Were these relationships different from those you recall in civilian practice? If so, to what do you attribute the changes? (Prompt: examples)

11. In your opinion, were nurses able to expand their roles and responsibilities during the war beyond those nursing practices permitted in civilian hospitals? If so, why do you think this was possible?

12. If not, what prevented nurses from expanding their knowledge and skills in the military

setting?

13. After the war ended, how did your nursing practice change? (Prompts: in military settings, in civilian settings)

14. In what ways do you think postwar nursing practice changed because of wartime experiences?

15. Are there any other experiences of nursing during the war that you would like to share? (Prompts: a humorous incident, a first-time event, an unusual happening, a frustrating situation)

16. If you would like to recommend other Nursing Sisters whom you feel should be invited to participate in this research, who would they be?

APPENDIX 5: RECRUITMENT NOTICES

Are you a Canadian Nursing Sister who served in World War II and interested in participating in a nursing history research study?

Do you know a Canadian Nursing Sister who served in World War II and is interested in participating in a nursing history research project?

What's involved?

- A minimum of one audio-taped oral history interview, lasting approximately 60 - 90 minutes
- An opportunity to share your experiences of changes in nursing practice which may have taken place during the war
- Contact: Cynthia Toman by email at ctoman@attglobal.net, by phone at (613)748-7960, or write to 2391 Ogilvie Road, Gloucester, Ontario K1J 7N4
- I am also interested in locating existing interviews or transcripts, records and documents, letters and photos related to the World War II Canadian Nursing Sisters.

APPENDIX 6: SUMMARY OF THE TOMAN NURSING SISTERS INTERVIEWS

SUMMARY OF THE TOMAN NURSING SISTERS INTERVIEWS, 2001					
#	Service	Nursing Sister	Postings	Date	Interview Length
1	RCAMC	Harriet J. T. Sloan	C UK E	14 Mar 01	80 min.
2	RCAMC	Pauline Lamont Flynn	C UK E	3 Apr 01	86 min.
3	RCAMC	Eva Wannop	C UK (Basingstoke)	25 Apr 01	73 min.
4	RCAF	Margaret M. Allemang	C	26 Apr 01	73 min.
5	RCAF	Muriel McArthur	C UK (#6 Bomber Group)	14 May 01	77 min.
6	RCAF	Frances M. Oakes	C UK (East Grinstead)	15 May 01	73 min.
7	RCAMC	Constance Betty Nicolson Brown	C UK M (Sicily, Italy)	3 June 01	76 min.
8	RCAMC	Lois Bayly Tewsley	C UK E	11 June 01	66 min.
9	RCAMC	Pauline Cox Walker	C UK E M (Italy)	13 June 01	80 min.
10	RCAMC	Margaret Van Scoyoc	C UK E	13 June 01	84 min.
11	RCAMC	Margery MacLean Root	C UK E M (# 14 CGH)	15 June 01	85 min.
12	RCAMC	Doris Taylor Rasberry	C UK	19 June 01	90 min.
13	RCAMC	Doris V. Carter	C UK E M (North Africa, Sicily, Italy)	22 June 01	180 min.
14	RCN	Dorothy Surgenor Maddock	Stadacona	26 June 01	45 min.
15	RCN	Elizabeth Dean Doe	Stadacona, Niobe, Sydney	30 June 01	75 min.
16	RCAMC	Estelle Tritt Aspler	C UK E M	13 Aug 01	120 min.
17	RCAMC	Helen K. Mussallem	C UK	24 Sept 01	90 min.
18	RCAMC	Jean Frances Ferguson Sutherland	C UK E (#4 & #6 CCS)	10 Oct 01	82 min.
19	RCAMC	Elizabeth Young Ramage Hamilton	C	12 Oct 01	47 min.
20	RCAMC	Beatrice Cole Hunter	C UK	13 Oct 01	78 min.
21	RCAMC	Margaret Roe Dewart	C UK E M (Italy)	15 Oct 01	66 min.
22	RCAMC	Mary M. Bower White	C UK	20 Oct 01	60 min.
23	RCAF	E. June Parker	Goose Bay, France, USA	23 Nov 01	92 min.
24	USANS	Betty Riddell	Papua, New Guinea	26 Nov 01	85 min.
25	SAMNS, RCAMC	Isabel Morrison Fraser	South Africa, UK, E	27 Nov 01	48 min.
Legend: C = Canada; UK= England; E = Europe; M= Mediterranean				TOTAL	33.6 hrs

APPENDIX 7: NURSING SISTER INTERVIEWS FROM OTHER SOURCES

NURSING SISTER INTERVIEWS FROM OTHER SOURCES					
#	Service	Nursing Sister	Postings	Date	Interview Length
REGISTERED NURSES ASSOCIATION OF BRITISH COLUMBIA					
1	RCAMC	Ruth Littlejohn McIlrath (by Nina Rumen) at Vancouver and Burnaby, BC	C UK M, Lady Nelson	23 Nov 1988, 20 Oct 1987	5 tapes (> 5 hrs.)
2	RCAMC	Edna Rossiter (by Nina Rumen) at Vancouver	C UK E PM Pacific Command	27 Oct 1987	5 tapes
3	RCAMC	Joan Doree (by Nina Rumen) at Vancouver	C UK, Lady Nelson, Basingstoke (plastics)	11 Feb 1987	2 tapes
4	RCAMC	Eleanor Kunderman (by Audrey Stegen) at Gibson's, BC	C	26 Oct 1987	1 tape
5	RCAF	Enid Matheson (by Elizabeth Kirkwood) in Hawaii	C UK, East Grinstead Basingstoke (neuro)	22 Feb 1989	1 tape
6	RCAMC	Jean Mary Ciceri (by Nina Rumen) at Victoria, BC	C UK, Basingstoke (psych)	13 Jan 1987	7 tapes
7	SAMNS	Ellen Jean (Wheeler) Keays (by Sheila Zerr) at White Rock, BC	South Africa (Durban, Piet Retef, Liberia, Tripoli)	16 Aug 1994	1 tape
NATIONAL ARCHIVES OF CANADA					
8	RCAMC	Gaëtane LaBonté Kerr (by Lisa Weintraub)	C UK E	11 April 1985	99 min.
9	RCAMC	Kay Christie (by Joan Williams)	C, Hong Kong	20 Nov 1975	65 min.
10	RCAMC	Grace Patterson (by Joan Williams)	C UK E	18 Nov 1975	60 min.
11	RCAMC	Patricia Moll (by Lisa Weintraub)	C UK M North Africa, Italy	5 July 1985	132 min.
12	RCAMC	Margaret Van Scoyoc (by Lisa Weintraub)	C UK E	4 June 1984	155 min.
13	RCAMC	Ella Beardmore (by Joan Williams)	C UK E	26 Nov 1975	63 min.
MCMASTER UNIVERSITY					
14	RCAMC	Kay Christie (by Charles Roland)	C Hong Kong	8 Dec 1982	Transcript, 75 pp.

ALBERTA ASSOCIATION OF REGISTERED NURSES MUSEUM AND ARCHIVES					
15	RCN	Joan Suzanne Verral (Maynard) Ferguson (by Kristi Rigaux) at Lethbridge, AB	Newfoundland, Calgary (Tecumseh)	7 March 1995	53 min.
16	RCAMC	Lenore Lancaster Menard (by Terina Rindal) at Lethbridge, AB	C UK M	14 March 1995	61 min.
MARGARET M. ALLEMANG CENTRE FOR THE HISTORY OF NURSING					
17	RCAMC	Constance Bond Young (by Ella Beardmore)	C UK E, CCS #2	4 July 1989	Transcript
18	RCAF	Norma Fieldhouse (by Margaret Allemang)	C	16 Feb 1988	Transcript
19	RCAMC	Susan Isabel Rowland (by Ella Beardmore)	C UK, #2CGH	15 May 88	Transcript
20	RCAMC	Berna Thompson Tuckwell (by Ella Beardmore)	C UK	10 June 1988	Transcript
21	RCAMC	Elizabeth Pense Neil (by Norma Fieldhouse)	C UK M ,#15CGH,#5CCS	March 1987	Transcript
22	RCAMC	Margaret Helena Kellough (by Margaret Allemang)	C UK M E , #15CGH, #5CCS	April and May 1987	Transcript
23	RCAMC	Eva R. Wannop (by Margaret Allemang)	C UK	28 Aug 1991	Transcript
24	RCAMC, SAMNS	Florence Louise Jamieson (by Margaret Allemang)	C UK S. Africa	24 April, 3 May 1987	Transcript
25	RCAMC (physio)	Elizabeth Harpham Orford (by Margaret Allemang)	C UK (physiotherapist)	9 Oct 1991, 26 Jan 1993	Transcript
26	RCAMC	Kathleen G. Christie (by Margaret Allemang)	C Hong Kong	5 April 1992, 3 Jun 1992	Transcript
27	RCAMC	Dorothy Agnes Potts (by Margaret Allemang)	C UK E	30 Sept 1987	Transcript
28	RCAMC	Helen Morton Rendall (by Margaret Allemang)	C UK M	14 and 21 March 1986	Transcript
29	RCAMC	Dorothy A. Macham (by Norma Fieldhouse)	C UK M E Basingstoke, #5CCS	No date given	Transcript
30	RCAMC	Margaret H. Mills (by Margaret Allemang)	C UK E	5 April 1991	Transcript

APPENDIX 8: BIOGRAPHICAL SUMMARIES OF NURSING SISTERS

INTERVIEWED BY CYNTHIA TOMAN

Harriet J.T. (Hallie) Sloan

Hallie Sloan was born at Winnipeg, Manitoba but grew up in Saskatchewan and graduated from the Vancouver General Hospital School of Nursing (1940). She has Irish and British ancestry. Her father was a First World War veteran and she enlisted in the RCAMC on February 1942 at the age of 25. Hallie served as a Nursing Sister in Canada for 35 months and overseas for 19 months in England, France, Belgium and Holland (for a total of 55 months). Hallie transferred to the Interim Forces and then the Permanent Forces postwar. She was the Command Matron with NATO forces in Germany (1953), Command Matron Canadian Western Command (1954-56) and Canadian Forces Medical Services Training Centre (1959), Major Principle Matron (1960), and Lt. Col. Matron-in-Chief Canadian Forces Medical Services (1964-68). On retirement in 1968, Hallie served her profession at the Canadian Nurses Association until the early 1980s. She was interviewed 14 March 2001 at Ottawa, Ontario.

Pauline Lamont Flynn

Pauline Murray Lamont Flynn was born in Denfield, Ontario of Scottish parents. She enlisted with the RCAMC in Ontario on her twenty-third birthday in 1943 after graduating from the Toronto Western Hospital (1941). She worked as a general duty nurse and industrial nurse in the Bren Gun factory at Toronto to gain the requisite nursing experience prior to military service. She served as a Nursing Sister from 1943 to 1946 (45 months) with 25 months in Canada and 20 months overseas in England with No. 9 and No. 4 CGH, in Belgium with No. 2 CGH, and in Holland with No. 3 CCS. She was assigned to escort thirty war brides with their twelve children on her way home to Canada in 1946. Pauline's post war career included DVA nursing at Sunnybrook Military Hospital and at Shaughnessy, British Columbia prior to marriage and raising a family. She was interviewed 3 April 2001 at Ottawa, Ontario.

Eva Wannop

Eva Wannop was born at Carmangay, Alberta to English and Canadian parents. She graduated from the Holy Cross Hospital School of Nursing in Calgary (1939). After a year of experience in private duty nursing, she had saved the funds for further study and was accepted by the University of Toronto for a course in nursing administration, supervision, and public health. Eva requested the university to hold her position and they did, so she enlisted in the RCAMC (September 1940). Her mother was against her enlistment and refused to 'see her off' but her father did. She was posted in Canada (22 months) and England (38 months), serving at Basingstoke Neurological and Plastics Hospital where she developed special skills with burns and plastic surgery patients. Eva had been issued khaki in preparation for moving to Europe when the war ended. She was discharged after 60 months of service in August 1945 and returned to take up her public health course at the University of Toronto. She worked as a public health nurse and industrial nurse with the Manulife Insurance Company until retirement in 1979. She was interviewed 25 April 2001 at Toronto, Ontario.

Margaret M. Allemang

Margaret Allemang was born in Toronto, Ontario of British and German parents. She graduated from the University of Toronto School of Nursing (1940). After 1.5 years experience of general duty nursing and as an assistant head nurse at the Toronto General Hospital, she joined the RCAF in February 1942. Margaret was posted to various stations within Canada for the next 44 months (to December 1945). On discharge, she used her veteran's credits to complete a BScN degree at the University of Toronto, followed in later years by Master's and PhD degrees from the University of Washington. Margaret became a professor and researcher at the University of Toronto School of Nursing for the rest of her career. She was interviewed 26 April 2001 at Toronto, Ontario.

Muriel McArthur

Muriel McArthur was born in Oro, Ontario. Her parents were English and Scot. An aunt raised her after their deaths when she was seven years old. Two other aunts (Mary Christina McCuaig and Isabella Ann McCuaig) were Nursing Sisters during the Great War. Muriel initially obtained a Teacher's Certificate and taught public school for one year before entering nurses' training at the Toronto General Hospital where she graduated in 1937. She enlisted in the RCAF during December 1941 after working as a general duty nurse, a summer camp nurse, and a private duty nurse for 3.5 years. She served in Canada (36 months) and Yorkshire, England at #6 Bomber Command (21 months) for a total of 57 months, and then transferred to the permanent forces in September 1946. Her postwar postings included NATO headquarters at Metz, France. Prior to her retirement from the military, she was the first Matron-in-Chief of the integrated Canadian Forces Medical Services, Nursing Service (1960-1964). Muriel worked briefly in Edmonton at the University of Alberta Hospital after her retirement from the military. She was interviewed 14 May 2001 at Barrie, Ontario.

Frances Marion Oakes

Frances Oakes was born at Fergus, Ontario. Her parents were Scot and English, with Lord Lister as one of her grandfather's nephews. She graduated from the Kitchener-Waterloo Hospital School of Nursing in 1930 after which she took several postgraduate courses in x-ray and operating room technique at the Montreal General Hospital and the Toronto General Hospital. Fran worked as an OR supervisor until October 1940 when she became one of the first nurses (and thus first women) in the RCAF as it became a separate branch of the Canadian forces. She served in Canada at the St. Thomas Technical Training School that formed part of the British Commonwealth Air Training Plan and had a 700-bed hospital unit. Fran was one of the first two RCAF nurses posted overseas and instrumental in setting up the specialized surgical unit at East Grinstead in Sussex, England. She was made an honorary member of the "Guinea Pig Club" for her work with men who underwent extensive reconstructive surgery following their burns. She served 56 months in Canada and 24 months overseas, for a total of 80 months or 6.6 years (the longest serving Nursing Sister interviewed for this research). At the end of the war, Frances transferred to the permanent forces as Principal Matron, RCAF until her mandatory retirement in February 1958. In this role, she was responsible for Nursing Sisters who staffed medical facilities along the postwar early warning military establishments in northern Canada known as the DEW Line and along the Alaskan highway. Many of the nurses who served under Fran credited her as the impetus for nurses' training in air evacuation and other educational opportunities. She was interviewed 15 May 2001 at Guelph, Ontario.

Constance Betty Nicolson Brown

Betty Brown was born in Scotland, the sixth of seven children. She immigrated with her parents to Canada to Winnipeg and graduated from the Winnipeg General Hospital School of Nursing (1940). She completed a postgraduate course in Operating Room technique and worked two years in the OR prior to enlisting with RCAMC No. 5 CGH in January 1942. Betty was posted in Canada, in England at Taplow, in the Mediterranean (at Sicily and Italy), and returned to Canada on compassionate leave due to family illness. She continued to serve at Fort Osbourne and volunteered for the Pacific campaign. Betty served a total of 52 months, 25 months in Canada and 27 overseas. Two older sisters had been a nurse and a Volunteer Aid Detachment with the British forces during the Great War. On discharge, Betty married a RCN officer. Betty was interviewed 5 June 2001 at Ottawa, Ontario.

Lois Bayly Tewsley

Lois Tewsley was born at Ottawa, Ontario as the only child of Canadian parents with British ancestry. She graduated from the Western division of the Montreal General Hospital School of Nursing (1937) and practiced in general duty and private duty nursing for five years before enlisting in the RCAMC (January 1942) which did not please her mother. Lois served in Canada, England, and Europe until January 1946 (21 months in Canada and 26 overseas, for a total of 47 months). While overseas, Lois was posted to No. 2, No. 8, and No. 22 CGH and No. 6 CCS. She married while overseas and resigned her commission to return to Canada for the birth of her first child at Ottawa, Ontario.

Pauline Cox Walker

Pauline Walker was born at Wolverhampton, England and immigrated with her parents to Quebec. A 1937 graduate of Montreal General Hospital, Pauline worked 3.5 years as a general duty nurse, an operating room nurse, and an industrial nurse at Grand-Mère, PQ. She enlisted in the RCAMC May 1941 and served in Canada, and in England and the Mediterranean with No. 14 CGH (for a total of 50 months) until July 1945. Only three of those months were in Canada while 47 months were overseas. Pauline was on the *Santa Elena* when it was torpedoed near Gibraltar. She worked in a Field Surgical Unit – one of at least four small mobile units that moved rapidly with the troops. After discharge, Pauline went to university for a public health diploma and worked in public health until marriage in 1947. She was interviewed on 13 June 2001 at Kingston, Ontario.

Margaret Van Scoyoc

Margaret Van Scoyoc was born at Montreal to English and Dutch parents. Her mother was a teacher who graduated from Oberlin College. Margaret graduated from the Montreal General Hospital School of Nursing (1936). Her pre-enlistment experience included work in Bermuda and at a munitions factory in Quebec. With five years experience in general duty, public health, VON and industrial nursing, she enlisted in the RCAMC during December 1941. She served in Canada (10 months) and overseas in England and Europe with No. 12 CGH (30 months) prior to transferring to the Permanent Forces in October 1946. She retired from the military in February 1966 and worked at the Montreal Children's Hospital as a Central Supply Nurse. She was interviewed on 13 June 2001 at Kingston, Ontario.

Marjorie MacLean Root

Marjorie Root was born at Campbelltown, New Brunswick (the fourth of eight children) to Canadian parents with English and Scot ancestry. She graduated from the Montreal General Hospital (1939). She did private duty nursing for 1.5 years, and enlisted in the RCAMC December 1940. Four brothers served with the RCAF during the war. She was posted in Canada (11 months) and overseas in England and the Mediterranean (48 months) for a total service of 59 months. Marjorie was on the *Santa Elena* that was torpedoed. After discharge, she nursed at St. Anne-de-Bellevue prior to marriage in 1945 and at the Ottawa Civic Hospital until the birth of her first child while her husband studied pharmacy on his veterans' credits. She was interviewed 15 June 2001 at Ottawa, Ontario.

Doris Taylor Rasberry

Doris Rasberry was born at Little Harbour, Nova Scotia. Her parents were Canadian of British and German ancestry. She graduated from the Women's General Hospital School of Nursing in Montreal (also known as the Reddy Memorial Hospital) in 1940. She completed postgraduate courses and worked as a general duty nurse, an operating room nurse, a head nurse of the out-patient clinic, and an assistant-supervisor for 2.5 years prior to enlistment in the RCAMC during October 1943. She was posted in Canada (17 months) and overseas in England and Europe (19 months) for a total of 34 months service. Her two brothers served with the Army and Navy while her sister was a CWAC—thus, four of the five children in her family served during the war. On discharge (August 1946), Doris worked at Queen Mary Veterans' Hospital (under the DVA) until her marriage to a veteran in 1951. She returned to nursing from 1962 to 1984 in out-patient clinics. She was interviewed on 19 June 2001 at Pointe Claire, Quebec.

Doris V. Carter

Doris Carter was born in England (the second of seven children) and immigrated with her parents as a baby. Her father had served with the CEF during the First World War and two brothers served in the Canadian forces (RCN and RCAF) during WWII. Doris completed Normal School for a teaching certificate but decided teaching was not for her. She graduated from the Royal Victoria Hospital in 1935 and worked in private duty nursing until enlisting in the RCAMC October 1940. She was posted in Canada (4 months) and overseas (54 months) in England, the Mediterranean, and Europe for a total of 58 months. Doris served with No. 1 CGH, No. 4 CCS, No. 8 CGH, No. 15 CGH, No. 5 CGH, and No. 5 CCS. On discharge, she used her veterans' credits to complete a public health diploma at McGill University and worked in public health the rest of her career, retiring in 1975. She has published her memoir as *Never Leave Your Head Uncovered: A Canadian Nursing Sister in World War Two* (Waterdown, Ontario: Potlatch Publications, 1999). Doris was interviewed at Ottawa, Ontario on 22 June 2001.

Dorothy Maddock

Dorothy Maddock was born at Cornwall, Ontario. Her father had been a First World War veteran and her mother a schoolteacher—both Canadians and of the United Empire Loyalists line. Dorothy graduated from the Montreal General Hospital in 1943. After a half-year of experience in general duty and operating room nursing, Dorothy enlisted in the RCN the day before VE Day in May 1945 (as preparations were being made for the Pacific theatre of war). She was posted in Canada 8 months, resigning in April 1946 to marry. She worked part-time briefly after marriage

until her first child was born, and returned to nursing during the 1960s in renal dialysis. Doris retired in 1982. She was interviewed on 26 June 2001 at Ottawa, Ontario.

Elizabeth Dean Doe

Elizabeth Doe was born at Kingston, Ontario and recalls her father's war injuries from being 'gassed at Ypres' during the Great War. She graduated from the University of Toronto with a Bachelor of Household Science in 1940 and completed her dietician internship at the Toronto General Hospital in 1941. She worked as a dietician and teacher at Hamilton General Hospital for a year prior to enlisting in the RCN (1943) as a Nursing Sister (Dietician). Elizabeth recalled teaching male student nurses in the area of dietetics—one of the first experimental programs to train men as nurses. She was posted in Canada (12 months) and at the *HMCS Niobe* in Scotland (18 months) for a total of 30 months. Elizabeth married a naval officer at the *Niobe* in 1944 and was discharged in October 1945. He became an oceanographer for the Fisheries Department and they traveled widely in South America and Europe while raising a family. She was interviewed at Ottawa, Ontario on 30 June 2001.

Estelle Tritt Aspler

Estelle Aspler was born at Montreal, Québec (one of seven children). Her parents immigrated from the Austrio-Hungarian Empire between the years of 1886-1890. She graduated from the Women's General Hospital (also known as the Reddy Memorial Hospital) in 1941 after a first attempt at teaching public school. She worked as a general duty nurse for 1.5 years prior to enlisting with the RCAMC as a Nursing Sister. Estelle was posted in Canada (17 months) and overseas in England and Europe (27 months) for a total of 44 months, serving with No. 18 CGH, No. 8 CGH, and No. 7 CGH. In addition, she volunteered for the Pacific theatre. Soon after her discharge in August 1946, she married a veteran and retired from nursing to raise a family. She returned to nursing briefly in the 1970s. She was interviewed at Montreal, Québec 13 August 2001.

Helen K. Mussallem

Helen Mussallem was born at Prince Rupert, British Columbia. Her parents were Lebanese and immigrated to Canada in 1899. She graduated from the Vancouver General Hospital in 1937 with the highest award for operating room technique. She went on to complete courses in supervision and teaching, and worked primarily in the OR for six years prior to her enlistment in the RCAMC during August 1943. Helen was posted 14 months in Canada and 15 months overseas (in England with No. 19 CGH at Marston Green) for a total of 29 months. She volunteered for the Pacific theatre and was in preparation when Japan surrendered. On discharge in April 1946, Helen used her veterans' credits to complete a course in supervision, administration and teaching at McGill. She went on to complete a Bachelor of Science in Nursing degree at McGill University as well as a Masters and PhD at Columbia University (1962). She researched and authored a major study on the state of nursing in Canada, published as the *Royal Commission on Health Services: Nursing Education in Canada* (Ottawa: Queen's Printer, 1965). Helen became executive director of the Canadian Nurses Association in 1963, and became involved in international nursing projects in more than forty countries. She was interviewed on 24 September 2001at Ottawa, Ontario.

Frances Ferguson Sutherland

Frances Sutherland was born at Edmonton, Alberta to Canadian and Scot parents. Her father

was a veteran of the Great War. Frances graduated from the Royal Alexandra Hospital in 1938. She completed postgraduate courses, and practiced in both general duty and private duty for 4.5 years prior to enlistment in the RCAMC as a Nursing Sister in January 1943. Her postings included 19 months in Canada and 19 months overseas (in England and Europe) for a total of 38 months of service with No. 12 CGH, No. 7 CGH, No. 6 CGH, No. 6 CCS, and No. 10 CGH. She was a volunteer for the Pacific theatre of war. After discharge in September 1945, Frances was instrumental in establishing a school for nursing aides in Calgary where she taught for ten years. She went to Ceylon for five years, establishing nursing programs. Later, she served as president of the Alberta Association of Registered Nurses and on the Canadian Nurses Association executive committee. Frances was interviewed on 10 October 2001 at Edmonton, Alberta.

Betty Young Ramage Hamilton

Betty Hamilton was born at Galston, Scotland and immigrated with her parents to Canada at the age of three. She graduated from the Misericordia Hospital in Edmonton (1939). She completed a postgraduate course and worked as a general duty nurse, an assistant head nurse, and a public health nurse for the Department of Social Hygiene for 4.5 years prior to enlistment in the RCAMC, May 1945. She was posted 12 months in Canada and volunteered for the Pacific theatre. On discharge in May 1946, Betty returned to the hospital while waiting for placement at university. She married in 1949 and worked part-time due to the severe nursing shortage while her disabled veteran husband took care of their baby. She returned to public health, becoming a supervisor of Alberta District Nurses and retiring in 1972. Betty was interviewed on 12 October 2001 at Edmonton, Alberta.

Beatrice Cole Hunter

Bea Hunter was born at Wapella, Saskatchewan to Canadian and English parents. She graduated from the Regina General Hospital (1944). She worked in general duty very briefly and was called to enlist (March 1944), in contrast to most of the RCAMC Nursing Sisters. She was posted 12 months in Canada and 20 months overseas with No. 19 CGH (in England) for a total of 32 months service. After discharge in November 1946, Bea completed a Bachelor of Science in Nursing degree and taught at St. Paul's Hospital School of Nursing in Vancouver. She returned to Edmonton as a clinical teacher and finally as Director of the School of Nursing at the Misericordia Hospital in Edmonton (1974-1982). In the late 1960s, she married an engineer responsible for drilling the Leduc No. 1 oil well and wrote a book based on oral histories from the workers' perspectives on the experience: *Last Chance Well: Legends and Legacies of Leduc No. 1* (Edmonton: Teddington Lock, 1997). She was interviewed on 13 October 2001 at Edmonton, Alberta.

Margaret Roe Dewart

Margaret Dewart was born at Neepawa, Manitoba, one of eight children born to her British parents. Margaret's mother was a nurse who trained in Minneapolis. Margaret graduated from the Winnipeg Children's Hospital (1941) and worked three years in general duty nursing until she enlisted in the RCAMC (1944). She was posted 6 months in Canada and 25 overseas (in England, the Mediterranean, and Europe) for a total of 31 months of service with No. 4 CGH, No. 17 CGH, No. 1 CGH, and No. 23 CGH. She was a volunteer for the Pacific theatre. After discharge in October 1946, Margaret re-enlisted in the permanent forces from April 1947 to November 1948 when she married and raised a family. She was interviewed on 15 October 2001 at Edmonton, Alberta.

Mary Marguerite Bower White

Mary White was born at Blairmore, Alberta as the third of five children with Irish-Canadian ancestry. Her father was a veteran of the Great War, gassed at Ypres. Mary graduated from the Holy Cross Hospital in Calgary (1938) and completed postgraduate courses in operating room technique at the Mayo Clinic in Minnesota. With four years experience in general duty and the OR, Mary enlisted in the RCAMC in June 1942. She was posted in Canada 16 months and overseas (in England) 17 months for a total of 33 months service with No. 11 CGH and No. 7 CGH. Married overseas, Mary was discharged in March 1945 to return to Canada for the birth of her first child. Ten years later, she took a refresher course and returned to nursing. Her published memoir is entitled *Hello War, Goodbye Sanity* (Canada: Mary M. White, 1992). She was interviewed on 20 October 2001 at Surrey, British Columbia.

E. June Parker

June Parker was born at Regina, Saskatchewan. Her father was a British soldier and her mother was a Territorial Forces Nursing Sister during the Great War. June enlisted in the RCAF (WD) in 1943 working as a radar technician in British Columbia. With her veteran's benefits, she went to the University of Manitoba for a year of Home Economics, hoping to get into physiotherapy. On the death of her father and the family's move to England, June completed nurses' training at the Leed's Infirmary in 1954 and enlisted in the RCAF as a Nursing Sister in 1959. She served in England, Labrador, Canada, and with NATO forces in France and Germany retiring in 1974. June completed the Air Evac course at Brooks Air Force Base in the USA (1963). She was posted to the Operational Training Unit (OTU) at Trenton, Ontario where she was involved in establishing the Canadian Air Evac course with F/L Ella Manix. Along with Peggy Corkum and Eve Gibbons, these four nurses became the first instructors with Sgt. Ballantyne in Air Evac (1963). June described this course as unique as it was "all medical ranks, all services, French and English, men and women, three weeks course in class, pool, chamber, and five days flying (usually a Hercules or whatever aircrew were training on) to Vancouver, San Francisco, Colorado, New Jersey, or Trenton. Students reversed roles daily, applying their training and improving their skills. Some of the ranks were highly trained and we nurses learned a lot from them!" June was interviewed on 23 November 2001at Ottawa, Ontario related to postwar military nursing practice.

Betty Riddell

Betty Riddell was born at Winnipeg, Manitoba, the daughter of a RCAF veteran of both world wars with both Welsh and Scottish origins. She graduated from the Misericordia Hospital School of Nursing in Winnipeg (1938) and completed postgraduate courses in the operating room. She worked in private duty briefly and decided to enlist with the United States Army Nurse Corps because of the long waiting list for nurses in the Canadian forces. She enlisted at Detroit, May 1943 and was posted in the United States and Papua, New Guinea—serving 36 months until April 1946. After discharge, she completed a public health degree at the University of Minnesota and was a school nurse in Los Angeles until returning to Canada where she worked in public health. She later entered the Canadian civil service and worked in nursing research until retirement in 1980. Her experience offers a good comparison to the Canadian military nurse's experience and she represents a large number of Canadian nurses who were not able to enlist with the Canadian forces. Betty was interviewed on 26 November 2001 at Ottawa, Ontario.

Isabel Morrison Fraser

Isabel Fraser was born at Halifax, Nova Scotia to Scottish parents. Her grandmother and mother had both been nurses trained in Boston. Both Isabel and her twin sister became nurses and Nursing Sisters but they graduated from different training schools. Isabel graduated from the Victoria General Hospital in Halifax (1940). She worked in private duty for 1.5 years and enlisted in the RCAMC (1942), immediately volunteering for the South African Military Nursing Service (a special draft). She served her one year contract there at Baragwanath and returned to Canada, re-joining the RCAMC in August 1943. With her combined service, Isabel served 11 months in Canada and 35 months overseas (in England and Europe with No. 23 CGH, and in South Africa) for a total of 46 months. She also volunteered for the Pacific theatre. On discharge, she married a regimental medical officer and retired to raise a family. Isabel was interviewed on 27 November 2001 at Ottawa, Ontario.

APPENDIX 9: DEMOGRAPHIC ANALYSIS OF THE INTERVIEWED NURSING SISTERS

The interviewed nurses closely resembled the NSD demographic profile with the exception of stratification, to assure that RCAF, RCN, and SAMNS perspectives were represented in the interviews. Eighteen of the nurses (72%) served in the RCAMC, three (12%) served in the RCAF, two (8%) served in the RCN, and one (4%) served with the SAMNS while two others served in the postwar RCAF and with the United States Army Nurse Corps respectively. Their average age was two years younger on enlistment than the average age of Nursing Sisters in my database, with a range of 22-34 years old and an average age of 26. More than half (57%) were between 25-28 years of age. They were primarily of British ancestry (80%) with the remaining nurses (20%) of American, Germany, Lebanese, and Austrian ancestry. All but one was unilingual English and all were female. Twenty-two of them (88%) remained single throughout their terms of service while 12% married overseas and an additional 28% married on discharge. They were dominantly Protestant (96%) and typically United Church adherents while one nurse was Jewish.

The average oral history participant had three years of nursing experience on enlistment, with a range from no experience to eight years. They had typically worked as general duty nurses, private duty nurses, operating room nurses, supervisors, instructors, industrial nurses, and public health nurses prior to enlisting. Not only were they fully qualified and registered with their provincial professional associations but most of them had taken post-graduate courses in operating room technique, supervision, and teaching. These nurses served in all but one theatre of war (Hong Kong) with an average of 18.9 months in Canada and 24.2 months overseas, for a total of 43 months (or 3.5 years). Only three nurses did not go overseas. Eight nurses (34%) served between 4 and 5 years, and one served 6.6 years prior to transferring into the permanent forces. The largest proportion of these Nursing Sisters married after discharge (43%) and with few exceptions, 'retired' from nursing. Five of them (22%) went to university under their veterans' benefits for public health certificate programs while one completed a Bachelor of Science in

Nursing degree under veteran's benefits and subsequently, a Masters and Doctorate degree. Four Nursing Sisters (17%) transferred into the permanent forces postwar and followed long-term nursing careers there, while another worked for the Department of Veterans Affairs as a civilian nurse. Only two Nursing Sisters returned to civilian hospital nursing but this was a temporary arrangement until marriage.

SECOND WORLD WAR CANADIAN MILITARY NURSES: FATHERS' OCCUPATIONAL CLASSIFICATION, ACCORDING TO INTERVIEWED NURSING SISTERS (N = 23)		
CATEGORY	NUMBER	PERCENT
Farming, Agriculture	5	21.7
Professional, Business, Clerical, Finance, Public Service, Managerial	15	65.2
Skilled, Semi-skilled, and Unskilled Labour	3	13.0
	23	99.9

APPENDIX 10: RESEARCH PLAN

After receiving approval from the University of Ottawa Social Sciences and Humanities Research Ethics Board (Appendix 1), I contacted leaders and key informants of the Nursing Sisters Association of Canada who provided the names of Nursing Sisters currently on their membership list. Potential participants received a letter of information and a consent form (Appendices 2 and 3). Lt. Colonel (Retired) Harriet J. T. Sloan (a Second World War Nursing Sister) made initial recommendations based on the different medical settings and theatres of war in which nurses served. She also agreed to do the first interview and pilot test the interview questions (Appendix 4). I then recruited nurses using a participant 'snowball' method and by invitations to participate that I placed in various professional and alumnae association newsletters: the Canadian Association for the History of Nursing, the Margaret M. Allemang Centre for the History of Nursing, the Edmonton unit of the NSAC, and the British Columbia History of Nursing group (see Appendix 5 for an example of the recruitment material). I phoned those who responded to establish a relationship, explain the study further, and evaluate the feasibility of doing an interview with them.

All former Nursing Sisters who served in the Canadian military forces between 1939 and 1945 were welcome to participate in the research. Province of origin or enlistment was irrelevant for the purpose of representation since the armed forces brought nurses together within medical units from across different regions, unlike the situation in the First World War. As well, the Nursing Sisters were very mobile postwar and where they live now, is usually not their original home community. I was more concerned to balance the different practice settings and theatres of war, including Canada, for this thesis. The most important criteria were health status and memory of the participant followed, by geographic accessibility. I interviewed one Nursing Sister who served immediately after the war to illuminate some postwar military nursing aspects, and one nurse who served with the United States Army Nurse Corps to represent the thousands of Canadian nurses who found themselves on a waiting list for the Canadian forces. Two Nursing Sisters were not interviewed after the initial arrangements had been made. One woman had a

death in the family close to the scheduled interview, and the other woman's husband suddenly needed to be placed in a long-term care facility which precipitated stressful events for her. I did not feel that it was ethically appropriate to conduct those interviews.

All twenty-five interviews were conducted between February and November 2001, at the participants' homes (Appendix 6). I mailed the interview questions to anyone who requested them prior to the interview. No one declined to be interviewed after reviewing the questions. I reviewed the letter of information with each person, and received signed, informed consent prior to conducting the interview. Each interview was audio-taped and lasted from 45 minutes to 180 minutes with breaks as needed. Participants had the option to break up the session into shorter time periods, if desired, but none of them did. The tapes have been transcribed and analyzed according to oral history methods and requirements of the University of Ottawa Research Ethics Board. Any participant who requested to review her material was permitted to do so. One woman asked to hear her tape and we listened to it together. She asked me to remove 19 seconds from it but at the same time, she provided additional details. A second woman asked to see her transcript. I mailed her a copy and followed up with a phone call, after which she requested that I not use portions of her interview, and that I delete brief portions on the tape, which I did. She sent additional written material that elaborated on her original interview.

To access the military records, I submitted a letter of request describing the research involved, why I needed the information, and how I planned to use it. I received permission to use the records under specified conditions that assured anonymity and confidentiality. I surveyed the first set of files to determine what type of information was consistently available and useful for demographic analysis of the Nursing Sisters. Data were extracted primarily from the attestation papers or 'Officer's Declaration' form, the 'Particulars of Officer's Family' form, the Certificate of Service form, the 'Nursing Service' form, and the 'Discharge Interview Summary.' The data were then used to construct a Microsoft Access® 2002 electronic database for analysis. Access allows the use of both quantitative and qualitative data from which simple demographic statistics and

comparisons can be generated. Tables and graphs reported in this research have been prepared with this program.

I was not permitted to select records under the restricted access conditions, but I was able to work with the archivist to achieve as balanced and randomized sample as possible, based on a process we developed to sample by the first letter of last names. Concerned about potential sampling bias, I sought ways to compensate for, or reduce, that possibility. The Nursing Sisters records are not filed as a group, nor identified by gender. Each record has two identification numbers (one from the military, and one from the archives) but they are organized according to alphabetical order, by last name. There is a nominal roll for RCAMC Nursing Sisters but none for the RCN or RCAF Nursing Sisters. Since the RCAMC enlisted the largest number of Nursing Sisters by far, I used their records as the basis for data extraction, and developed a method of proportional, letter sampling that reflected the RCAMC pattern. After the formation of the RCN and RCAFas separate services, each branch developed their own forms—further complicating data collection. Their records did not indicate gender or occupational category. The only way to retrieve Nursing Sisters records was to request them by the individual nurse's name. In order to include RCN and RCAF nurses in the study, I had to locate potential names for selection by the archivist, which I did by using a 1958 Nursing Sisters Association of Canada membership list.

Letter sampling raises many issues and is extremely complex for studying women because of a common practice in which women changed their surnames upon marriage. This became particularly problematic for this all-female population, due to the inconsistent manner of filing these records—sometimes under their original last name and sometimes under their married name. My initial decisions were guided by consultation with Lisa Dillon, formerly at the University of Ottawa Institute of Canadian Studies, and a discussion by Michael D. Ornstein and A. Gordon Darroch on letter sampling issues: "National Mobility Studies in Past Time: A Sampling Strategy," *Historical Methods* 11, no. 4 (1978): 152-161. I systematically compared my sample to the RCAMC Nominal Roll, and requested additional records from specific letter groups as necessary to maintain a similar distribution. While this was an imperfect method, I compensated

partially by increasing the sample size to obtain at least 1000 nurses and become increasingly representative of the whole population. Appendix 10 shows the final distribution of these records by letter sampling methods.

It was difficult to determine how many files would be adequate for generalization from the analysis, since the literature is variable and there were an unknown number of non-nurses included in the Nursing Sister rank. With a range from 3600 to 4800 Nursing Sisters and my estimate of 4381 nurses (Table 2.5 in Chapter 2), I set a goal to review at least 1000 nurses' records in order to increase generalizability from the sample. By the time I had reviewed approximately half of the records desired, I realized that non-nurses made up almost 10% of the records, that there would be some wastage due to records which were redundant because nurses had enlisted more than once, and that there were a small number of records with inadequate information. Therefore, I increased my target to 1150 records, in order to retain 1000 files belonging to nurses after accounting for this wastage. Since the RCN, RCAF, and SAMNS nurses were fewer in number, I sampled a proportionately smaller number of their records. The Nursing Sisters Database included 1145 Nursing Sisters: 1052 nurses, 22 dieticians, 34 physiotherapist aides, 15 occupational therapists, and 22 home sisters. Since analysis revealed that 91.8% of these files belonged to nurses and 8.1% belonged to non-nurses, my final sample represents 24% of estimated 4381 Nursing Sisters who were nurses. This proportion can be corroborated through Department of National Defence statistics for the RCAMC Nursing Service which was the largest of the nursing services, and their statistics reveal a corresponding proportion among the occupational and professional groups within the rank as 92.1% nurses and 7.9% non-nurses.[1]

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[1] "Appointment Statistics—Nursing Sisters, Physiotherapy Aides, Occupational Therapists, Dieticians and Home Sisters," 000.8 (D93), Directorate of History and Heritage, Department of National Defence, Ottawa.

APPENDIX 11: COMPARISON OF LETTER SAMPLING: RCAMC NOMINAL ROLL AND THE NURSING SISTERS DATABASE

COMPARISON OF LETTER SAMPLING: RCAMC NOMINAL ROLL AND THE NURSING SISTERS DATABASE				
	RCAMC Nominal Roll		Demographic Sample	
First Letter of Last Name	Number	%	Number	%
A	104	2.8	28	2.6
B	377	10.0	91	8.3
C	293	8.0	76	7.0
D	178	4.8	31	2.8
E	50	1.3	30	2.7
F	141	3.8	33	3.0
G	181	4.9	41	3.8
H	239	6.5	49	4.5
I	18	0.4	18	1.7
J	87	2.3	26	2.4
K	95	2.6	30	2.8
L	185	5.1	31	2.8
M	561	15.3	150	13.8
N	49	1.3	48	4.4
O	54	1.4	40	3.7
P	156	4.3	65	6.0
Q	5	0.1	5	0.4
R	161	4.4	74	6.8
S	321	8.8	102	9.4
T	139	3.8	56	5.1
U	13	0.4	4	0.4
V	26	0.7	5	0.5
W	189	5.2	50	4.6
Y	19	0.5	5	0.5
Z	5	0.1	1	0.1
TOTALS	3646	98.8	1089	100.1

APPENDIX 12: PARENTS' OCCUPATIONS

NURSING SISTERS DATABASE (N = 526): FATHERS' OCCUPATIONS ACCORDING TO THE 1941 CENSUS CATEGORIES			
CENSUS OCCUPATIONAL CATEGORY	FATHERS' OCCUPATIONS	NUMBER	PERCENT
Agriculture, Fishing, Hunting, Trapping	farmer, fisherman 3, fox rancher 1	180	34.2
Professional, Finance, Public Service	barrister 1, chemist 2, civil engineer 5, clergy 10, druggist 3, editor 1, electrical engineer 2, engineer 10, journalist 1, judge 1, lawyer 4, mechanical engineer 1, mining engineer 1, missionary 2, newspaper publisher 1, physician 18, architect 1, school principal 1, veterinarian 2, professional musician 1, bank manager 5, Insurance agent 7, manager 1, securities 1, real estate agent 2, banker 2, Chairman government commission 1, civil servant 1, civil service engineer 1, civil service 1, customs collector 1, firefighter 2, fishery inspector 2, income tax inspector 1, kitchen inspector 1, market inspector 1, munitions inspector 1, post master 1, postal clerk 5, power commissioner 1, public utilities superintendent 1, RCMP 1, school inspector 1, secretary local ration board 1, secretary of school board 1, secretary board of revenue commissioners 1, secretary dept. of education 2, secretary-treasurer rural municipality 1, Senator and farmer 1, statistical worker 1, superintendent liquor board 1, vital statistics registrar 1	119	22.6
Clerical and Business	general agent 1, station agent 1, auto business 1, fruit dealer 1, general merchant 2, grain buyer 1, agent 1, grain man 3, grocer 1, miner salesman 1, oil company agent 1, Salesman, sales agent, sales clerk 9, shipper 2, store keeper, store manager 2, store owner 6, wholesale boots and shoes 1, wholesaler 1, hotel clerk 1, private secretary 1, accountant 7, assessor 1, assistant secretary 1, bank clerk 2, budgeting clerk 1, chartered accountant 2, chef comptable 1, city shipper 1, clerk 2, filer 1, tax clerk 1,	57	10.8
Managerial	lumber contractor 1, mining foreman 1, mining operator 1, creamery manager 1, superintendent sulfite dept. 1, superintendent 1, supervisor 1, winery manager 1, building contractor 1, contractor 4, electrical contractor 1, electrical foreman 1, foreman 3, hauling contractor 1, marble contractor 1, boathouse manager 1, dry dock supervisor 1,	41	7.8

	foreman 1, general manager 1, lock master 1, master mariner 1, river boat captain 1, stationmaster 3, decorating contractor 1, department manager 1, general manager 4, retail manager 1, tourist camp operator 1, hotel proprietor 1, laundry manager 1, contre-maitre 1		
Skilled labourers	lumberman 5, miner 6, nickel industry worker 1, butcher 1, jewelry business 1, machinist 2, manufacturer 2, mechanic 4, orthopedic appliances maker 1, paper maker 1, photo engraver 1, printer 2, shoemaker 1, Iron Foundry 1, tailor time keeper 2, tinsmith 1, plumber 1, watch maker 1, welder 1, wood worker 1, cabinet maker 1, carpenter 11, electrician 1, CNR and CPR workers 30, express car driver 1, telegrapher 2, telephone linesman 1, barber 1, undertaker 1,	85	16.2
Semi-skilled labour	commercial traveler 4, farm implement agent 2, merchant 8, labourers 7, plant worker 1, mill worker 1, molder 1, separator man 1, ship caulker 1, steel worker 1, stock keeper 2, war worker 1	30	5.7
Unskilled labourer	hardware store 1, ice dealer 1, caretaker 2, cemetery caretaker 1, chauffer 1, janitor 1, night watchman 1, turn key 1, watchman 1	10	1.9
Independent means	Gentleman 1, mard-rand 1, rentier 2	4	0.7
Total responses		526	50
Cannot be determined	Soldier and officers 10, incapacitated 6, unemployed 4, retired 52	72	6.8
Not indicated		454	43.2
	Total	1052	

APPENDIX 13:

ORAL HISTORY PARTICIPANTS, PARENTAL OCCUPATIONS AND DEATHS

ORAL HISTORY PARTICIPANTS, PARENTAL OCCUPATIONS AND DEATHS		
Parental Status	Father's Occupation	Mother's Occupation
	General Manager	
	Caretaker	
Both dead	Farmer	
	Miner / Banker / Salesman	Crochet Factory Supervisor
Mother dead	Farmer	Nurse
	Civil Service	
	Civil Engineer	Teacher
	Housing Contractor	
	Farmer / Stonemason	
	Commercial Traveler	
	CNR Stationmaster	Teacher
	Accountant	
	Civil Engineer	
	Accountant	
	Fisherman	
	CPR Engineer	
	Civil Service Engineer	Teacher
	Physician	Teacher
	Lawyer	
	Auto business	
	Farmer	
Father dead	RCMP	Store clerk
Father dead	Contractor	Teacher

ORAL HISTORY PARTICIPANTS, FATHERS' OCCUPATIONS BY 1941 CENSUS CATEGORIES (N = 23)			
CENSUS OCCUPATIONAL CATEGORY	FATHERS' OCCUPATIONS	NUMBER	PERCENT
Agriculture, Fishing, Hunting, Trapping	Farmers 4, Fisherman 1	5	21.7
Professional, Finance, Public Service	Civil Service 2, Civil Engineer 2, Physician 1, Lawyer 1, RCMP 1, Banker 1, Accountant 2	10	43.5
Business, Clerical	Auto business 1,	1	4.3
Managerial	Stationmaster 1, Contractor 2, General Manager 1	4	17.4
Skilled Labourer	CPR Engineer 1, Storekeeper 1	2	8.6
Semi-skilled Labourer	Commercial traveler 1,	1	4.3
Unskilled Labourer		0	

ORAL HISTORY PARTICIPANTS, MOTHERS' OCCUPATIONS BY 1941 CENSUS CATEGORIES (N = 23)			
CENSUS OCCUPATIONAL CATEGORY	MOTHERS' OCCUPATIONS	NUMBER	PERCENT
Professional, Finance, Public Service	School teacher 5, Nurse 1,	6	26.1
Business, Clerical	Store clerk	1	4.3
Managerial	Supervisor	1	4.3

APPENDIX 14: "A 'PRACTICE' RAID"

Contributed by the Public Health Nursing Section, New Brunswick Association of Registered Nurses, *Canadian Nurse* 37, no. 7 (July 1941): 478.

Ready, aye ready, for action are they
Nurses for service by night or by day
Women of courage, and prompt one and all
Whenever the sirens of warning may call.
Theirs is the spirit that nothing can daunt
Theirs is the answer to dictators' vaunt
And theirs is the spirit of Empire's might
Which will win a great victory for God, King, and Right.

APPENDIX 15: "OUR CANADIAN NURSING SISTER"

Lyrics by John Murray Gibbon, Arranged by Harold Eustace Key
(Toronto, Canada: Gordon V. Thompson, 1946)

In the battle clearing station, she had hands to soothe all pain,
And she brought a new elation like a song with sweet refrain.
By your bed she might be sitting with the drug that you must take;
Or along the tent was flitting, there a fairyland to make.

Were there any other fairies who could make the world so gay?
She was light as any air is as she wafted care away.
Oh, could any one resist her who had any eyes to see?
Our Canadian Nursing Sister was the Fairy Queen for me.

APPENDIX 16: *CANADIAN NURSE* ADS



Photo U.S.A.

WAR EFFORT SPEEDED BY NEW SUCCESS OVER ATHLETE'S FOOT



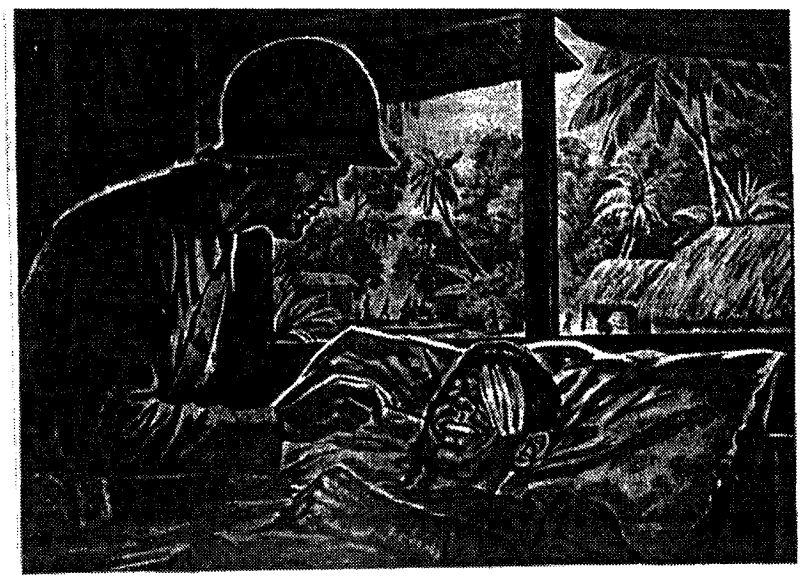
...for symptoms ...hlete's Foot—...peeling be...toes, cracks, ...skin, itching.

EVERY NURSE must keep her *feet* in most perfect condition to keep working and marching to victory. But Athlete's Foot is a real threat, as surveys show it infects 7 out of 10 adults—including nurses—sometime during the year. And the disease rages at its worst in the presence of heat and perspiration during summer! Fortunately, a new fungicidal powder—Mennen *Quinsana*—is scoring great success against Athlete's Foot. Quinsana action is based on knowledge that the fungi which cause infection cannot live under certain *alkaline* conditions, and may thrive in shoe linings, as well as feet, creating a vicious circle of *re-infection*.



Use 2-way treatment with Quinsana as regularly as soap and water, to help *prevent* as well as to get quick, effective relief from Athlete's Foot. Even mild cases may suddenly become serious. Inflammation may mean *germ* infection; see physician. (Quinsana is also excellent for excessive perspiration, foot odor). *Pharmaceutical Division, The Mennen Company, Toronto, Canada.*

"War Effort Speeded by New Success over Athlete's Foot," *Canadian Nurse* 40, no. 5 (May 1944): 349.

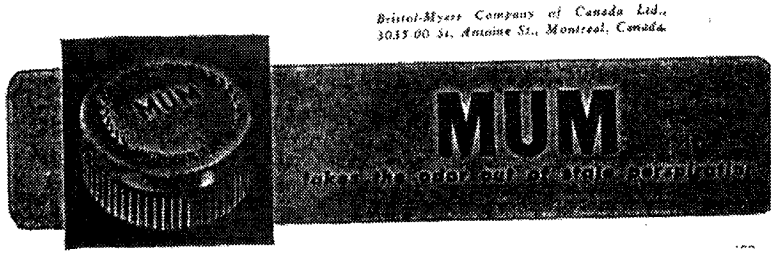


Army nurses are on the go

ARMY nurses certainly have plenty to do these days, and still they must keep well groomed. That means attention to underarm freshness. MUM, the snow-white vanishing cream brings quick deodorizing victory over stale perspiration odor wherever it may arise. Just a dab, in half a minute, acts effectively for many hours. No irritation, no staining of clothing, no interference with normal sweat secretions.

And MUM is the watchword for use on sanitary napkins, and to soothe and refresh tired "marching" feet. Interesting literature on request.

Bristol-Myers Company of Canada Ltd.,
3055 00 St. Antoine St., Montreal, Canada.



"Army nurses are on the go," *Canadian Nurse* 39, no. 7 (July 1943): 499.



Navy nurses are busier than ever

"FULL SPEED AHEAD" is the order of the day for Navy nurses and there's precious little time for personal fastidiousness. MUM does its share in maintaining body sweetness by routing disagreeable perspiration odors. Snow-white, vanishing MUM is a pure deodorant cream which goes into action quickly and stays on duty for long hours. No irritation, no staining, no disturbance of normal sweat gland functions when you use effective MUM for protection.

Signal for MUM during sanitary napkin time. And try it for refreshing hot, tired feet, too. Literature on request.

Bristol-Myers Company of Canada Ltd.
3035-00 St. Antoine St., Montreal, Canada.

"Navy nurses are busier than ever," *Canadian Nurse* 39, no. 9 (September 1943): 633.

Unprecedented times? Unprecedented problems



TODAY, more women are contributing to our national war effort than ever before. The unprecedented responsibility placed on them for full-time activity, intensifies many of their personal problems to an equally unprecedented degree . . . particularly that of menstrual hygiene.

Working steadily with men in near proximity—often wearing close-fitting slacks or coveralls—with less opportunity for private retirement than in more leisurely or more domestic times—it is little wonder that so many have found in Tampax the ideal means for improving their hygienic habits, as an aid to uninterrupted activity.

Ten years ago Tampax itself was unprecedented—since which time, well over five hundred million of these vaginal tampons have been purchased. Indeed, the only unprecedented thing about Tampax today, is the unusual enthusiasm evoked by the freedom it gives from the prospect of internal or external irritation . . . from all possibility of noticeable bulkiness . . . and from the exposure of the flux to odorous decomposition.

Tampax is available in three absorbencies—Super, Regular, and Junior—to suit personal daily needs. From its compressed size (which permits insertion without orificial stress), it expands *flat* in situ—an exclusive feature—conforming with comfort to the intravaginal configuration. Its cross-fibre stitching—also exclusive—prevents disintegration, so that dainty removal may be effected intact without probing.

If you have never personally examined Tampax, why not break a precedent, too? The coupon is for your convenience.

CANADIAN TAMPAX CORPORATION LTD.,
533 College St., Toronto, Ont.

TAMPAX

"Unprecedented times, unprecedented problems?"
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