

Front Lines and Frontiers: War as Legitimate Work for Nurses, 1939–1945

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Over 4,000 nurses served with the Canadian armed forces during the Second World War, comprising a second generation of military nurses known by rank and title as Nursing Sisters. Military medical records and personal accounts reveal that military nurses enjoyed an elite professional status based on their relative closeness to the front lines of combat and to the frontiers of medical technology. Reductions in morbidity and mortality rates were frequently attributed to the presence of Nursing Sisters in forward field units. While Nursing Sisters capitalized on their position within the armed forces to enhance their expertise and develop expanded practice roles, such efforts were contingent on geographical setting, the availability of physicians and medical orderlies, and the social construction of medical technologies as men's or women's work. Flexibility and autonomy were more evident closer to the front lines, where patient acuity was higher, skilled personnel fewer, and risk-taking more acceptable. Such flexible boundaries, however, were "for the duration" only.

Plus de 4 000 infirmières ont servi dans les forces armées canadiennes durant la Deuxième Guerre mondiale, formant une deuxième génération d'infirmières militaires. On découvre à l'étude des dossiers médicaux militaires et des récits personnels que les infirmières militaires jouissaient d'un statut professionnel d'élite du fait d'être à proximité relative des zones de combat et aux premières loges de la technologie médicale. La réduction des taux de morbidité et de mortalité étaient souvent attribuée à la présence des infirmières militaires dans les unités de campagne sur les fronts de guerre. Si les infirmières militaires profitaient de leur position au sein des forces armées pour gagner en expertise et accroître leur rôle de praticiennes, de tels efforts étaient fonction de l'emplacement géographique, de la disponibilité de médecins et de préposés aux soins et de la construction sociale voulant que les technologies médicales soient du ressort des hommes ou des femmes. Il y avait davantage de souplesse et d'autonomie près des lignes de front, où l'acuité des besoins du patient était plus grande, le personnel qualifié, moins nombreux et les

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risques, plus acceptables. Cette flexibilité ne valait toutefois que « pour la durée » du conflit.

THE INTERSECTION of war, gender, and medical technology legitimated the presence of female military nurses in the Canadian armed forces during the Second World War — the only women serving in this all-male domain at the beginning of the war. At least 4,079 Canadian nurses served with one of the three Canadian services during the Second World War. Like their foremothers from the First World War, they were known by rank and title as Nursing Sisters (NS). As they became increasingly essential for the functioning of military medical units, Nursing Sisters enjoyed an enhanced professional and social status based partially on their closeness to the front lines of combat and the frontiers of medical technology. NS Margaret Allemang said, “If you’d been to the front, you were special.”¹ NS Irene Lavalée, however, pointed out the contingency of military nursing roles and war as an enabling set of conditions: “We were only military nurses because there was a war.”² War reconfigured some aspects of their work and relationships, but there is little evidence that these changes transferred to postwar or non-military settings.

Since the late 1980s and early 1990s, several important historiographical debates have emerged regarding war as a “gendering activity”. Joan Scott argues that there is one basic theme in this literature, framing war as either a positive or a negative “watershed” experience for women, with four variations: new opportunities that did or did not open for women during war, new political rights for women based on their wartime participation, female antipathy to war and women as leaders of pacifist movements, and long- and short-term impacts of war on women.³ Ruth Pierson suggests that dichotomous metaphors in this body of literature stereotypically portray women as “beautiful souls” and men as “just warriors”.⁴ For the most part, this literature considers women as a universal group in relation to war and the military. When military nurses are represented in the studies, they appear primarily as victims of a militarization process, and their work remains invisible. This study examines the porous gender and professional boundaries and contingent nature of war that created a legitimate space for nurses’ work within the context of the Second

1 Margaret M. Allemang, audio-taped interview with author, Toronto, April 26, 2001.

2 Irene Lavalée, personal communication with author, July 25, 2001.

3 Joan W. Scott, “Rewriting History”, in Margaret Randolph Higgonnet, Jane Jenson, Sonya Michel, and Margaret Collins Weitz, eds., *Behind the Lines: Gender and the Two World Wars* (New Haven: Yale University Press, 1987), pp. 21–30.

4 Ruth Roach Pierson, “Beautiful Soul or Just Warrior: Gender and War”, *Gender & History*, vol. 1, no. 1 (Spring 1989), pp. 77–86; Jean Elshtain, *Women and War* (New York: Basic Books, 1987), pp. 10–11.

World War — challenging both the “watershed” and “beautiful souls” discourses.

Although the care of sick and wounded soldiers has been a long-standing problem for the armed forces, as historian Roger Cooter points out, a significant shift in public perceptions of that care took place at the end of the nineteenth century when “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”.⁵ Increasingly, tactical plans for major military invasions had to incorporate the delivery of adequate medical services not only as a manpower issue, but also in response to societal expectations and the social debt owed to the citizen soldier. Indeed, decisions concerning medical treatments were often closely linked to military objectives; the discovery and use of penicillin, for example, was classified as “top secret” during the Second World War.⁶

Significant issues arose concerning *who* should provide this care and *where*, especially during times of war when personnel needs increased dramatically. The Canadian militia had always maintained fully qualified medical physicians and surgeons within the ranks, increasing the number as needed. Although 12 civilian nurses accompanied the Canadian contingents to South Africa between 1899 and 1902, it was 1904 before a fully integrated nursing service was established within a newly organized Canadian Army Medical Corps. From the beginning, this permanent force nursing service accepted only trained professional nurses and granted them the “relative rank” as officers — the first armed forces to do so.⁷ This decision set the Canadian forces apart from other armed forces that depended on auxiliary nursing services and large numbers of temporary assistants with little or no training.⁸ The civilian nursing work

5 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, GA: Rodopi, 1999), p. 4.

6 Donald H. Avery, *The Science of War: Canadian Scientists and Allied Military Technology during the Second World War* (Toronto: University of Toronto Press, 1998).

7 G. W. L. Nicholson, *Seventy Years of Service: A History of the R.C.A.M.C.* (Ottawa: Borealis Press, 1977), p. 138, and *Canada's Nursing Sisters* (Toronto: Samuel Stevens Hakkert & Company, 1975), pp. 116–118; W.R. Feasby, ed., *Official History of the Canadian Medical Services, 1939–1945*, vol. 1: *Organization and Campaigns* (Ottawa: Queen's Printer, 1956), pp. 311–312.

8 There is a large body of literature on the VADs, particularly among British historians. British 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) nurses, see Vera Brittain, *Testament of Youth: An Autobiographical Study of the Years 1900–1925* (New York: Macmillan, 1933; Seaview Books, 1978, 1980) and *Chronicle of Youth: War Diary, 1913–1917*, ed. Alan Bishop with Terry Smart (London: Gollancz, 1981; New York: William Morrow, 1982). 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*, vol. 45, no. 3 (1996), pp. 167–172.

force, perceiving the salvage of soldiers to be legitimate nursing work, made this complete reliance on fully qualified professional nurses not only possible, but highly desirable.

Although military historian Colonel C. P. Stacey pronounced Canada to be a very “unmilitary community”, civilian nurses volunteered for military service in overwhelming numbers during both twentieth-century world wars. For the largest cohort of Canadian military nurses, those who served during the Second World War, the intersection of war, gender, and medical technology enabled such an enthusiastic response. What was the nature of nurses’ work during the war? How did roles shift between the various medical personnel within military medical units? How did geographical and social spaces construct different kinds of work within this gendered military and medical hierarchy? These nurses volunteered in such large numbers, for example, that, only ten days after the call to mobilize medical units (September 1, 1939), a moratorium was placed on their enlistment.⁹ Their enthusiasm persisted throughout the war, and 30 per cent of enlisted nurses had already extended their commitment to volunteer for a Pacific campaign before the war finally ended in August 1945.¹⁰

Until the formation of Women’s Divisions in the Army, Navy, and Air Force beginning in 1941, Nursing Sisters were the only women serving in the Canadian military, where they capitalized on an inherited reputation as professional nurses, professional soldiers, and “quintessential” women.¹¹

VADs are not the focus of this article, however, because the Canadian armed forces never enlisted untrained or semi-trained women as “nurses” or nursing assistants; they never needed to do so. For research on Canadian VADs, see Linda Quiney, “‘Tradition and Transformation’: Recent Scholarship in Canadian Nursing History”, *Journal of Canadian Studies*, vol. 34, no. 3 (Fall 1999), pp. 282–291; “Assistant Angels: Canadian Voluntary Aid Detachment Nurses in the Great War”, *Canadian Bulletin of Medical History*, vol. 15, no. 1(1998), pp. 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*, vol. 8 (1998), pp. 105–124. For further controversies surrounding the use of VADs in Canadian contexts, refer to Desmond Morton, *A Peculiar Kind of Politics: Canada’s Overseas Ministry in the First World War* (Toronto: University of Toronto Press, 1982); 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).

9 C. P. Stacey, *Official History of the Canadian Army in the Second World War: Six Years of War*, vol. 1: *The Army in Canada, Britain and the Pacific* (Ottawa: Queen’s Printer, 1955), pp. 3 and 43; Nicholson, *Seventy Years of Service*, p. 138.

10 These dates are generally accepted as the parameters of the Second World War from a military perspective, although nurses’ experiences both predated the formal Declaration of War and lasted beyond the closure of the last Canadian medical unit in Europe during May 1946.

11 Nursing was one of several women’s occupations that sought professional status at the beginning of the twentieth century. Leaders claimed that scientific underpinnings differentiated between trained and untrained nurses, and they 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

They were not members of a religious order, but graduates of hospital schools of nursing who had successfully completed three years of apprenticeship training, as was customary in North America through most of the twentieth century.¹² A small number held specialty certifications, while even fewer nurses held university degrees. Thousands of nurses were on a waiting list to join the Canadian forces, while still others eagerly enlisted with British, American, and South African medical services — so they would not “miss the war” — contrasting sharply to the conscription of men from 1940 and to the campaign for the conscription of American nurses during 1944–1945.¹³

The primary sources for this study include: 55 oral history interviews; military personnel records for 1,145 individual Nursing Sisters (a sample consisting of 26 per cent); relevant professional nursing and medical literature of the period; records of professional nursing organizations; relevant archival documents and photographs of the Department of National Defence; and both private and published diaries, memoirs, and letters of

in Canada. See George M. Weir, *Survey of Nursing Education in Canada* (Toronto: University of Toronto Press, 1932), who suggests that nurses were professionals in spite of definitional constraints (pp. 51–65); Kathryn McPherson, *Beside Matters: The Transformation of Canadian Nursing, 1900–1990* (Toronto: Oxford University Press, 1996), pp. 6–7, 20–21. By the time of the First World War, Canadian nurses from recognized hospital training schools had established themselves in the very few military nursing positions available. Their training established them as professional nurses according to the time, while relative rank established them as professional soldiers according to the accepted distinction between officers and “other ranks”. I use the term “quintessential women” here in reference to the prevailing idealized image of every woman as a nurse, although this is problematic. The international Red Cross poster “The Greatest Mother in the World”, for example, portrays this image vividly, as Meryn Stuart points out in “War and Peace: Professional Identities and Nurses’ Training, 1914–1930”, in Elizabeth Smyth, Sandra Acker, Paula Bourne, and Alison Prentice, eds., *Challenging Professions: Historical and Contemporary Perspectives on Women’s Professional Work* (Toronto: University of Toronto Press, 1999), p. 172.

12 McPherson, *Beside Matters*; Barbara Melosh, “*The Physician’s Hand*”: *Work, Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982); Susan M. Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850–1945* (New York: Cambridge University Press, 1987).

13 Stacey, *Official History of the Canadian Army in the Second World War*, pp. 3, 43, 118–122. For the American situation, see Stella Goostray, *Memoirs: Half a Century in Nursing* (Boston: Boston University Mugar Memorial Library, 1969), pp. 126–127; 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 “shock” and “fear” within the profession regarding US President Franklin Roosevelt’s recommendation to amend the *Selective Service Act* to induct civilian nurses into the armed forces. Phillip and Beatrice Kalisch describe the battle and passage of a bill to draft American nurses that narrowly escaped enactment by days when the war in Europe ended with the signing of the Armistice in May 1945. 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*, vol. 22, no. 5 (September–October 1973), pp. 402–413.

the Nursing Sisters themselves.¹⁴ The Canadian Nursing Sisters were posted to all of the major theatres (the United Kingdom, Northwest Europe, the Mediterranean, and Hong Kong) as well as to military hospitals across Canada and in Newfoundland, the United States, and South Africa. Besides serving in diverse 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. Two of them became prisoners of war for 21 months under the Japanese army in Hong Kong. Sources from Nursing Sisters serving in all of these settings are part of this study.

Major debates on the use of oral histories 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 interviewer and 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.¹⁵ Denyse Baillargeon, in her excellent comparison of presumed objectivity in empirical knowing with the presumed inferiority of subjective memory, 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.¹⁶

The Department of National Defence Nursing Sisters personnel files held by Library and Archives Canada are a rich source for extraction of

14 There are two published memoirs and a three-volume anthology of military nurses' recollections and photographs from 1885 to the mid-1990s: Doris V. Carter, *Never Leave Your Head Uncovered: A Canadian Nursing Sister in World War Two* (Waterdown, ON: Potlatch Publications, 1999); Mary M. White, *Hello War, Goodbye Sanity* (private publication, 1992); Edith Landells, ed., *The Military Nurses of Canada: Recollections of Canadian Military Nurses*, vols. 1–3 (White Rock, BC: Co-Publishing, 1995–1999).

15 Paul Thompson, *Voice of the Past: Oral History* (Oxford: Oxford University Press, 1978); Joan Sangster, "Telling our Stories: Feminists' Debates and the Use of Oral History", in Robert Perks and Alistair Thomson, eds., *The Oral History Reader* (London: Routledge, 1998), pp. 87–100; Henry W. Hodysh and R. Gordon McIntosh, "Problems of Objectivity in Oral History", *Historical Studies in Education*, vol. 1 (1989), pp. 137–147; Trevor Lummis, "Structure and Validity in Oral Evidence", in Perks and Thomson, eds., *The Oral History Reader*, pp. 273–283.

16 Denyse Baillargeon, "Histoire orale et histoire des femmes : itinéraires et points de rencontre", *Recherches féministes*, vol. 6, no. 1 (1993), pp. 53–68. For a valuable discussion between a cognitive psychologist whose expertise is memory storage and an oral historian, see Marigold Linton, "Phoenix and Chimera: The Changing Face of Memory", in Jaclyn Jeffrey and Glenace Edwall, eds., *Memory and History: Essays on Recalling and Interpreting Evidence* (Lanham, MD: University Press of America, 1994), pp. 69–88.

demographic variables. These records were created during the war and consistently collected certain kinds of information related to vital statistics, family members, language, origins, training and previous nursing experience, postings, length of service in different theatres, and postwar plans. Because the records were selected randomly by a system of proportional letter sampling based on last names, they reveal a wider diversity among Nursing Sisters and complement the oral histories significantly. I extracted 34 variables from each of the 1,145 records, finding that these records allowed a more comprehensive analysis of rank-and-file nurses than oral histories or memoirs alone. Documentary sources such as these files appear to constitute more objective, reliable, and therefore more accurate data. But there are still important issues to consider, such as who created them, their characteristics, the access restrictions imposed, and the sampling method used. There were, for example, several versions of some forms, and the forms were completed by many different people in local enlistment centres, at different times, with numerous opportunities for inaccuracies, omissions, and inconsistencies — in short, myriad ways in which these records have been constructed by those who created them.¹⁷ Standardized forms are useful for collecting information consistently from a large sample, but they also create silences through what is asked and not asked and therefore what we can know based on them.

Gender is a particularly useful concept for analysis of military nursing because it exposes the multiple ways in which power is unequally distributed while providing a rich framework for the examination of intersecting variables such as class, race, ethnicity, language, marital status, and age.¹⁸ It exposes both the “fundamental differences that divide gendered subjects” and the “historically specific processes that unite people into a shared

17 These records are restricted, and findings can only be reported as aggregate data or in a manner that assures anonymity of the nurses. Only three files had to be rejected because the folder contained too little content, although many records had been badly damaged by flooding. Where files had been dried but were in an extremely fragile state, I replaced them with additional records.

18 Scott, “Rewriting History”, pp. 21–30; Margaret R. Higonnet and Patrice L.-R. Higonnet, “The Double Helix”, in Higonnet *et al.*, eds., *Behind the Lines*, pp. 31–47; Margaret R. Higonnet, *Nurses at the Front: Writing the Wounds of the Great War* (Boston: Northeastern University Press, 2001); Cynthia Enloe, *Maneuvers: The International Politics of Militarizing Women's Lives* (Berkeley: University of California Press, 2000) and *Does Khaki Become You? The Militarisation of Women's Lives* (Boston: South End Press, 1983); Pierson, “Beautiful Soul or Just Warrior”, pp. 77–86; Elshtain, *Women and War*; Susan R. Grayzel, *Women's Identities at War: Gender, Motherhood, and Politics in Britain and France during the First World War* (Chapel Hill, NC: University of North Carolina Press, 1999); Angela K. Smith, *The Second Battlefield: Women, Modernism and the First World War* (Manchester and New York: Manchester University Press, 2000); Ruth Roach Pierson, *Canadian Women and the Second World War* (Ottawa: Canadian Historical Association, 1983) and *They're Still Women after All!: The Second World War and Canadian Womanhood* (Toronto: McClelland & Stewart, 1986).

gendered consciousness”.¹⁹ The Nursing Sisters were always situated in relation to military men with whom they served — medical officers, other military officers, and medical orderlies. Gendered roles permeated these relationships through socially constructed masculine and feminine expectations that mediated both their professional and personal lives. Indeed, the key defining characteristic of Canadian Nursing Sisters was their femininity. They were women first and nurses second, according to prevailing military practice that classified all enlisted women as Nursing Sisters regardless of their occupational category, simultaneously denying professional status to men who were fully qualified as nurses until 1967.

Historiography

Military nursing history intersects with military history, women’s history, and medical and nursing histories. For the most part, historians avoid the study of military nurses partially because the association of nurses with war and killing runs counter to conventional thought. There is an interpretive uneasiness that obscures both their presence in the armed forces and war as nurses’ work. Most accounts treat war as antithetical to nursing and nurses as idealized women who epitomize both femininity and pacifism. As Australian historian Jan Bassett concludes, historians have generally either ignored or sanctified military nurses’ experiences, feminists have overlooked military nurses as ideologically unsound, and military nursing histories consist predominantly of anecdotal collections and chronologies.²⁰

19 Kathryn McPherson, Cecilia Morgan, and Nancy M. Forestell, eds., *Gendered Pasts: Historical Essays in Femininity and Masculinity in Canada* (Don Mills, ON: Oxford University Press, 1999), p. 4–5.

20 Jan Bassett, *Guns and Brooches: Australian Army Nursing from the Boer War to the Gulf War* (New York: Oxford, 1992), pp. 1–2. See Sarnecky, *A History of the U.S. Army Nurse Corps* and “Nursing in the American Army from the Revolution to the Spanish-American War”, *Nursing History Review*, vol. 5 (1997), pp. 49–69; Elizabeth M. Norman and Sharon Elfried, “The Angels of Bataan”, *Image: The Journal of Nursing Scholarship*, vol. 25, no. 2 (Summer 1993), pp. 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*, vol. 3 (1995), pp. 105–127, and *We Band of Angels: The Untold Story of American Nurses Trapped on Bataan by the Japanese* (New York: Random House, 1999); Diane Burke Fessler, *No Time for Fear: Voices of American Military Nurses in the Second World War* (East Lansing: Michigan State University Press, 1996); Joyce Hibbert, *Fragments of War: Stories from Survivors of the Second World War* (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, UK: Cakebread Publications, 1989); Barbara Brooks Tomblin, *G. I. Nightingales: The Army Nurse Corps in World War II* (Lexington: 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*

Prevailing discourses portray the Canadian military nurses as “extraordinary women”, patriots, heroines, angels, and sometimes feminists.²¹ Official military histories refer to the Canadian Nursing Sisters primarily as “morale builders”, while the media portray them stereotypically engaged in classed and feminized activities such as tea parties, meeting royalty, shopping and sight-seeing, and marrying officers.²² Military medical histories consider Canadian Nursing Sisters only briefly, as a support service for the armed forces.²³

American anthropologist Cynthia Enloe examined ways in which war and military discourse depended on women’s support for the recruitment

Nursing Profession, 1939–1969 (Peterborough: DSM, 2000) and *Nurses at War: Women on the Frontline, 1939–45* (Stroud, UK: Sutton Publishing, 2000).

- 21 Nicholson, *Canada’s Nursing Sisters*; Harold M. Wright, *Salute to the Air Force Medical Branch on the 75th Anniversary Royal Canadian Air Force* (Ottawa: Privately published, 1999); Rita Donovan, *As for the Canadians: The Remarkable Story of the RCAF’s “Guinea Pigs” of the Second World War* (Ottawa: Buschek Books, 2000); Jean Bruce, *Back the Attack: Canadian Women during the Second World War – at Home and Abroad* (Toronto: Macmillan of Canada, 1985); 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* (Ottawa: Department of National Defence, 2001); Barbara Dundas, *A History of Women in the Canadian Military* (Montreal: Art Global, 2000).
- 22 A large body of Canadian Second World War military history includes: Stacey, *The Army in Canada, Britain and the Pacific* and *Official History of the Canadian Army in the Second World War*, vol. 3: *The Victory Campaign: The Operations in North-West Europe, 1944–1945* (Ottawa: Queen’s Printer, 1960) and vol. 2: *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. 3: *Crucible of War, 1939–1945* (Toronto: University of Toronto Press, 1986); Tony German, *The Sea is at Our Gate: The History of the Canadian Navy* (Toronto: McClelland & Stewart, 1990). Recent military historians have significantly broadened their analyses to include Canadian socio-political and economic factors: 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* (Edmonton: Hurtig, 1990); 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); 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); Jeffrey A. Keshen, “Revisiting Canada’s Civilian Women during World War II”, *Histoire sociale/ Social History*, vol. 30, no. 60 (November 1997), pp. 239–266, *Saints, Sinners, and Soldiers: Canada’s Second World War* (Vancouver: University of British Columbia Press, 2004), and *Propaganda and Censorship during Canada’s Great War* (Edmonton: University of Alberta Press, 1996).
- 23 Feasby, ed., *Official History of the Canadian Medical Services*, vol. 1 and vol. 2: *Clinical Subjects* (Ottawa: Queen’s Printer, 1956); Nicholson, *Canada’s Nursing Sisters and Seventy Years of Service*; Bill Rawling, *Death Their Enemy: Canadian Medical Practitioners and War* (Quebec: AGMV Marquis, 2001); Wright, *Salute to the Air Force Medical Branch*; Donovan, *As for the Canadians*; Stanley T. Richards, *Operation Sick Bay* (West Vancouver, BC: Cantaur Publishing, 1994).

and re-enlistment of men, for sanitary and caring tasks required to keep troops healthy, and for replacement labour that released men for combat. She was one of the first scholars to include military nurses in discussion of the militarization of women's lives, asking, "Does khaki become you?"²⁴ Margaret Higonnet studied gendered military roles and argues that, while some military women and men experienced more flexible roles in the armed forces, they still retained the same relative position of power respective to one another.²⁵

First World War women's historians have compared the porous boundaries between "war fronts" and "home fronts" in Britain and France,²⁶ analysed women's war writings (including several left by untrained, semi-trained, and trained nurses),²⁷ examined how class destabilized the disciplinary ideal of both voluntary and trained British nurses,²⁸ and explored the complicity of French nurses that led to their invisibility in public memory.²⁹ Canadian historians of nursing have recently expressed increased interest in the Canadian Nursing Sisters of both world wars. They are beginning to analyse the complexity of transforming civilian nurses into military nurses, as well as their experiences and responses to war as nurses' work.³⁰ Here, I privilege nurses' work as central to their identity. Work legitimated their presence in a traditionally male domain as their skills reduced morbidity and mortality rates significantly on the front lines.

24 Enloe, *Does Khaki Become You?*

25 Higonnet and Higonnet, "The Double Helix", pp. 33–34.

26 Janet S. K. Watson, *Fighting Different Wars: Experience, Memory, and the First World War in Britain* (Cambridge, UK: Cambridge University Press, 2004), p. 261.

27 Grayzel, *Women's Identities at War*; Smith, *The Second Battlefield*; Higonnet, *Nurses at the Front*; Brittain, *Testament of Youth* and *Chronicle of Youth*, ed. Bishop; Carol Acton, "Writing and Waiting: The First World War Correspondence between Vera Brittain and Roland Leighton", *Gender History*, vol. 11, no. 1 (1999), pp. 54–83; Jane Marcus, "Corpus/Corps/Corpse: Writing the Body in/at War", in Helen M. Cooper, Adrienne Auslander Munich, and Susan Merrill Squier, eds., *Arms and the Woman: War, Gender, and Literary Representation* (Chapel Hill and London: University of North Carolina Press, 1989), pp. 124, 137.

28 Sharon Ouditt, *Fighting Forces, Writing Women: Identity and Ideology in the First World War* (London and New York: Routledge, 1994).

29 Margaret H. Darrow, "French Volunteer Nursing and the Myth of War Experience in World War I", *American Historical Review*, vol. 101, no. 1 (February 1996), pp. 80–106.

30 Susan Mann, ed., *The War Diary of Clare Gass, 1915–1918* (Montreal and Kingston: McGill-Queen's University Press, 2000) and *Margaret Macdonald: Imperial Daughter* (Montreal and Kingston: McGill-Queen's University Press, 2005); Stuart, "War and Peace"; Geneviève Allard, "Caregiving on the Front: The Experience of Canadian Military Nurses during World War I", in Dianne Dodd, Tina Bates, and Nicole Rousseau, eds., *On All Frontiers: Four Centuries of Canadian Nursing* (Ottawa: University of Ottawa Press, 2005), pp. 153–167; Cynthia Toman, "'Ready, aye ready': Canadian Military Nurses as an Expandable and Expendable Workforce", in Dodd *et al.*, eds., *On All Frontiers*, pp. 169–182, and "'An Officer and a Lady': Shaping the Canadian Military Nurse, 1939–1945", in Andrea Martinez and Meryn Stuart, eds., *Out of the Ivory Tower: Feminist Research for Social Change* (Toronto: Sumach Press, 2003), pp. 89–115.

Military and Civilian Nursing Contexts Prior to the Second World War

When two Canadian military contingents left to serve with the British forces in South Africa (October 1899 and January 1900), four civilian nurses volunteered for each contingent. They served as auxiliary members of the British Army Reserve, however, where they acquired the title of Nursing Sister in accordance with British tradition and were paid as Lieutenants, although they did not yet carry the title or authority accompanying that relative rank. On their return from South Africa (1901), the Canadian Militia Reserve formally organized a nursing service and integrated it into the medical corps. Nurses who served in South Africa, along with two others, became the first official Canadian military nurses, with Georgina Pope as their first Matron.³¹

In 1904 the Army Medical Department established two divisions — a permanent force Army Medical Corps (PAMC) to staff small hospital units in military districts across Canada, and a non-permanent Army Medical Corps (NPAMC) to be called up as needed for field units. As only trained nurses could enlist, Nursing Sisters were well established as both professional nurses and professional soldiers. Scarcely a decade later, the First World War reinforced these two images while also shaping military nurses as ideal women who epitomized “patriotism, femininity, piety, and duty to others” within a prevailing ideology of maternal roles in caring for soldiers.³² Although there were only five Nursing Sisters in the permanent force at the beginning of 1914, that number increased to approximately 3,141 during the First World War. These South African and First World War nurses comprised the first generation of Canadian Nursing Sisters.³³ The Royal Canadian Army Medical Corps (RCAMC) reverted to a pre-war establishment of 43 medical officers and five permanent-force Nursing Sisters.³⁴ That number increased slightly and varied only between five and thirteen during the interwar years.

RCAMC Matron-in-Chief Elizabeth Smellie reminded newly enlisted Nursing Sisters in 1940 that “the nursing sister is fortunate in that she isn’t — as the men often are — cut off from her regular work. She keeps on with her chosen profession, and she faces an opportunity of invaluable experience not only in nursing but in learning to understand humans — and if she is ready to give as well as to get, there are certain

31 Nicholson, *Seventy Years of Service*, pp. 46–51.

32 Stuart, “War and Peace”, p. 172.

33 McPherson, *Bedside Matters*, p. 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.

34 King George V of England bestowed the title of “Royal” Canadian Army Medical Corps (RCAMC) on the permanent force at the end of the First World War.

intangible qualities she is bound to acquire even in the midst of war.”³⁵ But civilian nurses did not need to be reminded of these benefits. Nor did they need any encouragement to enlist.

During the 1920s and 1930s, civilian nurses worked primarily in private-duty nursing after graduation from hospital schools where they had worked their way through three years of training. The Depression proved especially devastating for these nurses since few people could afford their services; with no universal health care insurance in place, there was therefore precious little nursing work to be had.³⁶ Dr. George Weir conducted a landmark study on the state of nursing education in Canada at the end of the 1920s, just prior to the onset of the Depression. He identified at least two key concerns regarding private-duty nursing from this study, and war provided solutions to both. One was a concern held by private-duty nurses that they might lose skills and expertise after graduation because they no longer worked within hospital settings where nursing care and technology was constantly changing. Weir referred to private-duty nursing as a “starved life”, writing that the 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.”³⁷

The other concern was related to overwhelmingly inadequate opportunities for paid work. According to Weir, approximately 40 per cent of private-duty nurses were almost continuously unemployed, and another 20 per cent were only employed intermittently.³⁸ Building on Weir’s analysis, historian Kathryn McPherson demonstrates the extent of discrepancy between the annual income of private-duty nurses and living expenses during this period, arguing that incomes were grossly inadequate to meet the bare costs of living.³⁹ Some of the nurses whom I interviewed, for example, reported monthly wages of \$25 to \$55 prior to their enlistment. Another nurse described how she combined construction work with nursing, finding that laying steel reinforcements for concrete and reading blueprints was relatively easy, while her income was higher in

35 Elizabeth L. Smellie, “A Message from the Matron-in-Chief”, Canadian Broadcasting Corporation radio address, July 24, 1940, reprinted in *Canadian Nurse*, vol. 26, no. 9 (September 1940), p. 623.

36 Barbara A. Keddy, “Private Duty Nursing: Days of the 1920s and 1930s in Canada”, *Canadian Woman’s Studies/Les cahiers de la femme*, vol. 7, no. 3 (Fall 1986), pp. 99–102.

37 The Canadian Medical Association and the Canadian Nurses Association, concerned with working conditions and the standardization of nurses’ training, hired George M. Weir, as the head of the Department of Education at the University of British Columbia, to conduct this study, which was subsequently published as the *Survey of Nursing Education in Canada* (Toronto: University of Toronto Press, 1932). See pp. 80, 104, and 191.

38 Weir, *Survey of Nursing*, pp. 498, 15.

39 McPherson, *Bedside Matters*, p. 137.

the construction job.⁴⁰ Although these nurses needed adequate wages to support themselves, my research also reveals that they had significant financial obligations to help support dependent relatives — contradicting popular perceptions that women only worked for discretionary income. One or both parents of at least 30 per cent of the Nursing Sisters had died, while 8.5 per cent of them supported a dependent parent, other relative, or orphaned siblings. As officers, however, their military rank included a monthly salary of \$150 plus food, lodging, clothing, medical care, and travel. For many, this salary tripled their income and greatly facilitated the fulfilment of family commitments.

Becoming Military Nurses

Nursing Sisters were the only women serving with the Canadian armed forces throughout the First World War and into the Second World War. As the senior service, the RCAMC also provided nursing services for the Royal Canadian Air Force (RCAF) and the Royal Canadian Navy (RCN) until 1941, when they organized separate but parallel nursing services. Nursing Sisters were never part of the Women's Divisions of any of the armed forces. Instead, they constituted a separate, all-female rank 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 Canadian Voluntary Service medal for 1939–1945. There are seven figures on the medal — a man and a woman each for the Army, Air Force, and Navy — while a Nursing Sister stands alone at the top as a unique category.

Since the armed forces relied on the civilian profession to provide nurses whom they could subsequently recruit for temporary service during times of war, the commonly accepted admission criteria of nurse training programmes effectively shaped both the civilian and military work forces. Schools of nursing typically admitted only women, and nursing has been predominantly perceived to be women's work throughout most of the twentieth century. Several psychiatric hospitals did establish associated schools of nursing and trained a small number of men as well as women during the 1940s. This trend is noticeable in the 1941 census, in which 153 men reported their occupation as professional nurse. In spite of their availability and desire to serve, men were explicitly excluded as nurses by the armed forces until 1967.⁴¹ Training school

40 Dorothy M. (Grainger) Anderson, in Landells, ed., *Military Nurses of Canada*, vol. 1, p. 411.

41 Archives of Ontario, RNAO file 96B-1-09, Nursing Education Section, Minutes and Reports (1928-1941), "District #4 Report for March 1940" and CNA Annual Report for 1940; *Eighth Census of Canada, 1941, v. VII* (Ottawa: King's Printer, 1946), p. 328; 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*, vol. 28, no. 1 (1996), pp. 103-117.

admission criteria also effectively discriminated against women who were Asian, First Nations, Black, or Jewish — although I did find and interview one Jewish nurse. Demographic analysis of the 1,052 military nurses in my sample demonstrates the effectiveness of training schools in shaping the profession.⁴²

One notable exception was the negligible number of French-Canadian nurses to enlist in the military. Historians generally agree that the war divided Canada along linguistic and cultural lines, with French Canadians supportive of home defence but less supportive of involvement in what they considered a foreign, and predominantly British, war.⁴³ Conscription was extremely controversial during the First World War, threatening the very existence of a unified Canada. While similar feelings arose during the Second World War, at least two other factors were in play as well. Although first language is an inadequate indicator, my data reveal that only 0.3 per cent of my sample were unilingual French-speaking while the remaining 99.7 per cent spoke English as either their first or second language.⁴⁴ Oral histories suggest several explanations, such as the overwhelmingly English environment of the armed forces and pressure from within the Catholic Church against enlistment. One nurse confided that the priest in her home parish had threatened her family with excommunication if she enlisted — and so she did not. Other nurses recalled that French Canadians were sent to Kingston, Ontario, to learn English after enlisting. Although the RCAMC initially planned for an all-French-speaking hospital unit, it never materialized. The military medical units comprised an overwhelmingly English environment.

Besides graduation from a recognized training school, Nursing Sisters had to meet additional criteria regarding marital status and age. Official RCAMC regulations required them to be “unmarried or widowed

42 McPherson, *Beside Matters*, pp. 17, 118.

43 Desmond Morton, *Fight or Pay: Soldiers' Families in the Great War* (Vancouver: University of British Columbia Press, 2004), pp. 77–79. The best discussion of French-Canadian issues related to the military medical units is Michel Litalien, *Dans la tourmente : deux hôpitaux militaires canadiens-français dans la France en guerre, 1915–1919* (Outremont, QC: Athéna éditions, 2003), pp. 7–11. Although he studied nurses in the First World War specifically, these same issues remained unresolved for the Second World War. See also Library and Archives Canada [hereafter LAC], Oral History Collection, Concordia University, ISN 167796, Second World War NS Gaëtane Labonté Kerr, audio-taped interview with Lisa Weintraub, April 11, 1985.

44 The identification of French-Canadian nurses is problematic for a number of reasons such as the unreliability of surnames, birthplaces, or province in which nurses enlisted — since nurses often moved to where they felt they had the best chance for acceptance and even enlisted several times to circumvent restrictions. In addition, women of this era typically assumed their husbands' surnames on marriage and dropped their original surnames, which may or may not have corresponded accurately to their ethnic or cultural identities anyway. First language is one potential indicator, yet it is also subject to inaccuracy, for example, in cases in which a person felt it necessary to state a first language as “English” to improve her chance for selection.

without children”.⁴⁵ By 1943 regulations permitted Nursing Sisters to marry and remain in the military until they became “unable to meet physical requirements” (frequently a coded expression for becoming pregnant), at which time they were typically discharged “on compassionate grounds” or with a medical diagnosis of “physiological tumour”. Since married nurses could not serve in active theatres, however, many of them purposely delayed marriage plans until the end of the war was in sight. Initially, Nursing Sisters were to be between 25 and 45 years old, but these limits were extended in 1943 to include those from 21 to 55 years old, in anticipation of two major campaigns — one in the Mediterranean and one in Northwest Europe.⁴⁶ Demographic analysis demonstrates that Nursing Sisters were, on average, 28 years old at enlistment and that the majority served between four and six years — thus the average age increased over the course of the war. At least 9 per cent were over 35 years old, while two nurses from my sample were 52 and 54 years old respectively. Their age and mostly single status, along with the large pool of applicants, assured the armed forces of highly experienced nurses. They were also a relatively homogeneous group: white, Protestant, English-speaking, single women from both working- and middle-class families, sharing surprisingly strong British roots.⁴⁷

On the Front Lines

The First World War had been a relatively stationary war with troops entrenched on both sides of the combatant forces. The common practice was for casualties to be evacuated back from the front lines for medical care, although by the end of that war the medical services were experimenting with smaller, more mobile units. Technological changes in transportation, communication, and weaponry during the Second World War influenced where medical and nursing care took place, as the military made key decisions to move medical personnel further forward to the casualties rather than risk long lines of evacuation and the time lost before treatment due to the greater mobility of armies.

There was a great deal of ambivalence about posting nurses to active theatres of war or forward areas, however, based on larger social expectations that women needed to be protected and that nurses would only serve in safe settings, and a perception that support for the war effort would decline if women were raped, killed, or taken as prisoners of war as a result of their presence in forward units. Forty-six Canadian Nursing Sisters died during the First World War, and the bombing of

45 *King's Regulations and Orders for the Canadian Militia (1939)* (Ottawa: King's Printer, 1939), paragraphs 158 and 263.

46 Feasby, ed., *Official History of the Canadian Medical Services*, vol. 1, p. 325.

47 Toman, “An Officer and a Lady”, pp. 100–102.

military hospitals as well as the sinking of a hospital ship generated substantial outrage among the Allied countries.⁴⁸

These events compounded the anxieties and logistical challenges associated with posting women to the active theatres where they would live and work in close proximity to men 24 hours a day. The RCAMC, for example, trained “other ranks” (non-commissioned men) as medical orderlies partially to avoid the need for nurses in forward areas. As Major J. L. Patterson reported, these trained assistants could “go where Nursing Sisters cannot go”.⁴⁹ As military historian Bill Rawling points out, however, they were unable to substitute for fully trained professional nurses in terms of patient outcomes. Medical orderlies did greatly extend the number of casualties under one nurse’s care through the valuable assistance they provided.⁵⁰ In an interesting gender reversal, Nursing Sisters were able to shift some of their traditionally female domestic roles to the orderlies while retaining key technological roles as nurses’ work. For example, orderlies relieved nurses of such routine tasks as bathing, feeding, and transporting patients so that nurses could focus on medications, dressings, skilled assessments, and something else called “morale”. One war diary described the introduction of nurses to a Field Surgical Unit in February 1944 this way, 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.⁵¹

Thus Nursing Sisters were able to parlay their knowledge and technological skills into coveted positions with these “forward” units and specialized care teams. Their success, however, was dependent on at least three other influences: the setting, the availability of both physicians and medical orderlies, and the gendered perceptions of what constituted women’s work. While there were fewer differences between civilian and

48 J. G. Adami, “The Enemy Air Raids Upon Canadian Hospitals, May 1918: A Report to the D.G.M.S. Canadian Contingencies” and “The Sinking of N.M.H.S. ‘Llandovery Castle’”, *Bulletin of the Canadian Army Medical Corps*, vol. 1, no. 5 (August 1918), pp. 64–69, 69–73.

49 Department of National Defence Directorate of History and Heritage, 147.73–C–132009 (D2), J. L. Patterson, “Recommendations from Minutes of Matrons’ Conference” from “Correspondence and Minutes of Meetings re. Nursing Sisters – July ’43/Oct ’45”.

50 See Rawling’s discussion of nurses’ value in *Death Their Enemy*, pp. 196–198, 215, 220.

51 LAC, RG 24, series C–3, vol. 15941, No. 5 Casualty Clearing Station war diary, February 22, 1944.

military nursing practices within Canada, flexibility in roles and autonomy increased with the distance from Canada — with the greatest differences noted during the Italian and Northwest Europe campaigns of 1943 and 1944–1945 respectively. United by a common goal to “win the war”, military medical units challenged the traditional hospital division of labour that existed between civilian physicians and nurses. Nursing Sisters frequently referred to the unusual camaraderie and trust that they developed with members of the medical staff. Small units, positioned in forward areas located near or in battle zones, afforded many opportunities for physicians to teach and delegate new skills to nurses, as well as opportunities for nurses to develop the experience required for observation, monitoring, and supportive care related to those skills. In addition, mass casualties provided a large volume of patients who needed similar procedures, allowing nurses to consolidate these newly acquired skills. NS Nicolson, for example, contrasted her military and civilian experiences as follows:

[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 ... never did in training or in the hospital situation.... And you never hesitated. You just did [them]. 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.⁵²

It was less threatening to share these roles and cross traditional practice boundaries in these settings because of the increased distance from civilian practice settings — both literally and figuratively. The military medical hierarchy understood these changes to be temporary, “for the duration” only. When nurses who had served in these forward postings returned to England, previous constraints were re-imposed, and they were expected to relinquish expanded roles and autonomy. When NS Lois Bayly proceeded to follow through on medical orders as she usually did in the Casualty Clearing Stations in Europe, for example, she said: “I just did it automatically because I had been doing it ... like starting the intravenous and the Wangenstein [a type of suction equipment used in abdominal surgeries]....”⁵³ She was warned, however, that now she had to wait for a physician who would perform these procedures.

Nurses' work on the front lines was also contingent on the availability of men, both physicians and orderlies. When medical officers were occupied in surgery or at regimental aid posts, or when medical technologies

52 Constance Betty Nicolson Brown, audio-taped interview with author, Ottawa, June 3, 2001.

53 Lois Bayly Tewsley, audio-taped interview with author, Ottawa, June 11, 2001.

became too labour-intensive or inconvenient for physicians to manage, Nursing Sisters comprised a readily available and expandable work force. For example, NS Lily Clegg served with No. 2 Casualty Clearing Station 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 [lines].”⁵⁴ As the war continued, Canada gradually phased in conscription to meet manpower quotas in the armed forces. By increasing the number of Nursing Sisters and requiring recovering patients to assist them within the hospital wards, the military released medical orderlies for postings to combat units. As NS Joan Doree noted, “We had fewer orderlies because they were taken away to carry a gun ... they were so desperate for soldiers.”⁵⁵ In both of these situations, nurses filled personnel gaps — again creating occupational space and becoming essential to the functioning of the system as a whole.

While nurses’ work on the front lines was partially contingent on geographical setting and on the availability of both physicians and orderlies, it also depended on whether or not a particular skill was perceived to be “women’s work” — initially a sociological concept defined as work associated with the body, manual dexterity, repetition, or a need for meticulous attention to detail. This term has also been linked to “dirty work” or work that may be “designated dirty” because of its inconvenience, relative invisibility (and therefore lack of status), or its unsatisfying nature (characterized as repetitive, exhausting, routinized, stressful, or physically dirty).⁵⁶ 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. This gendered division of roles can be noted in the working relations between physicians and nurses.⁵⁷ For example,

54 Lily Clegg in Jean E. Portugal, *We Were There: The Navy, the Army, and the RCAF: A Record for Canada*, vol. 5 (Shelburne, ON: The Battered Silicon Dispatch Box, 1998), p. 2286.

55 Vancouver, Registered Nurses Association of British Columbia Library [hereafter RNABC], Oral History Collection, Joan Doree, audio-taped interview with Nina Rummen, Vancouver, February 11, 1987.

56 These concepts originate with Anselm Strauss, Shizuko Fagerhaugh, Barbara Sucek, and Carolyn Wiener, eds., *Social Organization of Medical Work* (Chicago: University of Chicago Press, 1985), pp. 246–251, 268–272. Recent research by Jocalyn Lawler and Margarete Sandelowski builds on the sociological concept of body work, referring to work performed *on* patients’ bodies and *with* nurses’ bodies as the primary tools: Jocalyn Lawler, *Behind the Screens: Nursing, Somology, and the Problem of the Body*, North American ed. (Don Mills, ON: Benjamin/Cummings Publishing Company, 1993), pp. 44–50, and *The Body in Nursing* (Melbourne, Australia: Churchill Livingstone, 1997); Margarete Sandelowski, *Devices and Desires: Gender, Technology, and American Nursing* (Chapel Hill, NC: University of North Carolina Press, 2000), pp. 10–11.

57 Strauss *et al.*, *Social Organization of Medical Work*, pp. 246–251, 268–272; Lawler, *Behind the Screens*, pp. 44–50; Sandelowski, *Devices and Desires*, pp. 10–11.

physicians typically asserted and maintained control over new medical technologies such as transfusions and penicillin as they were introduced, until the associated procedures became more familiar, routinized, and finally reconstructed as “simple enough” for nurses to handle.

Nursing Sisters on the front lines, for example, cared for patients with extensive burns, multiple extensive wounds, missing limbs or other body parts, and more, due to the types of weapons, tanks, and planes used during the war by both sides of the conflict. Although they were quite competent with dressings associated with civilian patient care, no amount of prior experience had prepared them for the number, complexity, or type of wounds encountered during the war. NS Pauline Lamont described the difference as follows:

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 [wounds].... The [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 judged the condition and passed that on to the [medical officer]. And they were very good about taking your word.⁵⁸

Lamont refers to “common sense”, underplaying the amount of observation, monitoring, and decision-making involved in caring for soldiers’ wounds and minimizing the efforts required to deal with dirty, infected wounds under make-shift conditions in borrowed buildings and tents — and, before 1943, without the benefit of antibiotics.

NS Barbara Ross described caring for an entire ward of soldiers with draining abdominal wounds after surgeons removed sections of the bowel, creating new openings onto the surface of the abdomen. She wrote, “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.”⁵⁹ Similarly, NS Frances Ferguson was with No. 6 Casualty Clearing Station near Caen, France, where “the burn cases and the tank injuries that came out of there were horrendous”. She described an assembly line to deal with large numbers of burned patients:

[Casualties] 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

⁵⁸ Pauline Lamont Flynn, audio-taped interview with author, Ottawa, April 3, 2001.

⁵⁹ Barbara Ross, in Portugal, *We Were There*, vol. 5, p. 2252.

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.⁶⁰

Besides the extensive trauma, soldiers' bodies were just as likely to be filthy and lousy on arrival from battles and trenches. Conditions were not much better further away from the front lines, where evacuation patients often arrived with foul-smelling casts and maggots in their wounds. This was due to an effort to avoid the massive infections and gas gangrene that had been so prevalent during the First World War — an approach known as the “Trueta method”.⁶¹ First, all the damaged tissue and contaminants were surgically removed from wounds as far as possible. Then sterile dressings or plaster casts, or sometimes both, were applied and left unchanged, intentionally, for the duration of the evacuation. This could involve extended periods of time during transport — sometimes up to 30 days. NS Betty Pense described changing dressings at No. 15 Canadian General Hospital in North Africa when it became the major evacuation point for 1,000 casualties from Cassino and the campaign in Sicily. Conditions were so bad that she recruited her recovering patients to assist her with the dressings because hordes of flies swarmed over any exposed wounds. As Pense said,

60 Frances Ferguson Sutherland, audio-taped interview with author, Edmonton, October 10, 2001.

61 See Rawling, *Death Their Enemy*, pp. 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, which so often provided the medium for bacterial growth, by extensive surgical debridement, packing the wound with sulfa powder and *tulle gras* (a vaseline-impregnated gauze dressing), and encasing the entire area in a plaster of Paris cast for immobility during evacuation. The purpose 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, and the wounds cleaned and re-dressed in the operating room.

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....⁶²

Both nurses and surgeons often endured long stints on duty on the wards and in operating theatres during battles and major campaigns such as the Italian campaign or the invasion of Europe that began on D-day in June 1944. Their work did become repetitive and routinized, especially when they had to admit, treat, and evacuate as many as 2,000 casualties in a 24 hour period for the larger hospital units. The nature of this work shaped and legitimated nurses' presence on the front lines of war. It also shaped and legitimated their presence on the frontiers of medical technology, as they both created and adapted to new roles.

On the Frontiers of Medical Technology

The Nursing Sisters capitalized on wartime opportunities to enhance their skills and expertise, becoming essential to the military medical service and shaping occupational spaces for women on the frontiers of medical technology. As medical services historian and RCAMC physician W. R. Feasby noted, "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."⁶³ Interestingly, Feasby included "professional nursing care" as one of twelve essential technologies for abdominal surgeries — along with morphine, oxygen, gastric suction, sulphadiazine, and penicillin (two different types of drugs used during the Second World War). Two surgeons who worked in forward surgical units were explicit in their opinions that orderlies "do a grand job but the patients seem to do better both practically and psychologically when sisters were there".⁶⁴ One unit's war diary attributed its declining mortality rate (under 10 per cent) in Italy to "better nursing",⁶⁵ while medical officer T. S. Wilson quantified the value of a

62 Margaret M. Allemang Centre for the History of Nursing [hereafter MMA], Oral History Collection, Elizabeth B. Pense Neil, interview with Norma Fieldhouse, Kingston, Ontario, March 1987.

63 Feasby, ed., *Official History of the Canadian Medical Services*, vol. 1, p. 189.

64 Feasby, ed., *Official History of the Canadian Medical Services*, vol. 2, pp. 207, 203–204.

65 F. Mills, "A Letter from a Field Surgical Unit C.M.F. (Overseas)", *Journal of the Canadian Medical Services*, vol. 1, no. 3 (March 1944), p. 187.

Nursing Sister this way: “Of especial importance in a surgical centre are the attached nursing sisters ... are often worth five to ten bottles of blood or plasma in the eventual outcome of a case.”⁶⁶ These attempts to quantify and to reify nurses strongly suggest the extent of their success in carving out roles and spaces in an all-male setting.

Specific medical innovations associated with the Second World War include drugs such as penicillin, anti-malarial drugs, and sodium pentothal for anaesthesia; infusions of saline, glucose, blood, and plasma; and immunizations against gas gangrene and typhoid (major causes of mortality during wars). Surgical innovations involved earlier and more extensive surgical debridement (removal of debris and damaged tissues from wounds), use of the Tobruk splint (a system for immobilizing leg fractures) and plaster of Paris casts (which were applied directly over open wounds for immobilization and evacuation), along with modifications to the system of triage (wherein priority for care was given to soldiers with the best chances for recovery and quicker return to the front). There was also considerable experimentation with reconstructive (or plastic) surgery for burn patients and with vascular surgery for injuries to arms and legs (to restore circulation to the limbs and prevent the need for amputations). In addition, the treatment of “battle-fatigued” (mentally stressed) soldiers underwent substantial change during this war.⁶⁷ Each of these innovations had associated nursing roles — either due to the skills involved, the labour and time-intensiveness of the care required, or the decision-making responsibilities that accompanied the care. As NS Pauline Lamont stated:

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.... I hadn't seen any of [these wounds] before (shrapnel, abdominal wounds, terrible tank burns, amputations).... 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.⁶⁸

Two innovations, blood transfusions and penicillin, provide especially useful illustrations of how Nursing Sisters came to be on the frontiers of

66 T. S. Wilson, “Resuscitation in Battle Casualties”, *Journal of the Canadian Medical Services*, vol. 2, no. 5 (1945), p. 520.

67 Feasby, ed., *Official History of the Canadian Medical Services*, vol. 2, and “The Canadian Medical Services”, in 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: HMSO, 1968), pp. 469–559; Nicholson, *Seventy Years of Service*; Rawling, *Death Their Enemy*.

68 Lamont Flynn interview.

medical technology and how they created occupational space by becoming essential to the functioning of the system. Both innovations have received widespread credit for reducing mortality and returning soldiers to the front lines, and almost every military nurse identified them as key medical technologies that emerged from the war.

Blood transfusions had been given in very limited amounts and situations related to blood loss since the First World War, and Dr. Norman Bethune demonstrated their efficacy during the Spanish Civil War (1936–1939). But it was during the Second World War that blood was used on an unprecedented massive scale, with plasma recognized for its osmotic properties and benefits in the reversal of shock in burns.⁶⁹

NS Teresa Woolsey described her work in a resuscitation ward (either a small room or a tented space) located next to the operating room, X-ray machine, laboratory, and dispensary facilities. This area was dedicated to urgent care and equipped with whole blood, plasma, oxygen, Wangensteen drainage, suction machines, and minor surgical equipment. As she said, “it drips with bottles and tubes”.⁷⁰ Resuscitation wards reached capacity later in the war, and transfusions became routine while nurses assumed increased responsibility for giving them. One medical report noted that all cases involving surgery of the abdomen, amputation, and compound femurs got a routine transfusion prior to surgery and that, in units forward of Casualty Clearing Stations, these surgeries typically constituted eight out of ten cases with a typical volume of five or six bottles (550 cc each).⁷¹

NS Eva Wannop worked extensively with burn patients for a period of five years in England, describing various responsibilities in preparing them for surgery to reconstruct missing body parts such as eyelids, noses, ears, jaws, and fingers:

[O]ne 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.⁷²

69 E. J. Pampana, “Scientific Progress and the Victims of the War”, *Canadian Nurse*, vol. 41, no. 1 (January 1945), pp. 45–49; William H. Schneider, “Blood Transfusion in Peace and War, 1900–1918”, *Social History of Medicine*, vol. 10, no. 1 (April 1997), pp. 105–126.

70 Teresa M. (Woolsey) Weir, in Landells, ed., *Military Nurses of Canada*, vol. 1, p. 246.

71 “A Canadian FTU.—C.A. Overseas”, *Journal of the Canadian Medical Services*, vol. 2, no. 2 (January 1945), pp. 113–114; Wilson, “Resuscitation in Battle Casualties”, pp. 520–530.

72 Eva Wannop, audio-taped interview with author, Toronto, April 25, 2001.

In a manner similar to blood transfusion, penicillin emerged during the war as a life-saving miracle, a “war weapon” to “kill” wound infections, and a military “top secret” that gave Allies an advantage by reducing the loss of life from infections.⁷³ Penicillin was not yet available for medical use 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).⁷⁴ Nurses did, however, have limited pre-war experience with sulphonamides, another promising group of drugs belonging to the sulfa family. This experience partially prepared them for the administration and monitoring of penicillin when it was introduced during 1943 in military medical units.⁷⁵

NS Margaret Fletcher wrote home about attending lectures on penicillin given by Professor Florey in London, England: “[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.”⁷⁶ In Italy, a “Canadian Penicillin Team” was attached to various forward units as the drug was introduced

73 Alice Whiteside Gray, “Penicillin”, *Canadian Nurse*, vol. 40, no. 1 (January 1944), p. 21. The secrecy surrounding the development of penicillin is well documented, but less is known regarding the suppression of research findings on transfusion that Rawling documents related to controversies among Wilder Penfield, Frederick Banting, and Hans Selye over publishing research findings on shock. See *Death Their Enemy*, pp. 132–133.

74 John C. Sheehan, *The Enchanted Ring: The Untold Story of Penicillin* (Cambridge, MA: MIT Press, 1982); Gladys L. Hobby, *Penicillin: Meeting the Challenge* (New Haven: Yale University Press, 1985); David P. Adams, “The Greatest Good to the Greatest Number”: *Penicillin Rationing on the American Home Front, 1940–1945* (New York: Peter Lang, 1991), pp. 10–11. Sheehan claimed that only the Manhattan Project equalled the effort and resources poured into the development of penicillin (*The Enchanted Ring*, 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*, vol. 2, no. 1 (November 1944), pp. 62–68. The allocation of penicillin was tightly regulated by the War Production Board, but by the fall of 1944 Squibb pharmaceuticals was advertising the eminent release of penicillin for civilian use in “Squibb Had Penicillin Ready”, *Canadian Nurse*, vol. 40, no. 10 (October 1944), p. 801.

75 “Life-Saving Drugs for the Wounded”, *Canadian Nurse*, vol. 36, no. 7 (July 1940), p. 450. Sulphonamides comprised a group of early pharmacological agents introduced during the late 1920s and 1930s that began to change both medical therapeutics and nurses’ work substantially. The sulphonamide group included sulphanilamide, sulphapyridine, and sulphaguanamide and were known better as Prontosil and Neoprontosil. Their therapeutic ranges by 1939 remain unclear, but their toxic manifestations were well known. See “Life-Saving Drugs for the Wounded”, p. 450; Pampana, “Scientific Progress and the Victims of the War”, p. 46; Perrin H. Long and Eleanor A. Bliss, *The Clinical and Experimental Use of Sulfanilamide, Sulfapyridine and Allied Compounds* (New York: MacMillan, 1939), p. 11; Hobby, *Penicillin*, p. 31.

76 University of Victoria Archives and Special Collections, British Columbia Archives, Margaret Fletcher fonds, 1933–1945, SC042 [hereafter Fletcher letters, BCA], letter from Margaret Fletcher to her family, October 28, 1943; Landells, ed., *Military Nurses of Canada*, vol. 1, p. 87.

experimentally. A 1944 fact sheet ended with this caveat: “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.” Penicillin was considered so scarce and so valuable that, in some medical units, it was withheld from prisoners of war, although NS Gaëtane LaBonté described giving it to German prisoners surreptitiously.⁷⁷

Early formulations of penicillin were far less potent than today. After a variety of initial experimentations that included insufflating (or blowing) a powdered form of penicillin into open wounds, clinical trials determined standardized dosages and showed that intramuscular injection of the drug was the most effective method of administration. The injections had to be repeated every three hours to maintain an effective, therapeutic blood level of the drug. 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!”⁷⁸ Thus administering penicillin became part of nurses’ responsibility and, in some medical units, it would occupy one nurse’s complete attention for an entire shift — earning nurses such titles as “Penicillin Queen” or “Penicillin Mary”, according to a typical poem produced by their patients.⁷⁹

To deal with the increased workload created by penicillin, Matron Evelyn Pepper added extra nurses to her Casualty Clearing Station staff in Italy. Yellow tags tied to an outside button or pocket of a soldier’s uniform enabled nurses to identify quickly those who needed injections during evacuation between units so that doses would not be missed.⁸⁰ As NS Lamont recalled,

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.... So you’d just go down the row. They all knew what was coming ... I think most of the patients (90%) all got penicillin.... 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,

77 LAC, RG 24, C-3, vol. 15940, No. 1 Field Surgical Unit War Diary, February 17, 1944; Edmonton, Alberta Association of Registered Nurses Library and Archives, scrapbook compiled by Frances Ferguson Sutherland, “Notes on Penicillin”, January 20, 1944; Labonté Kerr interview.

78 Claudia Tennant, in *Nursing Sisters of Canada Commemorative Directory* (Edmonton: Nursing Sisters Association of Canada, 1994), pp. 38–39.

79 MMA, Berna Tuckwell Thompson, interview with Ella Beardmore, Scarborough, Ontario, June 10, 1988; Mary Bray, in Portugal, *We Were There*, vol. 5, p. 2238.

80 Evelyn Pepper, in Landells, ed., *Military Nurses of Canada*, vol. 1, pp. 53, 56.

that we had to keep track of the penicillin, as much as we did morphine practically, because it was so precious.⁸¹

Some Nursing Sisters described using a large syringe (10–20 cc size) to give individual doses to multiple patients — with or without changing the needle between patients. This practice was based on a prevailing belief that penicillin was a “self-sterilizing” agent as well as the realities of time and availability of sufficient water to permit re-sterilization of the needles between dose schedules. They recalled barely completing one round of injections in time to begin the next round. With some exceptions, penicillin was restricted to military use for the duration of the war. As a result, Nursing Sisters on the frontiers of this medical technology became more knowledgeable and experienced in its use than civilian nurses or physicians. NS Margaret Kellough reported teaching civilian physicians about penicillin following the war, in an interesting role reversal in which physicians learned from nurses.⁸²

Nurses were also on the frontier of emerging psychiatric therapies for “battle fatigued” soldiers, or what might now be termed traumatic stress, especially in Italy during 1943–1944. 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 uses of insulin-induced coma therapy and Metrazol-induced convulsions (both treatments used drugs to produce effects on the body that were considered therapeutic at the time) as well as electric shock treatments. With the movement of troops to the Mediterranean and plans for an invasion of Europe, the treatment of psychiatric disorders assumed even greater importance related to salvaging all available manpower for combat duty.⁸³ When the Canadian forces landed in Sicily (July 1943), they were the first field formation to go into battle with a psychiatrist on strength.⁸⁴ NS Verna White was posted to this psychiatric unit. She recalled caring for patients who were kept under sedation with the drug sodium amytal

81 Lamont Flynn interview.

82 Jessie (Smith) Jamieson and Rita (Murphy) Morin, in Landells, ed., *Military Nurses of Canada*, vol. 2, pp. 157, 179; MMA, Margaret H. Mills, interview with Margaret M. Allemang, April 5, 1991; MMA, Susan Isabel Rowland, interview with Ella Beardmore, May 15, 1988; MMA, Margaret Helena Kellough, interview with Margaret M. Allemang, Toronto, April and May 1987; RNABC, Doree interview.

83 Terry Copp and Bill McAndrew, *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939–1945* (Montreal and Kingston: McGill-Queen’s University Press, 1990), p. 69.

84 A. M. Doyle, “Psychiatry with the Canadian Army in Action in the C.M.F.,” *Journal of the Canadian Medical Services*, vol. 3, no. 2 (January 1946), p. 93, and “Report of the Neuropsychiatrist on the Sicilian Campaign,” *Journal of the Canadian Medical Services*, vol. 1, no. 2 (January 1944), pp. 106–107.

for periods of up to three days, in a treatment known as “Deep Sleep”.⁸⁵ NS Marjorie MacLean referred to this as “narcosis therapy”, describing it this way:

[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.” ... 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.⁸⁶

During the invasion of Northwest Europe, No. 1 Canadian Neuropsychiatric Wing at Basingstoke, England, built on the experiences gained by medical units in Italy. Attached to No. 10 Canadian General Hospital, this unit increased in size from 75 to 200 beds, staffed by eight Nursing Sisters. Treatments were similar to those used in Italy, with the addition of supervised activity: continuous sedation with drugs such as medinal and paraldehyde, the use of sodium amytal to induce suggestible states, psychotherapy, and an occupational therapy programme in which patients produced surgical dressings and cleaned medical equipment as arranged with the Nursing Sister supervising No. 10 Canadian General Hospital. This psychiatric wing also had a convulsive therapy machine for shock treatments, but, fortunately or unfortunately, an adequate source of electrical power for operating it was lacking under invasion conditions!

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”.⁸⁷ It was widely recognized that “the resolution of many of these cases depend[ed] in large part on Nursing Sisters who have had neuropsychiatric experience”.⁸⁸

Royal Canadian Air Force (RCAF) Nursing Sisters at the specialized East Grinstead burn unit at Sussex, England, became an essential part

85 Verna L. White Lister, personal communication with author, Vancouver, October 18, 2001; Lister in Landells, ed., *Military Nurses of Canada*, vol. 1, pp. 254–256.

86 Marjorie MacLean Root, audio-taped interview with author, Ottawa, June 15, 2001.

87 Doyle, “Psychiatry with the Canadian Army”, p. 97.

88 G. S. Burton, “Report on No. 1 Canadian Neuropsychiatric Wing”, *Journal of the Canadian Medical Services*, vol. 2, no. 5 (July 1945), pp. 531–532; Feasby, ed., *Official History of the Canadian Medical Services*, vol. 2, p. 76.

of the treatment plan for re-integrating burned men into social activities outside the hospital. Chief plastic surgeon Dr. Archibald McIndoe is reputed to have “recruited the best-looking nurses he could find” for that 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.”⁸⁹ Beyond the contacts between nurses and patients during working hours, these nurses also escorted recovering burn patients to the local pub after work, building their social confidence to deal with severe disfigurement and functional limitations. NS Fran Oakes, for example, recalled being “detailed” for pub duty after working twelve hours, in addition to walking the four miles between the hospital and her billet.⁹⁰

Nurses demonstrated both ability and eagerness to function in expanded roles and take on new responsibilities in myriad ways that made them essential to the care of soldiers. This study clearly suggests that gender, rather than ability, constrained military nursing roles. Gendered expectations as to what constituted masculinity and femininity exerted a pervasive influence in military medical units, shaping where and how nurses served. The degree of role flexibility and practice autonomy depended partly on the geographical setting and partly on gendered discourse regarding appropriate women’s roles and women’s need for protection. Nurses experienced the most change while in active theatres of war, as they moved increasingly forward toward the front lines.

At the end of the war, however, some Nursing Sisters found themselves in contradictory positions related to postwar medical technology. On one hand, they were more familiar with penicillin, transfusions, intravenous therapies, triage, burns, and traumatic wound care, but, on the other, 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. Thus, as 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 had been gone and her lack of recent general nursing experience.⁹¹

Many Nursing Sisters lamented the loss of autonomy, the limited opportunities for expanded roles, and the restrictive practice environments that would characterize a return to civilian practice. In spite of conditions

89 Donovan, *As for the Canadians*, pp. 20, 128.

90 Frances Oakes, audio-taped interview with author, Guelph, Ontario, May 15, 2001.

91 RNABC, Ellen Jean Wheeler Keays, audio-taped interview with Sheila Zerr, White Rock, BC, August 16, 1994.

under which they had served, most were positive about their participation and reluctant to resume pre-war nursing roles. Analysis of 1,052 individual records indicates that approximately 70 per cent of these nurses did not return to traditional practice settings. While the majority married and left the profession, as expected of married women during the 1940s and 1950s, others clearly resisted a return to their pre-war practice roles by using their 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. Still others sought settings that allowed for comparable levels of autonomy and expanded roles such as nursing work in outpost and remote areas of Canada and work with the United Nations Relief and Rehabilitation Administration or the World Health Organization.⁹²

Conclusion

Conditions within military medical units during the Second World War legitimated the presence of nurses at both medical frontiers and military front lines, where they comprised an essential, but temporary and contingent, work force whose work consisted of “winning the war” through the care of sick and wounded soldiers. At the same time, Nursing Sisters capitalized on these front-line opportunities to enhance technological skills, to gain greater practice autonomy, to enjoy increased social status as officers, and to benefit from relatively stable employment, at least for the duration of the war. 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.

In general, more flexibility and autonomy was evident closer to the front lines and frontiers where patient acuity was higher, skilled personnel were fewer in number, and risk-taking was more acceptable. Flexible boundaries were extended only for the duration of the war, however, and nurses were expected to resume conventional relationships and roles once they left the front lines behind. 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 postwar Canada.

⁹² For example, NS Louise Jamieson went to India with the World Health Organization. MMA, Oral History Collection, Florence Louise Jamieson, audio-taped interview with Margaret M. Allemang, April 24 and May 3, 1987.

This study challenges traditional “watershed” and “beautiful souls” discourses in examining nurses’ enthusiasm for enlistment, the nature of their war work, how roles shifted between nurses and other personnel, and the significance of place in regard to “who” did what kinds of work. Gender bending was acceptable during the war because it was dependent on the context and understood by those in power to be temporary. The contingent and temporary nature of war work was also acceptable to the majority of Nursing Sisters, for whom careers were relatively short stages of life prior to marriage, as was the case for most nurses of this period. For the most part, they returned to traditionally gendered roles as wives and mothers, although we cannot know what choices they might have made had the civilian practice options been less constraining.