An Officer and a Lady

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Cynthia Toman

An Officer and a Lady
Canadian Military Nursing and the Second World War

UBCPress · Vancouver · Toronto

16 15 14 13 12 11 10 09 08 07 5 4 3 2 1

Printed in Canada on ancient-forest-free paper (100% post-consumer recycled) that is processed chlorine- and acid-free, with vegetable-based inks.

Library and Archives Canada Cataloguing in Publication

Toman, Cynthia, 1948-

An officer and a lady : Canadian military nursing and the Second World War / Cynthia Toman.

(Studies in Canadian military history, 1499-6251)

Includes bibliographical references and index.

ISBN 978-0-7748-1447-8

1. Canada – Armed Forces – Nurses – History – 20th century. 2. Military nursing – Canada – History – 20th century. 3. World War, 1939-1945 – Canada – Participation, Female. 4. World War, 1939-1945 – Women – Canada. 5. Canada – Armed Forces – Women – History – 20th century. 6. Women and war – Canada – History – 20th century. 7. World War, 1939-1945 – Medical care – Canada. 8. Nurses – Canada – History – 20th century. I. Title. II. Series.

D807.C2T64 2007 940.54'7571082 C2007-903461-6

Canada

UBC Press gratefully acknowledges the financial support for our publishing program of the Government of Canada through the Book Publishing Industry Development Program (BPIDP), and of the Canada Council for the Arts, and the British Columbia Arts Council.

This book has been published with the help of a grant from the Canadian Federation for the Humanities and Social Sciences, through the Aid to Scholarly Publications Programme, using funds provided by the Social Sciences and Humanities Research Council of Canada.

Publication of this book has been financially supported by the Canadian War Museum. The author and publisher also acknowledge the financial assistance of the Faculty of Health Sciences, University of Ottawa.

Printed and bound in Canada
Set in Fairfield by Blakeley
Copy editor: Barbara Tessman
Proofreader: Gail Copeland
Indexer: Patricia Buchanan

UBC Press
The University of British Columbia
2029 West Mall
Vancouver, BC V6T 1Z2
604.822.5959 / Fax 604.822.6083
www.ubcpress.ca

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Acknowledgments

There has been increasing interest in the Second World War Canadian nursing sisters since the early 1990s, resulting in several television documentaries and news articles, especially during the annual November Remembrance Week commemorations. Like other veterans, there are fewer nursing sisters every year and fewer opportunities to learn from their first-hand accounts about war as nurses' work. But, unlike the men who served during the war, these military nurses are marginalized within the official histories and seldom visible within official documents and archival collections.

I am deeply indebted, then, to the twenty-five nursing sisters – well into their eighties and even nineties at the time – who participated in oral history interviews. I extend a personal thanks to each one, for they are the main actors of this history, and it has truly been a pleasure and a privilege to work with them. Lt.-Col. (retired) Harriet J.T. Sloan patiently introduced me to military contexts, fielding a multitude of inquiries and providing introductions to military nurses across Canada, and graciously read developing manuscripts. She is a remarkable friend who served during the Second World War and later, became the matron-in-chief of the combined Canadian Forces Medical Services (1964-68). I dedicate *An Officer and a Lady* to the Second World War Canadian nursing sisters, with the hope that they might recognize themselves and their experiences within its pages.

A number of organizations and archives provided important and timely assistance and encouragement. In particular, I thank colleagues from the Canadian Association for the History of Nursing, the British Columbia History of Nursing Professional Practice Group, the College and Association of Registered Nurses of Alberta Museum and Archives, and the Margaret M. Allemang Centre for the History of Nursing. They helped to identify significant material relevant to the research, as well as potential nursing sisters from across Canada for the interviews. Judith Young facilitated the transcription of Margaret Allemang's oral history interviews, which included an additional fourteen Second World War nursing sisters, and pointed out

other sources held by the centre. The late Edith Landells shared generously from her experiences of publishing a collection of letters solicited from military nurses who served with various armed forces and periods. Anne Crossin, archivist at the Winnipeg General Hospital and Health Sciences Nurses' Alumnae Archives, and Lorraine Mychajlunow, archivist at the College and Association of Registered Nurses of Alberta Museum and Archives, facilitated access to the collections held by their respective organizations. Dr. Charles Roland, Hannah Chair for the History of Medicine at McMaster University, generously gave me a transcript of his interview with Nursing Sister Kay Christie shortly before her death in 1994. In addition, there were innumerable research assistants at Library and Archives Canada, the Canadian War Museum, and the Department of National Defence Directorate of History and Heritage who helped me with the mysteries of military records, photographs, documentary art, audiovisual collections, and even musical scores related to nursing sisters.

I was extremely fortunate to work with two excellent supervisors at the University of Ottawa during doctoral studies there. Dr. Ruby Heap guided me through the intricacies of history and women's studies while Dr. Meryn Stuart introduced me to nursing history as a field and mentored me along the paths of scholarship and academia. The Social Sciences and Humanities Research Council generously supported my studies and research through a doctoral fellowship.

Emily Andrew, senior editor for UBC Press, offered her enthusiasm and support for a book on the nursing sisters – even before I was ready to take that step. Dean Oliver, general editor of the Studies in Canadian Military History series at UBC Press, and the Canadian War Museum have generously supported this book as part of the series. Many thanks are due to the anonymous manuscript reviewers for their time, insights, and suggestions. The University of Ottawa Press and the Canadian Museum of Civilization, Sumach Press, and *Histoire sociale/Social History* kindly permitted the use of overlapping material from my previously published articles with them.

Families inevitably share in the process of "making history" through their many accommodations to the author's research and writing activities. A very special thanks to each member of my family for their sustaining support, even as they eagerly tracked my progress towards the finish line.

Abbreviations

CAMC	Canadian Army Medical Corps
CCS	casualty clearing station
CEF	Canadian Expeditionary Force
CGH	Canadian General Hospital
CHC	Canadian Hospital Council
CMA	Canadian Medical Association
CNA	Canadian Nurses Association
DVA	Department of Veterans Affairs
FDS	field dressing station
FSU	field surgical unit, also called a field surgical centre
FTU	field transfusion unit
ICN	International Council of Nurses
MO	medical officer
NS	nursing sister
NSAC	Nursing Sisters' Association of Canada
POW	prisoner of war
QAIMNS	Queen Alexandra's Imperial Military Nursing Service
RCAF	Royal Canadian Air Force
RCAMC	Royal Canadian Army Medical Corps
RCN	Royal Canadian Navy
RNAO	Registered Nurses Association of Ontario
SAMNS	South African Military Nursing Service
SEC	Special Employment Company
SIW	self-inflicted wound
USANC	United States Army Nurse Corps
VAD	voluntary aid detachment
WD	Women's Division

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Introduction

From the late 1800s through the Second World War, Western societies significantly changed their perceptions of medical and nursing care for sick and wounded soldiers. These shifts escalated during the First World War, coming to the fore in Canada with the political activism of veterans who engaged in a prolonged struggle for medical and social rehabilitation during the postwar period. They came to view care increasingly as a right, or a type of "social wage" that societies "owed" soldiers for services on behalf of their country or nation.[1] These changing social perceptions precipitated debates about who should provide such care and where it should be given, how military medical units should be organized and administered, and how civilian and military needs for medical personnel should be balanced during times of war when the demands for care increased dramatically. The role of nurses and skilled nursing care became increasingly important in these debates, which were conducted in the context of gendered constructions of femininity and masculinity – particularly within the military – as well as of nurses' own personal and professional agenda for an emerging field of paid women's work.

This book focuses on Canadian military nurses and their work during the Second World War (1939-45). It examines how gender intersected with class, ethnicity, and, to a lesser degree, race in transforming at least 4,079 civilian nurses into military nurses. Although race is not a primary focus in this analysis, it was a critical tool for the selection of the 'right kind of nurses' for the armed forces during this era – that is, white nurses. An exploration of white privilege in this context can inform understanding of broader issues of race. We are very limited in what we can and cannot know about the workings of race within this context, however, because non-white women are conspicuously absent from the rank and from the records.

I also seek a nuanced understanding of the complex issues of who became nursing sisters, why they enlisted, and the legacies of military nursing for postwar civilian practices. Through the study of a specific cohort of military nurses, this book explores the incongruities and ambivalence associated with

nurses and war work. It analyses how nursing skills and knowledge regarding medical technologies enabled civilian nurses to create female spaces within the male-dominated military world and illuminates ways by which nurses facilitated the expansion of medical technologies and nursing care within the armed forces.

The military – including its medical services – was a masculine environment throughout the nineteenth century. Physicians, surgeons, stretcher bearers, and orderlies selected from the ranks of enlisted men served with military medical services, staffing regimental aid posts and field ambulances as needed. During the Crimean War (1853-56), women such as Florence Nightingale exerted considerable social and political pressure for medical and sanitary reform within the British army. They were successful in introducing a small number of women volunteers, some of whom had formal training as nurses, to care for soldiers but these women served in an auxiliary capacity and not within the military itself.[2] By the time of the First World War, diverse groups of women in many countries sought ways to become involved in the care of soldiers as one way for women to participate in the war effort. Efforts varied from privately funding and operating their own women's hospitals located near battle zones to joining Voluntary Aid Detachment units or enrolling with auxiliary nursing services such as Red Cross hospitals. This range of trained, semi-trained, and untrained women precipitated a great deal of controversy both within and outside of the allied armed forces. Some of the controversies developed because volunteer nurses were not under military control; other controversies arose because they often lacked necessary skills, training, and discipline for military environments.[3]

With the formation of the first permanent nursing service as part of the Canadian Army Medical Corps (CAMC) in 1904, civilian nurses were fully integrated into the Canadian armed forces as soldiers; they enlisted as lieutenants with the specially created officer's rank and title of Nursing Sister (NS).[4] Graduation from a recognized school of nursing had become one of the basic requirements for enlistment with the CAMC by 1914, effectively excluding untrained and semi-trained women from the Canadian forces. Civilian nurses readily filled every available position with the CAMC during the First World War, thereby assuring an adequate supply of military nurses as well as a standardized set of nursing skills based on civilian training and credentials. They constituted the first generation of Canadian Nursing Sisters.

Trained Canadian civilian nurses volunteered again during the Second World War in numbers so large that the military placed a moratorium on their enlistment only ten days after the call to mobilize medical units, contradicting military historian C.P. Stacey's pronouncement of Canada as a very "unmilitary community."[5] They eagerly filled all nursing positions with the Royal Canadian Army Medical Corps (RCAMC) and, later, with the Royal Canadian Air Force (RCAF) and the Royal Canadian Navy (RCN)

when separate nursing service branches formed in 1940 and 1941. Thousands more added their names to a waiting list that grew longer each year; still others, tired of waiting, joined the allied American, British, and South African nursing services. This enthusiasm for enlistment contrasted sharply with the conscription of Canadian men beginning in 1940 and the contentious American campaign to conscript nurses in order to fill national quotas between 1943 and 1945 for the United States armed forces.[6]

This second generation of Canadian nursing sisters benefited from the legacy of their foremothers during the First World War, inheriting officers' status, privileges, and pay as well as work opportunities, travel, adventure, and access to the frontlines, where large numbers of men spent the war. Although nurses enlisted under the protection of the Geneva Convention, which classified medical personnel as non-combatant and neutral, Canadian nursing sisters increasingly perceived themselves as soldiers; they called themselves soldiers and they understood their work as "winning the war" through the salvage of damaged men.[7] They actively sought opportunities to move closer to the frontlines, readily accepting increased risk and danger as part of the job. The armed forces highly valued their knowledge and skills, reluctantly moving them forward as they demonstrated better outcomes for the soldiers under their care than less well-trained personnel could achieve. The military was adamant, however, that nurses were temporary; they were intended to serve only "for the duration" of the war, regardless of what the nurses wanted or needed.

These ordinary military nurses and the everyday work that they performed are the subjects of this book. Through social history and feminist approaches, I shift the analysis away from stereotypical portrayals as angels and heroines (images with which the nurses themselves are uncomfortable) to examine how gender, war, and medical technology intersected to legitimate their participation in a predominantly masculine military domain. Nursing sisters were witnesses to everyday events in hospital wards, tents, operating rooms, and casualty clearing stations as they cared for civilians and refugees as well as soldiers throughout the war. Their accounts offer alternative perspectives to irresolvable debates about the causes, politics, and strategies of war. As Erich Maria Remarque, author of the 1928 novel *All Quiet on the Western Front,* suggested, "A hospital alone shows what war is."[8]

The association of nurses with the armed forces, war, and killing is unsettling, partially because these contexts have been constructed as masculine domains and therefore antithetical to nursing, which is often seen as the epitome of femininity and pacifism. Our uneasiness and ambivalence regarding nurses as soldiers, however, has obscured their presence as well as the work that they performed on and behind the frontlines. They are women "out of place" or "dis-placed" from the more familiar civilian practice environments of the 1930s and 1940s such as hospitals and private duty settings.

Although positioned at the intersection of multiple fields of historical inquiry, military nurses remain all but invisible within national histories, military histories, women's histories, and nursing histories. For the most part, historians have treated them as a homogeneous category regardless of the very different historical contexts in which they served or the diversity among them. Nursing sisters contributed to their own invisibility through self-censorship and a reticence about sharing their war experiences, thus compounding the usual challenges of studying women's history through official records and documents. Jan Bassett, referring to the historiography on Australian military nurses, concluded that historians have generally ignored or sanctified military nurses while feminists have overlooked them as ideologically unsound, and that most military nursing histories consist primarily of anecdotes and chronologies.[9] A small body of international literature permits limited comparison of military nursing contexts and experiences, although little attention has been given to nurses' actual work or what it meant to larger war endeavours.

Canadian literature on the Second World War includes official histories, political and social histories, organizational histories, and popular histories that establish the chronology and document the larger contexts of the war, enabling us to situate the Canadian nursing sisters in relation to other men and women as well as major military campaigns that shaped their work.[10] The military medical services subsumed nursing sisters within their records and, similarly, within their histories while focusing on physicians (medical officers) and portraying nurses mostly as ancillary personnel.[11] One can catch glimpses of nurses' work hidden between the lines of these accounts describing infections, illnesses, trauma, medical technology, and medical and surgical procedures used during the war. When the Nursing Sisters' Association of Canada commissioned its organizational history in the 1970s, that volume became the first publication to focus specifically on military nurses.[12] It has remained the most commonly referenced account of Canadian military nursing, contributing importantly to documentation on the formation of various units, chronologies, and nursing leaders – a daunting task given the mobility of hospital units following the troops in battle. Veteran nurses frequently comment, however, that it is difficult to see rank-and-file nurses or their work reflected in this account. Jean Bruce referred to a "great historical silence" surrounding Canadian women and war service in 1979, when she documented women's activities on the home front and with military and paramilitary organizations. She described her book as a montage of personal stories, statements, and visual images. Her chapter on military nurses, like three other collections and an art book about women who served in the Canadian armed forces, relies heavily on the organizational history of the Nursing Sisters' Association of Canada.[13]

Most of the research related to women and war focuses on the First World

War period and tends to dismiss nurses as women whose gendered involvement in war neither threatened nor altered the status quo. This literature seldom distinguishes between trained professionals and semi-trained or untrained volunteers, however, treating "nurse" as a universal category. For example, Susan Grayzel, Angela Smith, and Margaret Higonnet have each studied women's participation in the First World War and contributed significantly to the field. Grayzel compared the porous boundaries between "war fronts" and "home fronts" in Britain and France, considering both informal and formal nursing as one type of wartime involvement and concluding that war continued, rather than shattered, the reconstruction of gender relations and identities.[14] Smith, who examined private testimonies and published accounts by three trained and semi-trained women who did nursing work in French hospitals during the First World War, used post-modern discourse analysis to uncover links between warfare and literary development.[15] She refers to military hospitals as a "second battlefield," challenges the angel metaphor, and suggests that women's power over hospitalized male bodies inverted the usual roles and expectations related to gender, class, and sexuality. Higonnet examined writings by two of the same women as Smith did, a trained nurse and a novelist/hospital volunteer, but from the perspective of literary criticism of their self-representation and portrayals of their soldier patients.[16] The strong dependence in this literature on a small body of women's writings limits what we can know, especially regarding everyday military nurses and their work.

Cynthia Enloe was one of the earliest scholars to include military nurses in her analysis of the militarization of women's lives. She argued that war and military discourse depend on women's support for the recruitment and re-enlistment of men, for sanitary and caring tasks required to keep troops healthy, and for replacement labour that released men for war.[17] Revisiting the topic fifteen years later, Enloe examined the insidious and pervasive ways in which both civilian and enlisted women become militarized. She analysed ways in which individuals and whole societies "come to imagine military needs and militaristic presumptions to be not only valuable but also normal," defining militarization as a "process by which a person or a thing gradually comes to be controlled by the military *or* comes to depend for its well-being on militaristic ideas." In this study, I build on significant questions raised by Enloe concerning what is gained and lost when nurses become integral to military systems.[18]

During the late 1980s and early 1990s, important work emerged on war as a "gendering activity." Both Joan Scott and Ruth Roach Pierson synthesized this body of literature, identifying key debates within it. Scott suggests there is one basic theme, which frames war as either a positive or negative "watershed" experience for women. The theme has four variations: new opportunities that did or did not open up for women during war; new political rights such as

suffrage that were based on women's wartime participation; women's antipathy to war and their consequent leadership of pacifist movements; and the long- and short-term impact of war on women.[19] For example, some authors challenge the construction of war as stereotypically male while others suggest that power, economics, and status among men and women tend to remain unchanged even in the armed forces. This argument is best represented by Margaret Higonnet's "double helix" concept that allows for variation while maintaining the same relative positions of power between military women and men.[20] According to Scott, these debates are irresolvable and problematic. She calls for more attention to state policies related to women and to metaphoric uses of gender representations. Pierson suggests that the women and war literature perpetuates two stereotypical, dichotomous metaphors that portray women as "beautiful souls" and men as "just warriors."[21] Jean Elshtain is a notable exception with her study of gendered discourses that contradict these images and portray both women and men as potential beautiful souls or just warriors. Elshtain refers to nurses as "battle zone witnesses to the spectacle of war," suggesting that nursing "allowed women to get close to that action of which they are not an active part."[22]

Recent circumstances have converged to facilitate historical research on Second World War nursing sisters. Although time was running out due to advancing age and declining health, many of these women were still available for interview during this study, offering unique opportunities to document their first-hand accounts. Families of deceased nursing sisters are also discovering letters, photographs, and diaries created during the war and are beginning to make them accessible to researchers. In addition, many recent fiftieth- and sixtieth-anniversary commemorations of war-related events, along with the creation of a new war museum in Ottawa and an increased urgency among aging veterans to share their experiences with Canadian youth, have generated renewed interest in the Second World War period. Now in their late eighties to mid-nineties, nursing sisters were ready to recall what it was like to make the transition from civilian to military life and back again, to care for both soldiers and civilian casualties in a wide range of settings and circumstances, and to work with other medical personnel under less than ideal conditions.

Twenty-five remarkable nursing sisters shared their first-hand accounts with me in audiotaped oral history interviews conducted during 2001.[23] We share a professional status as nurses, although I am an outsider to the military community, and when they occasionally chose not to share particular experiences, I respected the boundaries they set. I refer to these nursing sisters by their birth surnames (the names by which they were known on enlistment), and identify them directly within the text. I reference each individual's interview only when used for the first time in a chapter and thereafter, refer to that nursing sister simply by name. The appendix contains a brief biographical profile for

each. In addition to their interviews, I selected another thirty interviews from various collections in national, provincial, and private archives across Canada, to represent a broad range of wartime settings and contexts. I document the source for these additional interviews with both footnotes and names within the text. This combined set of oral history interviews is supplemented by memoirs, letters, diaries, scrapbooks, artifacts, and personal photographs of additional nursing sisters as well as material published in nursing and medical journals during and after the war.

To complement the interviews, oral histories and published materials, I generated a database based on demographic variables extracted from 1,145 individual Second World War nursing sister personnel files of the Department of National Defence (creating a 26 percent sample).[24] The resulting aggregated data provide new insights related to places of origin, residence, parentage, training, previous experience, average age, marital status, religious affiliation, languages spoken, postings, and postwar plans. In addition, these data include nurses who were dead or who were unavailable for interviews because of their location, health status, or memory loss. The data thus broaden our understanding of the cohort as a whole. The department's records were created during the war and originally intended to document the government's postwar obligation to veterans. Like other sources, they are limited according to who created each file, the modification of forms during the war, methods of transferring them between settings, and conditions of preservation.[25]

Official military documents and records were helpful in establishing the various contexts in which nurses served, although they revealed surprisingly little of these women's actual nursing practice. According to historian Tim Cook, the Army Historical Section produced a mass of documentary evidence on the Second World War: 200,000 Canadian Military Headquarters subject files, 20 million sheets of paper, and 132,000 war diaries. Cook concludes that "Clio's soldiers were not simple scribes or passive archivists … They actively sought out the war record, influencing … how the war would be captured and ultimately codified in print."[26] He points out how army historian C.P. Stacey directed the production of war records in the field during active campaigns as well as after the war and how he circulated accounts for revision and censored other information.[27] There are over five hundred individual war diaries pertaining to different types of medical units such as general hospital units, casualty clearing stations, field surgical units, field dressing stations, and transfusion units. A sampling of these diaries demonstrates their focus on organizational aspects and accounting rather than reflection of medical or nursing work. Depending on who was assigned recording duty, the records obscure as much or more than they reveal, especially about nursing sisters, who seldom appear except as personnel who transferred into and out of medical units.

Several theoretical perspectives inform my analysis of military nurses and

their work. Building on historian Kathryn McPherson's argument that the mastery of nursing techniques provided civilian nurses with marketable skills and expertise that differentiated them from non-professional caregivers, I analyse military nurses' work through the lens of medical technology associated with the Second World War.[28] Following social construction of technology approaches, I have adopted a broad conceptualization of technologies as large technological systems that are historically situated within specific socio-political and economic contexts.[29] Such systems are both socially constructed and society shaping. They include all the components and actors considered necessary in order to achieve a common system goal, such as physical artifacts; organizational structures such as manufacturing, transportation, and banking; scientific components such as books, articles, university teaching, and research programs; legislative and regulatory policies; and natural resources.[30] Within this framework, the artifacts may be physical or non-physical, and all components are interrelated, meaning that changes in one aspect effect changes in the rest of the system. Technological systems are constructed by system builders who hold the balance of power by controlling as much of the system as possible, for as long as possible.

Military medical technology, as understood within this framework, consists of more than instruments, equipment, and pharmaceutical products. It includes the skilled application of these tools, the associated knowledge to innovate and improvise under wartime conditions, and the therapeutic use of self when technology reached its limits. It includes the participation of medical personnel in research on drugs and surgical procedures as well as policies and regulations governing decisions about patient care. Technology includes training programs, transportation components in the chain of evacuation, physical and psychological screening tools that held power to determine who was a casualty, and systems for sorting patients and documenting their care – to name only some of the elements that constituted the Second World War military-medical-technological system.

By conceptualizing military nursing through this lens, it becomes possible to explore the complexity of nurses' work as well as the multiple variables that shaped it. Nurses mobilized their skills for the war effort, capitalizing on their expertise to secure decently paid work that also relocated them closer to the centre of wartime events. In the process, they also facilitated the use of increased medical technology ever closer to the frontlines, significantly increasing the number of casualties who were able to return to active duty as well as reducing the time involved for recovery. As a result, the provision of adequate nursing care became an important part of strategic planning for battles and campaigns such as the Invasion of Italy in 1943 and the Invasion of Northwestern Europe in 1944.

Focused primarily on system builders, however, the social construction of technology approaches may deny or minimize agency for other actors within

the systems. Such approaches also have limited explanatory ability regarding how social shaping takes place, how power is distributed and contested, and how variables of difference such as class, race, ethnicity, and gender work within such systems – questions that call for gender as an analytical concept. Gender analysis exposes the multiple ways in which power is unequally distributed within military medical systems, as well as "fundamental differences that divide gendered subjects" and the "historically specific processes that unite people into a shared gendered consciousness."[31]

War, gender, and medical technology intersected to transform civilian nurses into military nurses "only for the duration" of war, but many nursing sisters constructed an enduring identity as military nurses based on shared experiences. Yet most of them worked and socialized within the relatively confined environments of their immediate medical units during the war. How then did such a strong military identity develop? What purposes did this collective identity serve? And how has it contributed to shaping both a personal and social memory based on this period of their lives?[32] The concept of "symbolic community" has guided this part of the analysis. Although much of the original scholarship on symbolic community focused on nation building, sociologists and historians have expanded the concept well beyond spatial structures and regional boundaries to encompass social structures and relationships.[33] A.P. Cohen identified more than ninety definitions of community within the social sciences literature, for example, arguing on behalf of community as a mental construct distinguished through the constructed meanings shared by those who claim membership. He directs us to examine important questions such as how a community creates particular symbols, how it constructs a public face, how it remembers the past, and how it uses the past for present integrity.[34]

This book begins by situating Second World War nursing sisters in relation not only to nurses who served with the Canadian armed forces prior to 1939 but also to the socio-economic contexts of the 1930s. Most of these women were born or grew up during the First World War and either trained or searched for work as nurses during the Great Depression. The professional, technological, and military contexts of the interwar years made military nursing service a very attractive alternative. When Great Britain declared war on Germany in August 1939, civilian nurses were once again ready to enlist.

The armed forces considered nurses, once they were enlisted, to be an expandable and expendable workforce – one that it could readily transform into military nurses for the duration of the war. Civilian nurse leaders and hospitals resisted the flood of nurse resignations to enlist, lobbying the armed forces in efforts to balance the need for nurses in both practice settings. The military carefully controlled the public perceptions and media portrayals related to nursing sisters, particularly reinforcing messages about their safety and femininity. Nurses, in turn, negotiated significant social and professional

space within this traditionally male domain, although gender shaped all decisions about what they could do, and where and when they could do it.

The admission of women to the ranks generated a great deal of anxiety, especially in relation to their continuous close proximity to men in social and work settings as well as the potential for various types of danger. According to prevailing discourse of the time, women needed the protection of men, and wartime service threatened their femininity.[35] Therefore, the armed forces developed specific gender- and class-based regulations and policies that ensured that nursing sisters comported themselves as "officers" and "ladies" at all times. Although nurses contested these expectations to different degrees, the nurses' success was contingent on geographical distance from Canada and changing conditions during the war itself, which permitted increased flexibility.

Nurses were able to capitalize on their skills and knowledge as actors within a large military-medical-technological system dedicated to the care of military personnel. Innovations in medicine, surgery, and drugs brought opportunities to move closer to the frontlines of war and the frontiers of medical technology, where they learned new skills and challenged the established boundaries between physicians' work and nurses' work. The technological and military contexts in which they practised shaped the nursing care of soldiers, reconfiguring some aspects while maintaining others. But for the most part, those changes failed to transform postwar and non-military settings to any significant degree.

At the end of the war, there was no longer any need for a large military nurse contingent. The armed forces demobilized them as rapidly as possible, downsizing the number to a total of eighty nurses within all three service branches. Although a nursing shortage began to emerge in civilian settings during the 1940s, most nursing sisters married, left the profession, or sought non-traditional practice settings. Many of them maintained contact with one another through local and national nursing sister associations that met regularly over the following sixty years, developing an enduring symbolic community based on gender, shared experiences, and identities as military nurses. With time, this community solidified around certain portrayals of military nursing, adopting a set of rituals and symbols and forging a collective social memory. They actively promoted military nursing to younger generations of nurses while seeking to reconcile nursing ideologies with military objectives.

1

"Ready, Aye Ready": Enlisting Nurses

Nursing became respectable paid work for Canadian women, gradually more acceptable from the 1870s through the 1930s, due to a number of changes in both the medical and nursing fields. With medical technology on the rise in hospitals, nurses increasingly shifted their emphasis from domestic duties to technological skills, and such skills became the basis of nurses' claims to scientific legitimacy and professional recognition.[1] The standardization of nurses' training, improvement of their working conditions, and pressure for adequate pay became important issues that prompted the Canadian Medical Association and the Canadian Nurses Association to commission a study of nursing in Canada in 1929. The *Survey of Nursing Education in Canada,* published in 1932 and known popularly as the Weir Report, provides an excellent portrait of the state of civilian nursing and working conditions at the beginning of the decade prior to the Second World War.[2] One can safely infer that these conditions only worsened as economic depression deepened in Canada.

Like many Canadians, nurses struggled with varying levels of deprivation and uncertainty during the Great Depression. Nursing was often a second or even third occupational change for many single women in search of economic security. Historian Kathryn McPherson has described training programs as analogous to "riding the rails" for men of the same period, arguing that "while their brothers rode the rails looking for work and handouts, rural women went to nursing school."[3] Student nurses were able to trade their labour for room, board, and skilled training for at least three years, but this survival strategy could only be temporary. On graduation, these new nurses worsened the employment situation as the profession struggled with oversupply and underemployment in relation to the public's ability to pay for private nursing care in the days before universal public medical insurance. The vast majority of working nurses were single women practising in private duty, as hospitals did not typically employ nurses after graduation from training programs. Without the support of male relatives as breadwinners (thereby reducing

the burden on their families) and without hospitals as a significant source for employment, nurses experienced the Depression in particular gendered ways because government efforts to combat the economic crisis focused primarily on relief measures for jobless men.[4] Moreover, graduate nurses frequently found themselves with additional social and financial obligations that included needy family members. Attractive as it might have seemed during the Depression, joining the military medical services was not an option: the Canadian military system languished during the interwar years under the economic constraints, policies, and isolationism of the Mackenzie King government. With only a small reserve and an even smaller permanent nursing force, the military relied on the civilian profession to fill the ranks should the need arise.

This was the situation in August 1939. Combined social, professional, technological, and military contexts had shaped a large, readily available, feminine workforce in need of employment. Nurses were able to capitalize on their technical skills and extra post-training courses in operating room technique, teaching, supervision, administration, and mental nursing to enhance their qualifications to become nursing sisters. They exerted personal, family, and political influence wherever possible to get a coveted position in the armed forces. Military nursing provided work while permitting women to fulfill family obligations and enjoy perks associated with wartime service. One physician referred to military nurses in 1940 as "Happy Warriors" whose "training has taught … [them] to go in company with pain and fear and bloodshed – a strange privilege."[5] While nurses saved the military by supplying an essential workforce for the duration of the war, the military also saved nurses by providing them with much-needed work, and more.

Civilian Workplaces during the Great Depression

Hospitals grew in size and acceptance over the first half of the twentieth century, meeting the need for a cheap, dependable workforce by relying heavily on the labour of student nurses in their training schools. Hospitals typically hired only a small number of graduate nurses to serve as supervisors, educators, and "specials" for privately paying patients or patients needing more complex care than students could manage. At one large hospital, for example, student nurses constituted 70-80 percent of the nursing staff between 1924 and 1944.[6] For the most part, graduate nurses such as Gertrude LeRoy Miller, who was a Red Cross Outpost nurse during the 1930s, had to seek employment outside of hospitals. Miller valued the hardiness and autonomy of her remote practice setting, but she also described the working and living conditions as characterized by isolation, loneliness, dependence on the community, poverty, and improvisation.[7]

Most graduate nurses worked in private homes, depending on referrals from physicians or a local nursing registry and paid by the patient or patient's family.

Between 35 and 43 percent of all employed nurses during the early 1930s were private duty nurses, and according to the Weir Report, approximately 60 percent of these were either "intermittently" or "almost continuously unemployed," illustrating the dire circumstances of private duty nursing during this period.[8] Even when they found paid work, there was such a discrepancy between their wages and living expenses that they could not meet the basic costs of living during the 1930s.[9]

More than half (51.7 percent) of the 1,052 military nurses included in this study were private duty nurses before enlistment. Nursing Sister (NS) Eva Wannop, who worked to pay for a public health nursing course at the University of Toronto, earning $5 for a regular twelve-hour shift, noted that "if you had an alcoholic patient, it was $10. So it was more lucrative to get an alcoholic patient so that the money would accumulate [faster]."[10] Private duty nurses often reported waiting from two to four weeks between cases and sometimes working only five days in a month. Nursing registries tried to distribute work equitably among several nurses by regulating the number of working days each one could be assigned to a case. NS Muriel McArthur, however, "didn't get called for many patients" because she had trained in Toronto, and the local hospital near her home in Barrie, Ontario, "gave preference to their own graduates."[11]

Some hospitals experimented with reduced hours per shift for any graduate nurses that they did hire, and with hourly or "group nursing" fees, wherein a privately paying patient could hire a nurse by the hour rather than for the whole shift or a group of patients could share the costs of a private duty nurse, as ways to distribute available work among more nurses. Meanwhile, nursing schools reduced enrolments to stem the rising number of unemployed graduate nurses.[12] Graduate nurses who did find work in hospitals reported wages of $25 to $65 a month plus room and board. Some nurses crossed the border to the United States in search of work. NS Lois Bayly worked in Albany, New York, for example, while Betty Riddell travelled across the river daily from her home near the border to work in Detroit, Michigan. Many other nurses joined the ranks of the unemployed or took jobs as waitresses or sales clerks. NS Dorothy Grainger combined construction work with nursing, finding that laying steel reinforcements for concrete and reading blueprints was easy, and the wages were higher than in nursing jobs.[13]

At least 1.5 million Canadians were on relief by 1933 (an unemployment rate of 30 percent). Unemployment and welfare programs stretched dwindling resources that were inadequate at the best of times. Family members, including women, were considered responsible for the financial support of parents and siblings regardless of their own marital status or their ability to be self-sufficient, and welfare entitlements were adjusted accordingly.[14] Nurses bore social and legal responsibilities for parents and siblings, even when it was difficult to find enough work for their own support. As all soldiers enlisting

during the Second World War did, nursing sisters completed a form indicating the number of dependants and the amount of financial support they had provided to each one prior to enlistment. This information determined their eligibility for an additional "Dependent's Allowance" benefit, intended to compensate dependants while soldiers were on active duty. One nursing sister claimed poignantly that although she was her mother's only relative and would have liked to support her, she had not been able to do so "because [her] nursing salary was not big enough."

Within hospitals, student nurses found working conditions increasingly intolerable. Indigent patients crowded public wards, taxing both human and material resources and sometimes provoking drastic attempts to create change, such as the 1939 nurses' strike at St. Joseph's Hospital in Comox, British Columbia.[15] Changes in medical technology increased the workload for novice nurses, as hospitals became repositories for technology that had become either too expensive or too seldom used for individual physicians to own and operate, or too difficult to transport to private homes for either diagnosis or treatments. Physicians relied increasingly on nurses' constant presence at the bedside and their growing familiarity with medical technology such as X-rays, hydrotherapy, electrical therapy, specimen collection, and thermometry.[16]

Prior to the 1940s nursing techniques focused on preparing the equipment and the patients for procedures, assisting physicians during procedures, and cleaning up afterwards. Nurses perfected and routinized techniques such as the administration of counter-irritants, medications, enemas, douches, catheters, lavages, poultices, packs, stupes, and foments, creating parameters of safety around patient care and claiming scientific status related to the acquisition of these skills. They sterilized equipment and supplies, followed elaborate instructions for isolating infectious patients, and developed strategies for "feeding patients, assisting them with ablutions, and maintaining the cleanliness of bed and patient alike."[17] Graduate nurses worried about losing their skills in private duty, perceiving hospitals as easier places to maintain or update skills. They were continually taking certificate courses and acquiring additional skills in areas such as operating room technique, X-ray technique, tuberculosis nursing, teaching, supervision, and administration. These extra courses also enhanced their credentials for military service whenever positions did become available.

Military Workplaces between the Wars

Vacancies in permanent military nursing positions seldom occurred during the interwar years. When the First World War medical units demobilized in 1920, nursing sisters found themselves in a situation different from that of medical officers who had been assigned positions with various regiments, sanitary stations, and field ambulances – units that continued to function

after the war but on a smaller scale. Physicians could combine their reduced military responsibilities with a return to their private practices, but nursing sisters had been assigned to field hospitals that ceased to exist once the postwar care of soldiers came under the mandate of the Department of Pensions and National Health civilian rehabilitation hospitals. Some nurses worked in these hospitals initially, but as soldiers returned to civilian lives, this work tapered off.[18]

The postwar permanent force medical services, known as the Royal Canadian Army Medical Corps (RCAMC) after 1919, planned for twenty-five nursing sisters. Several reorganizations and economic recessions during the interwar period reduced military staffing and funding overall and authorized only twelve nursing positions throughout the period, with two exceptions where the transition of personnel overlapped briefly. The 1930 reorganization, for example, called for the small core of permanent force nursing sisters to be supplemented by a non-permanent reserve force of 1,110 nurses, but this plan was never implemented. Analysis of personnel records and annual reports of the Department of Militia and Defence for the Dominion of Canada demonstrates that the number of permanent nursing sisters ranged from eleven in 1920 to fourteen in 1931, with an average of twelve nurses and a reserve list that ranged from 127 nurses in 1923 to 399 nurses in 1925 – far short of the plans on paper.[19]

Only the permanent force nursing sisters had the stability of full-time paid work and military pensions at retirement. They served primarily as supervisors and administrators during the interwar period. They also trained "other ranks," or enlisted men, as medical assistants and stretcher bearers. Among other topics, nursing sisters taught first aid, certifying more than 50 percent of the "other ranks" and consequently keeping the requirement for nurses during peace time at a minimum level.[20] Reserve nurses were expected to be available for emergencies, epidemics, and occasionally for summer training-camp duty. This limited involvement left them economically dependent on private duty cases or a very flexible employer who could grant them time to fulfill their military assignments. For example, five reserve nursing sisters were "called out" to care for soldiers at the Royal Military College at Kingston, Ontario, during an influenza outbreak in 1924.

R.B. Bennett, prime minister from 1930 to 1935, developed a scheme to deal with massive civilian unemployment and labour unrest during the Depression by converting military camps into labour camps. The military benefited through the construction of airfields and fortification repairs at Halifax and Quebec, but medical services related to these projects were handled mostly through reserve nurses and local civilian hospitals. NS Elizabeth Pense, one of the reserve nurses, described the ratio between military patients and unemployed men in these relief camps as 5:50 with "lots of pneumonia" among the unemployed.[21]

As the decade progressed, it became increasingly clear that another war was imminent. Yet only one summer camp included military field training opportunities for medical units during this period, the one held at Camp Borden in 1938. No equipment had been added to the medical units or updated since the First World War. Policies indicated that units were to use British supplies if, and when, Canada entered another war. The RCAMC continued to rely on the civilian nursing profession to "fill the ranks," beginning with nursing sisters in the permanent and reserve forces. Nurses, like the physicians with whom they worked, were well qualified professionally but almost completely inexperienced with regards to wartime conditions. Physicians formed a special Military Section within the Canadian Medical Association in 1930, anticipating the need to plan for military and civilian needs during wartime as well as responses to bacteriological and chemical warfare.

The Canadian Nurses Association and the Canadian Red Cross shared a concern over civilian shortages if nurses enlisted in large numbers.[22] Beginning in 1926 they jointly created and maintained a "Reserve List" of nurses who had agreed to be available for emergencies, either within or outside of Canada. The officer commanding for each military district was supposed to have an updated list for his district. The "list" became problematic, however: nurses moved around in search of private duty cases or married and left nursing, making it difficult to keep the list current or to locate the nurses on it.[23]

The interwar permanent force nursing service consisted initially of eleven First World War nursing sisters who transferred directly from active service to the postwar permanent RCAMC in July 1920. Nine of them were over thirty-five years old at the time and remained in the military until retirement with pensions after serving between sixteen and twenty-eight years. The twelve nurses who eventually replaced them ranged in age from twenty-six to forty-six on enlistment. With the exception of six nurses who trained in the United States, the majority of the interwar nursing sisters trained in Ontario or Quebec, graduating between 1898 and 1915.[24] In 1939 they welcomed into their ranks the second generation of nursing sisters, to whom they passed the torch of military nursing in Canada.

American political scientist Cynthia Enloe has pointed out that the generation of Americans who grew up during the interwar period became a valuable pool of potential recruits for the military based on their experiences as children of the First World War and their socialization towards ideological expectations that made war a foregone conclusion.[25] In Canada, the severe working conditions of the 1930s combined with a legacy of military nursing that bestowed officer status, military benefits, and overwhelming social approval in addition to similar ideological expectations. Military nursing was consequently attractive to the large, valuable, and underemployed pool of trained civilian nurses. Indeed, Jean Wilson, writing on behalf of the Canadian Nurses Association, assured the Canadian government in August

Miss Smellie, as she was popularly known, began her military nursing career as a nursing sister during the First World War and rose through the ranks to assistant matron in the postwar CAMC nursing service. She retired from the CAMC to take public health courses, teach at the McGill University School for Graduate Nurses, work for Victorian Order of Nurses, and then assume leadership of the VON. The RCAMC seconded her at the outbreak of the Second World War to become the matron-in-chief of its nursing service. She often referred to herself as the "most retired" nurse in Canada due to her diverse roles in both the civilian and military nursing fields. *Kenneth Forbes, Colonel Elizabeth Laurie Smellie C.B.E., R.R.C., L.L.D. AN 20000105-054, Beaverbrook Collection of War Art, © Canadian War Museum*

1939 that, should the need arise again, "there would be an immediate rush by nurses to answer 'The Call' for their professional services." She claimed that civilian nurses would be ready to answer, "'Ready, aye Ready' to any emergency call."[26] And they did respond enthusiastically when the call came. The issues then became which nurses would serve and how to select the right ones from such a large number of applicants.

The "Right" Kind of Nurse

One might expect the demographic composition of national military forces to reflect that of the larger population, but many factors skew enlistment in favour of the privileged classes while exploiting persons disadvantaged by education, race, or gender. Some of these factors include prevailing socio-economic conditions, whether enlistment is voluntary or conscripted, who is deemed to be exempt from military service, specific eligibility criteria, and strategies used to either avoid or achieve enlistment. Conscription had threatened Canadian unity during the First World War, bringing down the governing Liberals and creating a crisis within the new Conservative administration, which narrowly averted dissolution through the formation of a coalition Union government.[27] The government enacted two special pieces of legislation that ultimately permitted the conscription of men in 1917. The Military Voters Act (1917), popularly known as the "Soldiers Vote," extended the suffrage to all serving soldiers, including nursing sisters, while the Wartime Elections Act (1917) enfranchised mothers and wives of soldiers. These groups of women thereby became the first Canadian women eligible to vote in national elections, a year before other women received the same legal status.

William Lyon Mackenzie King, prime minister during the Second World War, had been a member of the Liberal government at the beginning of the First World War, and he understood first-hand the dangers associated with conscription. He also understood Canada's position within the British Empire and the inevitable requests for an increasing number of Canadian troops in Europe. Prior to the war, King had been well known for his politics of diplomatic appeasement and for fiscal decisions related to armed forces budget reductions despite the threat of impending conflict. He wanted to avoid not only Canadian involvement in distant wars but also the conscription issue, which had caused so much political and social turmoil during the First World War. King had promised as late as the 1940 election not to implement conscription but, when events during the war forced him to alter his stance, he called for a plebiscite in 1942 to release him from that promise. King's government then brought in the conscription of men in stages, initially for home defence only, but later for overseas duty as well.[28]

Canadian nurses were exempt from conscription for at least two reasons other than gender: they volunteered far in excess of the numbers required, and the previous "oversupply" of nurses during the 1930s had turned into a national nursing "shortage" by 1942. While the conscription of nurses was never necessary in Canada, however, the United States struggled to meet its nursing quotas in spite of special training programs such as the Cadet Nurse Corps established in 1943, raising the age limit to permit older nurses to enlist, eliminating the marriage bar, increasing nurses' pay, and improving their status within the armed forces. A protracted struggle took place between Congress, the American Nurses Association, and American military institutions over the

conscription of nurses. A bill calling for their conscription passed the House of Representatives in March 1945 and narrowly missed Senate approval in April. Meanwhile a massive recruitment effort mounted by the army, Red Cross, and American Nurses Association proved successful, and by May, the War Department withdrew its second request for a draft of nurses, just days prior to the end of the war in Europe.[29]

Multiple factors influenced which nurses ultimately became nursing sisters. The civilian nursing profession controlled the training school admission criteria, curriculum, and examination process that credentialed a pool of the "right kind" of nurses for recruitment. The *King's Regulations and Orders for the Canadian Militia, 1939* included specific sections that established the basic eligibility requirements for nursing sisters related to citizenship, gender, age, marital status, and graduation from an approved school of nursing. The *Regulations* also required nursing sisters to be physically fit, less than forty-five years of age on enlistment, and either single or widowed without children.[30] Applicants were not accepted until the military verified their registration number and good standing with the relevant provincial professional nursing association. Thus, the demographic profile of military nurses closely reflected the civilian nursing workforce except for the relatively low number of French-Canadian nurses, which can only partially be explained in relation to prevailing French-Canadian perceptions of the war as a British endeavour.

The requirement to be graduates of approved training programs also meant that nursing sisters reflected and reinforced entrance criteria established by schools of nursing that were based on class, race, gender, age, and marital status. At the time, training programs systematically excluded black, First Nation, and Asian women as well as most men – with a few exceptions.[31] For example, a small number of Jewish women gained admission to the School of Nursing at Montreal's Women's General Hospital, while a small number of men trained as nurses at mental hospitals in Ontario and Alberta, as well as at the Victoria General Hospital in Halifax, Nova Scotia.[32] Although gender was not specifically mentioned by the *King's Regulations and Orders,* the military accepted only women as nursing sisters. According to prevailing social constructions of masculinity and femininity, men were combatants, not nurses. Men could go where women could not go, and by filling all nursing positions with women, the armed forces effectively reserved men who were fully qualified as nurses for the battlefield.[33]

The military required nursing applicants to submit references from an employer and from their clergy. A rigorous interview with the district commanding officer and a physical fitness test came next. The Royal Canadian Air Force (RCAF) went so far as to investigate the applicant's family background and home setting by sending investigators into the neighbourhood. Once a candidate was accepted, moreover, the armed forces used an initial training period of several months to screen out women perceived as being difficult to

manage. Reports on nurses discharged within the first six months (1.5 percent of my sample) typically described them as either "not suited" to the military or "unable to adjust to discipline," or commented that they "didn't fit in."[34]

The nursing profession itself exerted yet another influence on the composition of military nursing services by continuing to resist the use of volunteer nurses and voluntary aid detachments (VADs).[35] No VADs worked in Canadian military medical units overseas, and while a very few worked in military hospitals within Canada, that change occurred only towards the end of the war, when civilian hospitals grew anxious regarding an emerging nursing shortage. With the volunteer question resolved, the nursing profession turned its attention towards an equitable process for selecting and enlisting civilian nurses.

The Canadian Nurses Association (CNA), in conjunction with the Canadian Red Cross and the RCAMC, began to negotiate the recruitment process at the beginning of 1939 based on common concerns to balance civilian and military nursing needs in the event of war. Their "Plan for National Enrolment of Nurses for Emergency Service" used the responses of registered nurses to a survey administered through their respective provincial associations. The survey asked nurses to categorize their availability according to four options: Class A for both war and disaster; Class B for war only; Class C for disaster only; and Class D (nurses over age forty-five) as a reserve for the first three classes. Classes A, B, and C had a minimum quota set at 3,000 nurses each.[36] The lists were forwarded from the provincial nursing associations to each military district within that province for the purpose of calling up only nurses who were on the lists and had applied in that district. The *Canadian Nurse* journal reported in October 1939 that more than 3,000 nurses had already enrolled and were "now ready to be called upon for service in an orderly manner and without delay."[37] NS Fran Oakes was one of them. She had completed extra courses at both the Montreal and Toronto General Hospitals in operating room technique and supervision and had over ten years' experience when she became one of the first two nurses in the newly organized RCAF nursing service. Oakes said:

> We didn't know we were the first nurses … You see we were [enrolled for both] war and disaster at home or abroad … When we first graduated as nurses, you were given this piece of paper. Were you willing to serve at home or abroad, in war or in disaster … ? They contacted you; they gave you a post card. And I went to London and a little colonel, who wasn't as tall as I was, told me they had 999 well-qualified, experienced Army nurses. And they didn't need me. So I went back and minded my own business. And then, I got called in for the Air Force because when we signed up for war and disaster, it wasn't for any [particular] service.[38]

During the First World War, the medical and nursing staff of large teaching hospitals had mobilized together and formed complete medical units that

moved overseas together. This practice depleted major Canadian hospitals such as Toronto General and Montreal General of a great proportion of their staff – especially experienced teachers and supervisors. The CNA was determined not to repeat this pattern. Each provincial association received an initial quota in proportion to the number of nurses registered in their province. By 1940 all provinces except Quebec and New Brunswick had exceeded their quota, and 4,080 nurses had volunteered for various categories of war service. Of these, only 150 nurses were actually on active duty.[39] The Association of Registered Nurses of the Province of Quebec issued a rebuttal to reports that Quebec had not met its quota, reporting a total of 4,064 members in good standing, with 1,040 names (25 percent) on their enrolment list and 900 nurses willing to serve in the military.[40]

In spite of these strategies to ensure that military enlistment would be proportionally distributed across the provinces and hospitals, the list soon fell into disuse – partially due to difficulties of maintaining its accuracy, and partially due to the penchant of commanding officers for independent decisions.[41] In September 1940 Col. Potter, director general of Medical Services, told the CNA he could not ensure the use of the list because applicants were screened and selected in the local districts.[42] As was often the case, district medical officers requested nurses whom they knew and had worked with in civilian hospitals. Surgeons in particular developed preferences for specific operating room nurses who were familiar with their techniques and equipment preferences. NS Helen Morton recalled that one Toronto General Hospital physician went through the building over the Labour Day weekend immediately following the call to mobilize units in 1939, personally recruiting Agnes Neill as matron and forty staff nurses for duty with No. 15 Canadian General Hospital (CGH).[43] NS Betty Nicolson moved directly from the operating room at Winnipeg General Hospital to Fort Osborne Barracks because, as she said, "the surgeon was one of our doctors from Winnipeg General and he wanted a scrub nurse from his hospital, of course. So I was taken on strength immediately."[44] The RCAMC called up NS Doris Carter shortly after she met a surgeon from Montreal's Royal Victoria Hospital who assured her, "I've got your name on my hospital [staff list] and I'm going to be chief surgeon."[45] Although military medical units preferred nurses with at least two years' experience beyond training, NS Beatrice Cole received a phone call within two months of graduation from the Regina General Hospital in 1944, asking her if she wanted to enlist. Because she had not applied and was therefore surprised to get an interview, she asked the recruiter if they were calling all the new graduates. Told that they had been advised to phone her, she didn't find out until after the war that one of her patients, a First World War nursing sister, had recommended her.[46]

Nurses themselves circumvented the list in various ways. They submitted multiple applications, either to the same service or to different service

branches in order to increase the selection odds. One nurse applied to and was accepted by the RCAMC three times, according to her personnel file.[47] Nurses applied in several military districts in search of unfilled personnel quotas. NS Hallie Sloan applied to the navy, air force, army, and South African nursing services, for example. When each service replied that they had plenty of people "waiting in line," Sloan returned to her home community of Regina, where she found a vacancy with the RCAMC.[48] NS Lois Bayly gave up work in New York and returned to Canada in order to enlist.[49] As NS Mary Bower summarized, "We all were trying to get into the Army or Air Force or anything. We tried to go to Africa! Anything to get in the armed forces."[50]

An unknown number of Canadian nurses decided the waiting list was too long. They enlisted with Queen Alexandra's Imperial Military Nursing Service (QAIMNS) in England, or the United States Army Nurse Corps (USANC). Crossing the river to work in Detroit, Betty Riddell saw a billboard message every day: "Uncle Sam needs you!" She decided to inquire one day "if they would take Canadians. I almost didn't get back [to Canada]. They wanted to hold me." Other nurses, such as Isabel Morrison, served with the South African Military Nursing Service (SAMNS) as part of a special South African draft of Canadian nurses in 1942. After serving one year there, she remustered to the RCAMC.[51] Not all SAMNS nursing sisters were accepted into the RCAMC, however. Matron-in-chief of the RCAMC Nursing Service, Elizabeth Smellie, made it clear in a letter to the Department of National Defence that "many [nurses] were on the Reserve list with no immediate prospect of being called, and were glad to go to South Africa. They should not be considered before those who have been waiting a long time, with no opportunity to serve as yet."[52]

Other nurses took civilian positions at military hospitals, hoping that proximity and work record would favour their selection by commanding officers. Air Commodore J.W. Tice, director of Medical Services for the RCAF, expressed concerned over this practice, noting that some nurses were not "suitable" for appointment and that civilian positions on RCAF bases should be "without any undertaking as to subsequent appointments."[53] After 1941, a few nurses enlisted with the newly formed Women's Divisions to work as hospital assistants while hoping to remuster as nursing sisters. The military refused to allow changes in status, however, as this practice undermined plans to balance supply and demand with the civilian workforce. As well, nursing sisters belonged to the medical corps and were completely separate from Women's Divisions, with different rank, pay, and administration.[54] Nurses also used personal and familial influences such as mutual acquaintances or letters to members of Parliament requesting military appointments. They capitalized on relationships to fathers or brothers who were already serving in the forces, as illustrated by the files of underage and inexperienced nurses in the records.

By 1941, *Canadian Nurse* editorials reveal that professional concerns for meeting military nursing needs had shifted to concerns for meeting civilian nursing needs. Medical and nursing leaders took measures to prevent the enlistment of nurses who were already employed in civilian settings, to prevent nurses from leaving the country for employment elsewhere, and to increase the number of students in training. They interfered directly when specific skills or experience were required to maintain civilian practice. In October 1942, for example, Associate Minister of National Defence C.G. Power received a request to avoid enlisting public health nurses from a certain province since there was a "greater danger of epidemics in certain provinces where there are very large numbers of men in small areas."[55] The letter further explained that there was a crucial need for public health nurses to follow up with venereal disease cases among soldiers mobilizing in port areas. Public health nurses already required an official release from provincial ministers of health in order to enlist, but, as this letter complained, nurses were generally "dissatisfied" if denied permission and therefore it would be easier if the military didn't even offer them positions.

Thus, both nurses and their civilian employers influenced military enlistment, using a variety of strategies that altered the composition of military nursing services regardless of careful plans to be representative and provide equal opportunities for selection. As I will illustrate later, additional factors emerged during the war, such as the need for particular skills or knowledge, that enabled still other nurses to circumvent waiting lists and quotas.

Too Many or Too Few Nurses?

Provincial and national associations were anxious to meet the dual obligations to support the war effort and stabilize civilian nursing services.[56] With the military quota of nurses more than adequately met, Ethel Johns as editor of *Canadian Nurse*, challenged civilian nurses to consider home service as being as much a sacrifice as "spectacular" service overseas. Marion Lindeburgh, president of the CNA from 1942 to 1944, referred to nurses as soldiers "whether serving overseas or on the home front. The professional nurse … displays the marks of the good soldier. She will not desert the ranks at a time of crisis, nor will she seek shelter, leaving others to face the hardships and the struggle." Even public health nurses adopted the language of "soldiering" on the home front, as is evident, for example, in a poem on the civilian Air Raid Precautions program.[57] Wary of a return to the employment conditions that characterized the Depression, the profession was reluctant to increase the number of students in training, and ultimately the number of graduate nurses. The professional associations preferred to make full use of existing nursing resources, limit the number of military nurses, and continue the employment restrictions on civilian nurses for the duration of the war.

The total number of graduate nurses available for work in Canada during the war remains ambiguous. On one hand, the CNA reported an increasing

membership of 16,758 in 1940, 18,266 in 1942, and 19,137 in 1943. On the other hand, the 1941 census reported 27,114 active graduate nurses and 11,907 student nurses, for a total of 39,021 nurses, and data from the National Health Survey conducted during March 1943 suggest there were almost 55,000 "active" nurses (Table 1.1).[58]

Because it was not mandatory for a nurse to be a member of the CNA, the organization's records do not reflect the full number of Canadian nurses. At the same time, while many, if not most, nurses belonged to their provincial association, some belonged to more than one association in order to be able to work in several provinces. Because the 1941 census took place after nurse-recruitment campaigns, it potentially over-reports the number of actively practising nurses: retired and married nurses may have identified themselves in this category given the emergency plan focus on both active and inactive nurses. While these issues pose limitations on the interpretation of statistical analyses, the data reveal significant new demographic information and raise important questions about the nursing workforce and nursing shortages during this period.

The Royal Canadian Army Medical Corps (RCAMC) initially supplied medical and nursing services for the Royal Canadian Navy (RCN) and the Royal Canadian Air Force (RCAF) as well as for the army itself. All nursing sisters enlisted with the RCAMC until the RCN and RCAF organized their own respective services in 1941 and 1942, with small groups of nurses remustering to these nursing services. Because the Canadian troops overseas were initially stationed only in England, the RCAMC built up its nursing service slowly, minimizing effects on the civilian profession yet bringing some welcome relief to the employment crisis of the 1930s. By the time of the ill-fated assault on Dieppe in mid-1942, the number of nursing sisters had increased 110 percent, and the civilian profession began to worry about a shortage of nurses.

Before embarking on a general recruitment campaign for more nurses to enter training and the workforce, however, the CNA decided to obtain updated, accurate information about the nursing workforce through at least two endeavours. In January 1942, the organization appointed Kathleen Ellis as the CNA emergency nursing adviser, responsible for surveying nursing needs in each province and making recommendations at the annual general meetings. Suzanne Giroux was her French associate.[59] By December of the same year, CNA president Marion Lindeburgh warned nurses that if the profession did not ensure adequate nursing services throughout Canada, the federal government would do so by way of the National Selective Service of the Department of Labour and its Canadian Medical Procurement and Assignment Board.[60] The CNA also sent representatives to this board and participated with the board in the National Health Survey conducted during March 1943, the nursing alternative to the National Selective Service registration of all Canadian women under twenty-five years of age for the war

Table 1.1

Active Canadian nurses by province and enlistment status, March 1943

Province	Number of civilian nurses	Number of military nurses	Total	Percent enlisted
Prince Edward Island	391	43	434	9.9
Nova Scotia	939	151	3,090	4.9
New Brunswick	2,002	111	2,113	5.3
Quebec	7,834	317	8,151	3.9
Ontario	23,884	735	24,619	3.0
Manitoba	2,963	179	3,142	5.7
Saskatchewan	2,901	138	3,039	4.5
Alberta	3,600	110	3,710	3.0
British Columbia	5,937	224	6,161	3.6
Yukon/Northwest Territories	33	0	33	0
Canada	52,483	2,008	54,491	3.7

Source: Based on Canada, *Report of the National Health Survey,* part 8, *Nurses,* (Ottawa: King's Printer, 1945) 219.

effort.[61] This survey of graduate nurses, however, included everyone under the age of sixty-six, active or inactive, married or single, inquiring about their availability for emergency nursing service in Canada and their intentions regarding military nursing service.[62]

The CNA and the Canadian Hospital Council had access to both sets of data (from the emergency nursing adviser and the National Health Survey), as well as information about the number of nursing sister appointments forwarded from the armed forces branches. They combined these sources to analyze the nursing situation in Canada, make decisions about nursing education, and impose limits on civilian nurses' mobility.[63] The data generated by these surveys provide significant information regarding the availability and intentions of civilian nurses to enlist (Table 1.2), their pattern of application to the armed forces (Table 1.3), the number of nurses enlisted as of March 1943 (Table 1.1), and the number of military nursing sister appointments over the course of the war (Table 1.4).

As of March 1943, according to the National Health Survey, there were 52,483 civilian nurses in Canada. Of these, 47.5 percent indicated that they were unavailable for military service and another 29.6 percent did not indicate their availability (a total of 77 percent). Another 7.1 percent had already applied to the military and 15.8 percent were willing to apply. The armed forces reported only 2,008 nursing sisters on active duty at this time, a mere 3.7 percent of the combined total of 54,491 civilian and military nurses. Meanwhile, the number of applications had increased considerably (to 3,741) and exceeded the actual number of appointments, perhaps due to the National Survey query about willingness to apply (Tables 1.2 and 1.3). Some

20.5 percent of those who had already applied to the armed forces applied to more than one branch, and 4.4 percent applied to all three branches. With another 8,300 nurses willing to apply for military service, there would be no difficulty in recruiting military nurses in Canada. Based on these data, with nursing sisters constituting a mere 3.7 percent of active registered nurses – a much smaller proportion than the 37 percent reported for the First World War – the impact on the civilian nursing workforce should have been manageable.[64] Although the number of nursing sister appointments increased again in preparation for the 1943 Italian campaign and the 1944 European invasion, the armed forces can scarcely be blamed for creating a shortage, given the relatively low proportion of military nurses overall.

It is therefore highly doubtful that the perceived development of a nursing shortage was due to military enlistment. Rather, as the interim report of Emergency Nursing Adviser Ellis identified, there were multiple problems with the maldistribution of nurses. Based on information from the provincial registered nurses organizations, for example, 950 nurses were practising outside of the province in which they were registered, with an additional 625 nurses working in the United States. In addition, there had been a 10.9 percent increase in the actual number of hospital beds along with a 21.6 percent increase in overall bed-utilization. Lesser-skilled workers had replaced the experienced personnel lost to enlistment. Certain health care sectors such as mental hospitals, sanatoria, and rural areas were inadequately staffed. Hours and salaries varied by region and health care setting, and nurses often sought work in the better-remunerated areas. Moreover, discrimination against married nurses contributed to the perceived shortages.[65] These issues combined to create a nursing shortage perception that was out of proportion to the data, whereas other causes may have had more to do with the distribution of nursing services across regions and practice settings. Ellis' final report revealed a large gap between the total number of registered Canadian nurses and the number of nurses engaged in active practice (22,136) or potentially available for practice (16,818). At least 27,044 nurses reported that they were "employed other than as nurses," of which 93 percent stated they were housewives and mothers.[66] When comparing the proportion of nursing sisters to Ellis' total of 38,954 available or potentially available nurses then, military nurses still constituted only 5.2 percent of the active nursing population in 1943.

Nonetheless, the CNA called for constraints on nurses' mobility and employment options out of fear that the situation would worsen. A special appeal was made to Matron-in-Chief Elizabeth Smellie not to deplete hospital training schools of their experienced instructors and supervisors. In conjunction with the National Selective Service, the CNA was involved in decisions on all labour exit permits requested by Canadian nurses after May 1943. There were four categories of applicants, and "it was felt that only in very special circumstances could requests for permits from nurses in group

Table 1.2

Availability of Canadian nurses for enlistment, March 1943

Province	Available for military service (Not yet applied)	Available for military service (Applied)	Unavailable for military service	Not indicated	Total
Prince Edward Island	62	28	244	56	390
Nova Scotia	466	253	1,210	1,010	2,939
New Brunswick	318	125	1,057	502	2,002
Quebec	890	568	3,815	2,561	7,834
Ontario	3,845	1,555	11,335	7,149	23,884
Manitoba	611	236	1,194	922	2,963
Saskatchewan	506	214	1,483	698	2,901
Alberta	619	299	1,544	1,138	3,600
British Columbia	982	462	3,015	1,478	5,937
Yukon/Northwest Territories	7	1	12	13	33
Canada	8,306	3,741	24,909	15,527	52,483

Source: Based on Canada, *Report of the National Health Survey,* part 8, *Nurses,* (Ottawa: King's Printer, 1945), 218.

one [defined as registered nurses actively engaged in nursing in Canada] be given consideration; this would include nurses asking permission to go to the United States for post-graduate study during the duration [of the war]."[67] The CNA referred problems associated with the other three categories – "potential" student nurses applying to schools of nursing in the United States, married nurses who claimed they could not find work in Canada, and appeals from industries in other countries for Canadian nurses – to the individual provincial associations. Exceptions to the moratorium on labour exit permits were made for nurses over fifty-five years of age, nurses with "indifferent health," and student applicants "of special religious faiths and coloured students who cannot be placed in Canada."[68]

Changing Needs for Nurses during the War

Socio-economic conditions of the 1930s had shaped the context in which nursing sisters trained and entered the workforce, while leaders of the profession influenced the selection process, but events during the war itself constituted a third influence on the number and selection of military nurses.[69] In contrast to the First World War, the Canadian forces (and their medical units) entered this war as Allies with full responsibility for meeting the medical needs of Canadian troops rather than as "British soldiers recruited abroad." Defence Scheme No. 3 formed the basis of prewar planning, providing for an overseas field force. An official War Book contained details for organizing such a force but little else. The King government, aiming to strengthen national identity while distributing burdens and opportunities

Table 1.3

Applications to the armed forces submitted by Canadian nurses, March 1943

Province	Service							
	Army	Navy	Air Force	Navy Army	Navy Air Force	Army Air Force	Navy Army Air Force	Total
Prince Edward Island	18	3	2	1	4	0	0	28
Nova Scotia	137	59	21	14	5	8	9	253
New Brunswick	72	22	11	7	1	9	3	125
Quebec	283	89	79	42	16	34	25	568
Ontario	801	255	186	105	34	106	68	1,555
Manitoba	n/a	n/a	n/a	n/a	n/a	n/a	n/a	236
Saskatchewan	93	28	34	11	5	26	17	214
Alberta	n/a	n/a	n/a	n/a	n/a	n/a	n/a	299
British Columbia	230	73	64	27	14	33	21	462
Yukon/Northwest Territories	1	0	0	0	0	0	0	1
Canada	1,635+	529+	397+	207+	79+	216+	143+	3,741

Note: For Manitoba and Alberta, only the total number of applications was reported. Thus the Canadian total for each service was greater than the figure given in each case. The total for all services nationwide is accurate, since it includes the Manitoba and Alberta figures.
Sources: Based on *Report of the National Health Survey,* part 8, *Nurses* (Ottawa: King's Printer, 1945), 219.

(depending on one's perspective) equitably throughout different geographic regions, sought proportional representation for the armed forces.[70]

The initial commitment called for two military divisions (consisting of 50,000-60,000 all ranks) in support of the British army, as well as extensive involvement in the British Commonwealth Air Training Plan, with forty-eight air training centres scattered across Canada.[71] By the summer of 1940 a rapid German expansion into Belgium, the Netherlands, and France resulted in the formation of two more divisions, enactment of the National Resources Mobilization Act (NRMA), and a transition from "phony [sic] war" to "total war." The NRMA required all persons, services, and property to be available "as deemed necessary or expedient for securing the public safety, the defence of Canada …, efficient prosecution of the war, or for maintaining supplies or services essential to the life of the community."[72] The main medical needs during this first phase of the war involved screening recruits, administering immunizations, and managing communicable illnesses that occurred as large numbers of young men were transported across Canada, living together in large communal settings. A relatively small number of medical units in Canada and England, with limited nursing staff, were sufficient for these needs.

Between the summers of 1940 and 1943, a second phase of the war brought devastating air strikes during the Battle of Britain, the defeat of British forces in Hong Kong, and the failed Dieppe raid. There were five Canadian divisions (100,000-125,000 all ranks) overseas. With the exception of two battalions (1,975 soldiers) whose remnants became prisoners of war in Hong Kong after December 1941, Canadian troops were posted primarily for the defence of England and in preparation for the invasion of northwestern Europe.[73] Medical units increased correspondingly, particularly in preparation for casualties from Dieppe. Hospital units remained in England during this phase, and medical plans focused on evacuation of the wounded by trains and ships from the continent to military hospitals on the English coast. A small medical team, including two nursing sisters, accompanied the Canadian contingent sent to Hong Kong, working within British hospital units. They were there only three weeks when the Japanese attacked Pearl Harbor and overran Hong Kong in December 1941. The two Canadian nursing sisters were taken as prisoners of war, spending the next twenty-one months in a Japanese prison camp and a civilian internment camp.[74]

From the perspective of medical units, the second phase of the war involved treating more trauma, an increase in surgical care, and more experience in working under war conditions. This phase exposed various problems to be resolved prior to major campaigns and provided training opportunities, also known as "schemes," in northern England and Scotland.

The third phase of the war involved Canadian participation in two major campaigns: in Sicily and Italy beginning in July 1943, and the Allied invasion of

Table 1.4

RCAMC, RCAF, and RCN new nursing service appointments, 1939-45

Year	RCAMC	RCAF	RCN	SAMNS	Total	Cumulative
1939	151	0	0	0	151	151
1940	369	4	0	0	373	524
1941	380	237*	7	80	467	991+
1942	659	–	100	221	980	1,971+
1943	687	–	114	0	1,038	3,009**
1944	1,140	148	82	0	1,370	4,379
1945	270	23	38	0	331	4,710
Total	3,656	412	341	301	4,710	

* Total for 1941-43.
\+ Total plus RCAF appointments.
** Includes previous RCAF appointments.
Note: Table reflects only the total number of appointments made per year without adjusting for attrition or repeat appointments. It also includes non-nurses in the appointment statistics. The RCN and RCAF had no appointments initially because they had no nursing services. The SAMNS cohort was a one-time limited recruitment.
Sources: Based on data from "Appointment Statistics – Nursing Sisters, Physiotherapy Aides, Occupational Therapists, Dieticians and Home Sisters," 000.8(D93), Department of Defence Directorate of History and Heritage and RCAF memos of 2 December 1940, 23 October 1944, 30 January 1945, and a 1943 nominal list in files 400-1-1 and 400-2-1, RG24, E-1-b, v. 3365, LAC.

northwestern Europe beginning in June 1944. Involvement in these campaigns brought the medical units to peak strength and moved nursing sisters forward to the frontlines as they followed the troops in rapid advances across long distances. This phase introduced new settings in the Mediterranean and Europe (North Africa, Sicily, Italy, France, the Netherlands, Belgium, and Germany), different working conditions (frequently under canvas and requiring great mobility), and treatment innovations (increased use of blood transfusions and the introduction of penicillin). As well, the number of experienced nursing sisters in the field by this time permitted, and even favoured, the recruitment of younger nurses with less work experience as reinforcements to the rank.

The fourth and final phase was quite short in duration. By May 1945, 1,412 nursing sisters had volunteered for the Pacific campaign as the war in Europe drew to a close.[75] They had returned from overseas early to join others serving in Canada, in preparation for embarkation to the South Pacific, when Japan surrendered after atomic bombs were dropped on Hiroshima (6 August) and Nagasaki (9 August). For the military medical units, this last phase involved closing down hospital units and moving patients, first to England and then to Canada. For many patients and many nurses, there still remained long months and years of surgeries, recovery, and rehabilitation.

After they enlisted, almost all nursing sisters received an initial six-month posting in Canada. Some remained in Canada for their entire service, either by choice or because there were no overseas vacancies. RCAF nurses served

at most of the air training centres across Canada, often in small, relatively isolated units with only a few beds and little backup support. They also served at large training camps such as the one in St. Thomas, Ontario. Several small groups served in England at East Grinstead in Sussex, which specialized in the care of burn patients (typically pilots wounded during bombing assignments flown out of Britain), or with No. 6 Bomber Command in southern England at Odiham and Bournemouth. Two RCAF nursing sisters with No. 52 RCAF Mobile Field Hospital were the first Canadian nurses to arrive in Normandy, just thirteen days after D-Day on 6 June 1944.[76] RCN nursing sisters also served primarily in Canada, with the exceptions of those posted to RCNH *Avalon* in Newfoundland and HMCS *Niobe* in Scotland – land-based naval hospitals. A group of 301 nurses responded to the call for volunteers in South Africa.[77] They carried the same title and wore the same uniform as RCAMC nurses but once they left Canada, SAMNS nursing sisters served under the South African military authority with postings primarily in South Africa, although nurses who extended the original one-year contracts were posted to the Middle East, North Africa, and Italy as well.

Many facets contributed to the social construction of military nursing and nursing sisters. Medical units became an important part of strategic planning for major military campaigns – to manage human resources efficiently and minimize war "wastage." Whenever there was an increased need for nursing skills on the frontlines, eligibility criteria and military policies could be altered to enlist more nursing sisters.

Profile of Second World War Nursing Sisters

There is considerable variance in the literature regarding the number of Second World War nursing sisters, with an unknown number of non-nurses typically included in these reports and members of the RCN, RCAF, and SAMNS typically excluded from them.[78] After adjusting for multiple enlistments by the same persons, remustering of personnel when new nursing services formed, and non-nurses enlisted to the rank, I compared archival documents to reports from the secondary literature and estimated the total number of Second World War Canadian military nurses alone as 4,047 without the South African cohort or 4,348 with the South African cohort, compared to the 3,600 to 4,800 range found within the literature.[79]

I planned originally to review at least a thousand individual personnel records to increase the representativeness of my sample. On preliminary analysis, however, it became clear that non-nurses accounted for at least 8.2 percent of the records, that there were redundancies for some individuals, and that a few records contained insufficient data. The RCAMC was the only service to clearly document occupational categories other than nursing, and its figures of 64 dieticians, 64 occupational therapists, 58 home sisters, and 104 physiotherapist aides in its postwar statistical summary confirm the proportion

Although land-based hospitals, RCN medical units such as this one retained full naval traditions and language. Here unidentified nursing sisters and Surgeon Lieutenant Riddell leave the hospital at St. John's, Newfoundland, on 27 July 1942. *LAC/DND fonds/PA-137827*

of occupational categories within the rank that emerged in my analysis.[80] I therefore oversampled to ensure a final data set of at least a thousand nurses' records after adjusting for these factors. I sampled RCN, RCAF, and SAMNS records proportionately to the RCAMC records, resulting in a data set of 1,145 individual records: 1,052 nurses, 22 dieticians, 34 physiotherapist aides, 15 occupational therapists, and 22 home sisters (the last were responsible for the care and household management of the living quarters). Analysis indicates that, as nurses constituted 91.8 percent of the sample and non-nurses 8.2 percent, my

RCAF Nursing Sisters Jessie Young, Edna Millman, Elaine Matheson, Vera Soper, Jean Steinhoff, and Jackie Vanier arrived in England in September 1943, part of the newly formed No. 52 Mobile Field Hospital. They trained on the coast, receiving and evacuating patients to prepare for the D-Day invasion. Although an advanced team landed in Normandy only two days after D-Day, the full unit (including nurses) arrived on 19 June 1944. *Canadian Forces Joint Imagery Centre, PL-19964*

final sample represents 26 percent of the estimated 4,047 nurses who served through the Canadian armed forces during the war. This, then, is the sample for the demographic analyses that follow, compared to and supplemented by existing archival reports and records.

There were no legal restrictions on the title of nursing sister, and since gender superseded occupational classification, all women enlisted in the Canadian forces as nursing sisters prior to 1941. The Canadian Women's Army Corps (CWACs) and other Women's Divisions were formed between 1941 and 1942; in fact, RCAMC Matron Smellie was responsible for organizing the CWACs initially. When RCAF Matron Jean Porteous inquired if occupational therapists and physiotherapy aides could be called nursing sisters, for example, CNA General Secretary Kathleen Ellis replied that there was no objection because it was not a civilian title and "it only concerned the military."[81] Given that at least 8.2 percent of the nursing sister rank consisted of professionals other than nurses, it is important to clarify exactly who is included in particular demographic analyses and to differentiate between nurses and non-nurses.

The Canadian Army Medical Corps (CAMC) had established a precedent of including non-nurses in the rank, based on the very few women involved during the First World War. A small number of CAMC nursing sisters (nurses and non-nurses) served as physiotherapists, for example, but following the war, physiotherapy emerged as a distinct profession. The CAMC also included at least three dieticians and two women physicians as nursing sisters. During the Second World War, the different service branches made their own decisions regarding occupational categories included within the nursing sister rank. While physiotherapy aides and dieticians enlisted with the RCAMC and RCN as nursing sisters, the RCAF employed civilian physiotherapists in their units and delayed their enlistment until 1944, whereupon they assigned them to the Women's Division rather than include them in the rank. RCAF dieticians were also members of the Women's Division.[82] RCAMC and RCN occupational therapists enlisted as nursing sisters, but the RCN was the only service to include female laboratory technicians as well.[83] Home sisters were always members of the RCAMC and RCN nursing sister rank. They came from various backgrounds and occupational experiences, chosen for their "adaptability, resourcefulness, and diplomacy, … good educational background, pleasing personality, knowledge and experience in household management, and ability to direct as well as work with others."[84]

This practice of including non-nurses in the nursing sister rank proved problematic at times – for example, when immediate emergency nursing assistance was required during British air raids but the general public was unable to distinguish which nursing sisters were actually nurses. At the RCN land-based hospital in Scotland, the HMCS *Niobe*, policy required all nursing sisters to take turns being "on call" for night emergencies. As NS Elizabeth Dean, a dietician, recalled, "So I was put on call, too. I said, 'Well, that's fine. I can go down and make a cup of coffee or do something like that.' And the first time I was on call, a couple of Navy ratings … had had a real fight in a bar. And one of them was shot. So my kitchen became a morgue, and the others had to be surgically looked after, and the Matron decided, 'Well, I don't think Elizabeth should go on call because she is not much use.' Well, my kitchen was used!"[85]

Besides including non-nurses in the rank, the literature on distribution of nurses according to nursing service branches overestimates the total number of Second World War nurses. Without close critical examination of the data across the whole of the armed forces, it is easy to miss the impact of multiple enlistments and remustering when relying on enlistment figures tallied from monthly or annual official reports. My analysis, for example, reveals that at least 2.9 percent of the nurses served in more than one Canadian forces branch, while 22.8 percent of the Canadian nurses who initially served with the SAMNS served with a Canadian branch later (Table 1.5).[86]

The type and number of personnel required varied from service to service.

RCAF Nursing Sister Lynn Johnston, with one of several small Bomber Groups posted to southern England, may well have been one of the RCAF dieticians serving in the nursing sister rank. According to one caption for this photograph, she spent "many a long hour in the hospital kitchen trying to make British war rations please patients' palates." The RCAF was particularly interested in the nutrition of pilots as it related to peak performance on long bombing missions and excellence of night vision for air raids. *Canadian Forces Joint Imagery Centre, PL-33084*

The RCAF, for example, required fewer non-nurses because its medical units remained mostly within Canada, where civilian employees were readily available to work on local military bases. And because nurses contested RCAF attempts to alter their rank and status, the authorities seemed increasingly determined to keep other women workers out of the military. In contrast, the RCAMC operated at least 117 hospitals within Canada, 25 hospitals

Table 1.5

Distribution of sampled nurses within Canadian Armed Forces nursing services, 1939-45

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

Source: Based on data extracted from Department of National Defence personnel files for 1,052 Second World War Canadian military nurses, Library and Archives Canada.

of various sizes overseas, 2 hospital transport ships, several hospital trains, a small number of air ambulances operating between the continent and England, and a variety of mobile medical units deployed in several theatres of war.[87] With such a large organization and the need for flexibility in staffing them, it was essential for the RCAMC to have full control over all their personnel, both nurses and non-nurses.

Initial eligibility criteria required nursing sisters of all branches to be between twenty-five and forty-five years of age, although the minimum was lowered to twenty-three in May 1942, and to twenty-one by September 1943, while the upper limit increased to fifty-five years as the military prepared for two major campaigns.[88] With an abundance of applicants, the armed forces could be selective, and they were particularly interested in the more experienced nurses who had teaching and supervisory abilities, skills often missing in new graduates. NS Pauline Lamont recalled enlisting on her twenty-third birthday. NS Ella Beardmore applied every time she went to Toronto but always received the same response, that she was too young, until she finally got her acceptance.[89] Once there were sufficient experienced nurses in place, younger nurses could be safely accepted as reinforcements into established units where they could be mentored and monitored. As a result, the average age of nursing sisters decreased after 1943. Prior to 1943, only 0.9 percent of the nurses were between twenty-one and twenty-two years old at enlistment; after 1943, however, 3.6 percent were in that age bracket. Prior to 1943, 9 percent of the nurses were over thirty-five, and 3.2 percent of these were over forty. Nurses in their late forties and early fifties brought years of experience, including previous war experience, as was the case for the two oldest women in this sample, who were fifty-two and fifty-four years old on enlistment and had served during the First World War. Diversity of practice settings and roles accommodated this wide range of ages.

The nurses tended to be older, on average, than dieticians, physiotherapist aides, and occupational therapists, but younger than home sisters (Table 1.6). This can be explained partially by different training requirements. Nursing schools required applicants to be at least eighteen or nineteen years

Table 1.6

Canadian nursing sisters by occupation and age on enlistment

Occupation	Number in sample	Average age	Minimum age	Maximum age
Registered nurses	1,052	28.03	21	54
Physiotherapist aides	34	26.08	20	42
Dieticians	22	26.95	22	36
Home sisters	22	33.04	25	45
Occupational therapists	15	23.26	19	32

Source: Based on data extracted from Department of National Defence personnel files for 1,052 Second World War Canadian Nursing Sisters, Library and Archives Canada.

old, with junior matriculation as the minimum educational requirement for admission, and the training programs extended over three full years. The military preferred a minimum of two years' experience after graduation and often gave higher priority to more-experienced nurses. In addition, in a bid to enhance their credentials for application, many nurses took extra courses of six to twelve months' duration after graduation from training programs. While the youngest age for a nurse with full nursing credentials was twenty-one to twenty-two years, those with post graduate courses and required experience were typically twenty-three to twenty-five years old. Additional experience raised the average age higher still. In contrast, physiotherapist aides and occupational therapists were not only eligible for university programs at a younger age than nursing students but they had no experience requirements prior to enlistment. Some even completed the internship component of their training as part of their military service.

Many of the nurses (40.8 percent) were born during the First World War, trained during the Depression (between 1933 and 1937), and graduated into the nursing workforce during one of the worst employment periods. Like other children of their generation, many had lost one or both parents to the war or the global influenza epidemic of 1918-19: more than 30 percent of them reported the death of one or both parents. These nurses needed to work, not simply "to fill time" between school leaving and marriage, but for personal survival and family obligations: 8.4 percent indicated that they supported dependent relatives – parents, siblings, or relatives who had raised them in lieu of parents. The range of such support, which varied from $5 to $90 per month with an average of $30 per month, needs to be understood in comparison to average civilian nursing salaries during the 1930s. In spite of recommendations from the Weir Report and the CNA, the Depression had continued to exert downward pressure on nurses' salaries. The support of dependants was a significant commitment for nurses – one that a regular military salary of $150 per month plus food, lodging, clothing, and medical care made much easier.

As noted earlier, there were quotas for each military district in an attempt to equalize nursing losses to civilian hospitals. These quotas were proportioned according to provincial population and nursing needs but failed to take into account the large numbers of nurses who trained outside of their home provinces or their practice of registering both where they trained and in their home communities. Nurses could, therefore, apply to the military in more than one district. More nurses enlisted in British Columbia, Ontario, and Quebec because they trained at the large, well-known training schools in Vancouver, Toronto, and Montreal. Nurses frequently wrote their registration exams in the province where they trained and, because registration in a provincial association was required for enlistment, they could then apply to the military in that province.

By far the greatest proportion of military nurses in my sample were born in Ontario (31 percent); those born in Quebec (11 percent) and Saskatchewan (10.4 percent) constituted the second- and third-largest groups in the service. The largest number of enlistments also occurred in Ontario (35.6 percent), with enlistments in Quebec a distant second (16.7 percent). The Maritimes and the Prairie region, with the exception of Alberta, had substantially higher percentages of nurses enlisted compared to their civilian nurse population overall (4.5 to 9.9 percent), partially reflecting regional economic disparities. A small number of nurses enlisted in England, for a variety of reasons that will become apparent later.

Although the armed forces initially required at least two years' experience, some nurses evaded this restriction either by personal influence or because the military needed a particular set of skills. Nurses enlisted with an average of 4.7 years of experience, although 13.6 percent had ten or more years of experience. In reality, these averages meant that experience ranged from none, for those few nurses who enrolled as reinforcements at the end of the war, to twenty-nine years of teaching, supervision, and hospital administration.

At least 80.4 percent of the nurses in this study reported having had experience either in general duty nursing, private duty nursing, or some combination of both. Other nurses combined general duty nursing with a range of practice settings or even non-nursing work experience. Although they preferred private practice, they needed to take cases in hospitals as well, where they "specialed" patients too complex or unstable for student nurses to manage and wealthy patients who could afford a private nurse for hospital care. Other types of experience listed by the nurses included: public health (6.4 percent), operating room nursing (14.1 percent), psychiatric or mental nursing (1.7 percent), teaching (3.0 percent), supervising (19 percent), X-ray (1.6 percent), and military nursing experience either from the First World War or a term with the SAMNS (1.6 percent).

Nurses, in general, used a variety of educational paths to climb career ladders and the profession benefited from a trend of more girls completing

high school during the 1930s. As nursing programs increased the minimum age for entry to training, young women used this interim period between leaving high school and the start of nurses' training to develop a variety of other work skills that ultimately proved to be assets in their nursing roles.[90] A small number of Canadian nurses (1.1 percent), for example, were among other university students who "quietly endured a Depression economy, hoping to use their education as an instrument of survival" and armed themselves with "credentials expected to pay rewarding dividends at some point."[91] Other nurses took advantage of a variety of business courses marketed to young women of this period. Such courses were important for working- and middle-class women during the 1920s and 1930s, offering them ready access to overwhelmingly female courses such as typing, shorthand, stenography, and bookkeeping.[92] For many nurses, these secretarial courses had paved the way for earning teaching certificates, which, in turn, had covered the expenses associated with nurse-training programs such as uniforms, shoes, and textbooks. As well, during the Depression both clerical and teaching jobs were increasingly reserved for men but nursing was a "safe" and socially acceptable field of employment for women – one with little competition from men. Successful completion of prior educational programs was considered an asset when applying to a school of nursing. Business courses and teaching certificates provided good backgrounds for myriad educational, supervisory, and administrative roles that became part of graduate nurses' responsibilities. A surprising number of nursing sisters (6.2 percent) had earned teaching certificates and teaching experience before entering nursing programs, and at least 7.7 percent had completed business courses.

It was also a common practice for nurses to take so-called postgraduate courses after completing their basic training, in order to gain additional skills and consolidate recently acquired ones. Courses in operating room technique, obstetrics, pediatrics, tuberculosis nursing, industrial nursing, mental nursing, and dietetics supplemented basic training and created a more flexible, more experienced workforce. Larger teaching hospitals, such as the Montreal General, the Toronto General, and the Montreal Neurological Institute for mental nursing, typically offered these courses, which consisted of three to twelve months of specialized training. Teaching, supervision, and public health nursing were typical postgraduate programs, earning a certificate (for a one-year course) or a diploma (for a two-year course) at the University of Toronto, McGill University, or the University of British Columbia. At least 22.6 percent of the military nurses reported the completion of one or more of these courses prior to enlistment.

One conspicuous, although not surprising, characteristic of the nursing sister population was its exclusively feminine construction. In Canada, nursing had been stereotyped as women's work since at least the 1880s, and hospital schools of nursing reinforced this perception by admitting only

women to their programs, with a few exceptions such as the Victoria General Hospital in Halifax, and psychiatric hospitals in Alberta and Ontario.[93] As one CNA recruitment brochure promised, "You will not, as in other professions or business, be handicapped by having to compete with men for top positions – nursing is a woman's profession, and women hold top positions."[94]

Few men challenged that convention during the 1920s and 1930s, and although the Canadian census for 1941 reported 153 male nurses and 73 male student nurses, military policy continued to prohibit men from serving as professional nurses until 1967.[95] Hospital training schools typically required student nurses, and even graduate nurses hired as hospital employees, to live in residence – providing a ready argument for the exclusion of men based on prohibitive costs for separate facilities. As early as 1940, however, the Ontario Hospital at Hamilton, part of the provincial mental hospital system, accepted men into nurse-training programs that included an affiliation period at the Toronto General Hospital. Other Ontario Hospital sites followed suit, enrolling at least forty men on four sites.[96] Even when men gained access to training programs and could register in some provinces such as Alberta and Ontario, other provinces denied them registration, as the Association of Nurses of the Province of Quebec did until December 1969.[97] Without eligibility for provincial registration, these men could not join the armed forces as nurses. NS Estelle Tritt recalled working with a male ward master at No. 7 CGH who was a trained nurse and had been denied rank.[98] A few male nurses enlisted with the RCN and served as sick berth attendants on ships. But this was not the equivalent of serving as a professional nurse, nor did it carry the rank and status granted to nursing sisters. The RCN Nursing Service was for women only, just as the other armed forces nursing services were.

The marriage bar was another issue that caused a great deal of consternation between 1939 and 1943. Initially, as set out in *King's Regulations and Orders*, nursing sisters had to be unmarried or widowed without children. A candidate signed an "undertaking" on enrolment, not to request permission to marry within her first year of service and promising that if she did marry while overseas, she would "relinquish all claims" that she might have "to be returned to Canada at the public expense, and undertake to make no claim for transportation pertaining to such return." After the first year, nurses still required permission to marry from the commanding officer and had to resign their commissions.[99] Since schools of nursing admitted only unmarried and widowed women, and civilian graduate nurses who married had to resign their positions as well, the armed forces' policies were consistent with social expectations.

With an abundance of nurses waiting to enlist, there was little incentive to alter the marriage policy during the first years of the war. As the need for nurses increased and the war continued, however, obligatory resignation upon marriage became both unenforceable and problematic. One nurse

who signed the undertaking in June 1942 requested permission to marry only four months later. When denied permission, she married anyway and informed her commanding officer two days after the wedding. Marriage without permission carried the possibility of court martial, as well as the loss of benefits such as medals, war gratuities, and educational credits. It required the intervention of Matron-in-Chief Smellie to prevent such serious consequences in this particular case.[100] By January 1943, Matron-in-Chief Smellie informed nurses that "appointments of Nursing Sisters are not now automatically relinquished on marriage and the Nursing Sister would have to request her discharge if desired."[101]

According to RCAMC statistics, marriage was the primary reason for nursing resignations: two in 1939, twenty-five in 1940, fifty in 1941, and seventy-four in 1942. Discharges for 1943 dropped to sixty-two as more married nurses chose to remain in the service once that option became available. Three specific examples from the records illustrate how changes to marriage policy affected nurses. One nurse married in 1922, divorced, remarried, and then became a widow – making her eligible for enlistment. Another nurse married in 1942 but had to resign based on the current policy. She re-enlisted after becoming a widow and subsequently remarried in 1944 without having to resign. A third nurse married after the policy change and chose to remain in the service; she later became a widow and married again in the military.

RCAMC statistical reports support the analysis of marital status in my sample that 83.3 percent of nursing sisters remained single throughout their term of service; 0.8 percent were widowed on enlistment; 0.2 percent were divorced; 0.3 percent were married; and 15.3 percent married while in the military.[102] Married nurses presented problems, however, because of their repeated requests for postings near spouses and their pregnancies, which required them to be "boarded out" of the service. The director of Medical Services (Air) summed up his opinions in a 1943 memo: "Nursing Sisters rarely give as wholehearted service to the RCAF following marriage for the reason that their interests have changed and they naturally would prefer to live with their husbands." He even went so far as to document the changes in attrition rates after marriage with statistics.[103]

The military was losing experienced nurses to marriage just as plans were developing for the two major offensives of 1943 and 1944. At a matrons' conference during May 1943, Matron-in-Chief Smellie confirmed that married nurses would not be admitted to the armed forces but, if they married after enlistment, they could remain on duty as long as they were "medically fit" (i.e., not pregnant) or they could retire "on compassionate grounds."[104] A Department of National Defence memorandum justified the change, noting that "if nurses coming into the service feel that they must refrain from marriage during their service, very few nurses of the proper age could be induced to enter the Army, and one year 'undertaking not to marry' was all

that [could be] demanded of them."[105] Additional policies shaped marriage as a career-limiting move, however: married nurses were not permitted to serve in active theatres overseas. As a result, nurses typically delayed marriage until the end of the war, when they had little to lose in terms of nursing opportunities. Although only 0.6 percent of them had married prior to 1943, 2.9 percent married during 1943, and 9.4 percent between 1944 and 1946.

Canadian nursing sisters were a relatively homogeneous group in terms of race, ethnicity, origin, religion, and language, raising the question why. Scholars now examine race and ethnicity as socially constructed and historically situated concepts that require careful analysis of supposedly objective data such as census information, attestation papers (the official personnel information forms filled out on enlistment) and even one's self-identification, given what was at stake in claiming certain racial or ethnic origins.[106] Identities held different meanings that worked both for and against individuals. Decisions to disclose or hide ethnic origin or linguistic ability could ensure social acceptance that hinged on an individual's "sameness" with the dominant group. Conversely, identification with a non-dominant ethnic or language group could be perceived as a potentially valuable asset for overseas postings where soldier patients spoke a variety of languages. Some nurses who indicated that they spoke German or Ukrainian claimed these respective ethnic origins on the forms, for example, but others did not. Birthplace offers another potential indicator of ethnicity, as in the 1921 Canadian census, in which the population was assigned to one of two main categories: Canadian- and British-born persons, and those "Born in Other Foreign Countries."[107]

In order to examine race and ethnicity in relation to military nurses, I used multiple sources of information from the attestation papers regarding place of birth, citizenship, language, and religion, because no one type of information was adequate. All nursing sisters claimed either British citizenship, an essential criterion of military service, or referred to themselves simply as "Canadian," although Canadian citizenship did not officially exist until 1947. Analyses by place of birth, parents' place of birth or citizenship, religion, and spoken languages combine to reveal some important differences among the nurses, but the overall lack of diversity exposes systemic biases against the enlistment of black, Asian, and First Nations women. In the United States, black nurses engaged in a protracted and highly politicized campaign to gain entry to the armed forces during the Second World War. Historian Darlene Clark Hine argues that the war was a "watershed" experience that ultimately led to the breaking of the colour bar in the United States.[108] In contrast, black Canadian women who wanted to become nurses had to train in the United States or elsewhere, and there was no parallel black nursing organization in Canada to mount a campaign for inclusion in military service.

Military recruitment policies among First Nations men reveal multiple

forms of discrimination. For example, initial RCN recruitment policies required personnel to be of "pure European descent and of the White Race"; similarly, RCAF and army requirements stated that recruits were to be of "pure European descent with parents who were British subjects."[109] At the height of the conscription crisis in 1943, however, the Privy Council altered these requirements, permitting the recruitment of men of all racial origins.

Yet formidable barriers continued in the form of educational requirements and health standards that First Nations peoples still found difficult to meet. Given that, according to one study, 75 percent of First Nations children completed only one to three grades of formal schooling during the 1930s and few ever achieved junior matriculation (completion of Grade 12 in Ontario or Grade 11 in the rest of Canada),[110] the lack of educational opportunities would certainly have also prevented First Nations women from entering nurse-training programs.

According to the 1941 Canadian census, 72 percent of employed nurses were of British origin and 20.1 percent of French origin, with the remaining 7.9 percent from German, Italian, Jewish, Dutch, Polish, Russian, Scandinavian, or Ukrainian backgrounds. There were only seven "Indian" or First Nations nurses and thirty Asian nurses in the census, and no black nurses identified.[111] The military nursing profile was similar to the civilian profile. The vast majority of military nurses were born in Canada of either British or French backgrounds (92.6 percent) or born in Great Britain and immigrated as children to Canada (a further 4.7 percent). The remainder (2.7 percent) were born in continental Europe (Belgium, Denmark, Sweden, Italy, and Czechoslovakia), South America (Argentina and Peru), Asia (as missionaries' children in China), Russia, and South Africa.

But place of birth sometimes obscures a level of ethnicity that becomes more apparent when combined with analysis of parental birthplaces. Since one of the two variations for attestation forms did not request information on parents, 558 records (53 percent) did not provide it. Analysis of the remaining 494 records, which do include this information, indicates that only 60.7 percent of fathers and 63.8 percent of mothers were Canadian born, suggesting that approximately 40 percent of the nursing sisters were first-generation Canadians; 22.5 percent of fathers and 20.4 percent of mothers were born in Great Britain, indicating that the nursing sisters also had very strong British ties. Indeed Ethel Johns, editor for the *Canadian Nurse*, waxed eloquent on British professional and personal roots in 1940, ignoring the French-Canadian nursing heritage altogether and writing, "Although we Canadian nurses have distinct and vigorous characteristics of our own, our roots go deep into the rich soil of British tradition. The simplicity, the thoroughness, the devotion of the nurses in the Old Country are a continuing inspiration to us. This is the shining armour with which we may clothe ourselves in the day of battle."[112]

Although familial connections to Britain do not adequately explain such

strong Anglo-bias within the nursing sisters population, they do partially explain differences in volunteer rates compared to French-Canadian and American nurses. Other factors, such as the dominant language used within medical units and questions of reciprocity (mutual recognition of nursing credentials between countries), also came into play. The Canadian armed forces medical units functioned predominantly in English after initial plans for francophone units did not materialize. As several nurses pointed out, francophone nurses were typically posted to Kingston for language training soon after their enlistment.[113] NS Gaëtane LaBonté was one French-Canadian nurse who claimed that she enlisted "quickly while my parents were away for the summer. When they came back, it was 'fait accompli.'" LaBonté and her francophone nurse colleagues were among those sent to Kingston, where, as she said, "It was very hard for us who spoke English in a limited way … The nurses would give the lectures and they would stop. And then one of us would translate to make sure."[114] Her unit mobilized early and moved overseas quickly because the RCAMC wanted a French-speaking hospital unit ready to move to France when the opportunity arose. But France quickly fell to Germany, and LaBonté's unit spent the next two and a half years waiting in England, where "we thought the worst was over, as we had been transplanted very suddenly from our cosy French milieu to a completely different world in English … I was soon called 'All Wet' because [the matron] would order me to sing that thing of a song that my generation never sang: *Allouette*."[115]

It is unclear whether Quebec-trained nurses initially had reciprocity to practise in England, as their provincial association had an associative relationship only with the CNA. But Frances Upton, president of the English professional nursing organization in Quebec, reported in 1942 that, "reciprocity has been established between our organization and the General Nursing Council for England and Wales, a fact we have hoped for many a long day."[116] Whether this delay actually deterred French-Canadian nurses from enlisting is unknown: opposition to conscription in French Canada during both wars may well account for at least some of the discrepancies in enlistment rates.[117] Demographic analysis does illustrate that the vast majority of military nurses who were born in Quebec, or enlisted there, trained at one of the two large English-speaking schools of nursing in Montreal: the Montreal General Hospital or the Royal Victoria Hospital.

Language may serve as another indicator of ethnicity, particularly the one that a respondent lists first when answering a question about what languages are spoken and read. Nurses' responses to the language question may have been contingent on what they believed to be at stake personally, and there was no formal assessment of language performance. Based on their self-reports, then, 85.5 percent were unilingual anglophones, 0.3 percent were unilingual francophone, and 10.3 percent were bilingual in French and English. At least 4.0 percent were multilingual, speaking languages in addition

to English, French, or both: Danish, Dutch, Finnish, German, Icelandic, Italian, Norwegian, Polish, Russian, Slovak, Spanish, Swedish, Ukrainian, Arabic, Chinese, Flemish, and Czechoslovakian.

Religion is another variable loosely associated with race and ethnicity. The vast majority of military nurses reported themselves to be either Protestant (77.9 percent) or Roman Catholic (20.8 percent). In spite of discriminatory training-school admission practices, some Jewish women (0.4 percent) did acquire professional credentials and enlist in the armed forces as nursing sisters. NS Tritt applied at the Montreal General Hospital School of Nursing but found that it did not accept Jews, apparently because "they get married too soon." She reapplied successfully to the Reddy Memorial Hospital in Westmount, graduating in 1941. After working at the Jewish General Hospital to acquire the necessary two years' experience, Tritt joined the RCAMC.

Another notable aspect of homogeneity is the influence of class on the social construction of nursing. Although student nurses came from both working- and middle-class families, the nursing profession resembled other middle-class female professions regarding educational criteria for admission to training schools and the length of training programs.[118] Nurse leaders, in their push for recognition as a legitimate profession, had by the early 1940s raised the minimum educational criterion for admission to training schools to the junior matriculation level. At the same time, they achieved control over accreditation of schools of nursing, enabling them to regulate both the length and content of training programs. These two strategies effectively limited the profession to women who could afford both the time and expense of prolonged education, as they typically could not complete their training until they were twenty-three or twenty-four years of age.

Like race and ethnicity, class is a socially constructed and historically situated concept. It is one of several intersecting variables of difference and problematic as a category of analysis.[119] Although we lack clear criteria and means to determine class, it is generally understood as the "milieu within which one lives and from which one takes one's cues in almost all aspects of behaviour, but it is a milieu from which it is possible to escape and achieve some upward mobility."[120] Traditionally, sociologists have used indicators such as income, ownership of property, level of education, degree of occupational skill, and positions of responsibility or power to determine class. More subjective indicators include occupational ranking based on public opinion polls and ranking based on prestige in lieu of wealth or power. The most commonly used criteria, however, are: income, property ownership, education, and occupational status based on level of skill (professional, managerial, clerical, semi-skilled, unskilled, manual, or non-manual).[121]

Gender complicates class analysis, as women's experiences are not adequately reflected in the criteria traditionally used to determine class. The assumption that women "share" the family class position based on their father's occupation

RCAMC Nursing Sister Estelle Tritt. *Courtesy Estelle Tritt Aspler*

has dominated past analyses of class.[122] But women's historians warn that, although this practice of shared class is sometimes useful, it is fundamentally imperfect since "the terms 'working class' and 'middle class' should be regarded as a guide to the status and power of women's families rather than as a reliable measure of women's ability to command resources or to share in full the values of male capitalist society."[123] The nursing profession tended to attract women with both the resources and family support necessary for an extended period of training: assets associated with middle-class families.[124] As McPherson contends, the gendered configuration of household resources was a more crucial determinant of class than the position of the male head of household, and she demonstrates that nurses came from a range of class backgrounds. Student nurses typically had a higher level of education prior

to nurses' training compared to other working women, and yet working-class women were still well represented.[125]

Acknowledging the problems associated with the use of fathers' occupations as an indicator of class for women, I nonetheless adopted this approach to examine the class origins of military nurses. It is important to note, however, that these nurses were fully qualified professionals; the majority had at least two years of independent work experience prior to enlistment and at least 10.5 percent of them had either college or university education as well. Nurses were relatively privileged among working women, despite the Depression that left many of them barely able to live independently.

The Canadian census offers a comparison between the class positions of military nurses and the general population of the same period, in spite of the limitations with occupational census data in 1941.[126] The census categorized work into twelve main categories based on sectors of employment rather than social class indicators such as relationships to the means of production. For example, seven of the twelve categories included owners, managers, and labourers within the same categories of manufacturing, trade, construction, logging, mining and quarrying, personal service, and transportation and communication.

Personnel records asked if a soldier's father were living and, if so, what his occupation was. The formulation of this question resulted in a data gap if the father was dead, which was the case for 23.7 percent of the records. Deaths and files in which the occupation was not recorded constituted 43.2 percent of the records in this sample, while another 6.8 percent reported fathers only as retired, incapacitated, in the military, or unemployed, with no other indication of previous employment. Although the forms asked only if a soldier's mother were living, two nurses assertively added "housewife" as an occupation on the form. Data from the oral histories reveal that at least 34.8 percent of mothers had worked prior to marriage. Some also worked after marriage: one was a nurse, five were teachers, one was a grocery store clerk, and one was a factory supervisor.

Acknowledging these limitations, I adopted the 1941 census categories to examine the occupations of military nurses' fathers. In spite of socio-economic disruptions during the 1930s, the class backgrounds of nursing sisters remained remarkably stable, based on comparisons to both the Weir Report and McPherson's analysis of the civilian nursing workforce.[127] Among military nurses, 34.2 percent of fathers worked in farming, fishing, or ranching; 41.3 percent in professional, business, and clerical positions; and 23.8 percent in skilled, semi-skilled, and unskilled occupations; 0.7 percent were men of independent means. Thus, 23.8 percent of the nurses were from working-class families and 75.5 percent were from middle-class families.

The 1941 census considered nurses as professionals, categorizing them with architects, authors, clergymen and priests, dentists, civil engineers, judges

and magistrates, lawyers, physicians and surgeons, professors, social workers, and teachers – regardless of fathers' occupational status. Class was, and still is, problematic in nursing because it intersects with gender, race, and ethnicity to privilege some nurses over others. "Nurse" was not a universal category but rather reflects a wide range of roles that nurses assumed: hospital bedside care, administration of hospitals and schools, independent practice in outposts, management of employee health programs in industries, private duty and public health, teaching in hospitals and universities. Although Second World War nursing sisters came from both working- and middle-class backgrounds, they often parlayed their education, expertise, and military officer status to reposition themselves on an individual basis during and after the war.

It is difficult to compare Canadian military nurses with other military nurses because very few studies have examined them demographically, except for aggregate data. Reading American, Australian, and British literature "against the grain," however, one gleans some comparative insights. Approximately 52,000 American nurses served with the United States Army Nurse Corps (USANC) during the Second World War, working in over 120 military hospitals and on more than 40 hospital ships.[128] Frequently described as "young in years, and in the service,"[129] American women recruited into the new USANC Cadet Nurse Corps program received an abbreviated training program wherein they could spend the last six months of their training in federal hospitals, thus helping to meet the quota for military nurses.[130] American nurses have been portrayed as younger than their Canadian counterparts and less experienced in terms of postgraduate courses and graduate nurse experience. Whereas Canadian nurses enlisted with extensive post-training courses in operating room techniques and years of nursing work experience, for example, the USANC did not offer formal operating room courses until 1944, and nurses became proficient primarily through "on-the-job" training.[131] And whereas Canadian military nurses were from a range of class backgrounds, American nurses who served on the South Pacific island of Bataan, for example, have been described predominantly as having "grown up on farms or in towns … labored in the fields, made their own clothes, and read by lamplight, and they knew how to live lean, without amenities, and were accustomed to hard work. The Army had given them luxuries and a new life, and now it was time to pay the Army back."[132]

Like Canadian nursing sisters, all American military nurses were women. The service was also predominantly white, although black nurses lobbied for, and finally gained, admittance to the army during the conscription crisis when there were insufficient numbers of white volunteers.[133] Perceived as less-skilled workers and regarded by the American public as less desirable for the care of white soldiers, black military nurses reported that they were assigned to less pleasant cases such as prisoners of war. While Chinese-American, Puerto Rican, and Native American women were assigned to

racially integrated units, Japanese-American and black nurses served in segregated units.[134]

Australian military nurses shared a strong demographic resemblance to Canadian nursing sisters.[135] Analysis of 3,477 Second World War Australian nursing sisters indicates that 92.6 percent were Australian-born and 83.6 percent claimed Protestant church associations. Approximately one-third of them were daughters of farmers, and at least 22 percent had working-class backgrounds. The average age was 28.5 years, with a range of 22 to 39, which was narrower than that of Canadian nurses. All were British subjects. Like Canadian nurses, they had to be unmarried on enlistment and resign on marriage, until policies changed during 1942. To date, there have been no other analyses of demographic variables, training, or experience for comparison.

Accounts of Second World War British nursing sisters, primarily the Queen Alexandra's Royal Army Nursing Corps, contribute valuably to knowledge of the larger international military nursing context. But lack of attention to demographic analyses limits our ability to generalize from these accounts, to make comparisons across national nursing services, or to synthesize from the experiences of thousands of rank-and-file nurses who made up the vast majority of military nursing services.[136]

The social, professional, technological, and military contexts of the 1930s positioned Canadian nurses as a readily available, feminine workforce who volunteered in overwhelming numbers for the armed forces. Nurses had a great need for work, and they were well-prepared with skills, education, and nursing experience, which they used to enhance their applications for military service. Reliance on the civilian profession to train nurses and provide them with credentials relieved the military of the burdensome tasks and costs associated with the enlistment of nurses only for the duration of the war.

With access to such a large pool of recruits, the two remaining issues for the Canadian forces were how to balance military needs with perceived civilian needs for nurses, and which nurses to select. Eligibility criteria set by the military established the basic parameters for who could become nursing sisters, although other factors helped shape the actual distribution of demographic characteristics within these parameters. Hospitals, along with the nursing profession, imposed additional official and unofficial restrictions on enlistment. But the nurses were also actively influencing their own appointments and resisting various barriers that threatened to prevent appointments. Enlistment, however, was only the beginning of military nursing service. The next challenge was how to transform civilian nurses into military nurses.