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Abstract: This article analyses the federal government pension files of forty Canadian women who nursed for the Canadian Army Medical Corps (CAMC), exploring aspects of their health, work and family lives in the decades immediately following the First World War. The sample exclusively features nurses with ties to the region of Southwestern Ontario but in demographic terms is also largely representative of the entire body of CAMC nurses. Collectively, the files depict nurse veterans who mobilized their medical knowledge and professional networks when faced with challenging health situations, pursued diverse postwar employment strategies, and in some cases played crucial roles in the financial support of their kin. Clearly, the First World War did not discriminate by gender when it came to casting a long shadow over the health, careers and family relationships of those who served.

It would be difficult to find a story better suited to shatter the prevailing image of Canada's First World War nursing sisters as gentle, ladylike angels of mercy than that of Mary Mason.[1] A native of rural Huron County, Ontario, who spent much of her working life in Hamilton and Fort Erie, Mary spent twelve years fighting with federal officials over her entitlement to a pension, the amount she eventually received and her diagnoses themselves. A relentless but

[1] Nurse veterans for whom proof of death has been located are referred to by their full names; in keeping with federal privacy policy, others will be referred to by first name and last initial only. Since not all nurses will be identified by surname, for consistency's sake first names will be used in subsequent references within the text.

troubled self-advocate, Mary was alternately confident in her medical knowledge, suicidally depressed, righteously determined and angry to the point of violence. On one occasion, she refused to leave her bed in the Dominion Orthopaedic Hospital in Toronto until she received "satisfaction" and "justice." In the early 1930s, at the height of her struggle, she reportedly announced she would go to Ottawa herself and if officials there would not help, she would "do away with the first man she met connected with the Department and then herself." The stakes were high: whatever income Mary could scrape together as a single woman supported not only herself but her orphaned, invalid nephew. This was no one-dimensional saintly nurse, but a woman whose postwar life was shaped by a potent combination of poor health, an inability to work and family obligation.[2]

Cynthia Toman writes in her definitive study of Canada's First World War nursing sisters that these women "enlisted expecting to encounter some hardships and to endure whatever came their way, but they had not anticipated that their work would place them in danger and that, like other soldiers, some of them would die."[3] They probably gave even less thought to the long-term effects of their service if they survived. Mélanie Morin-Pelletier's research has shown that many nurse veterans who graduated from prominent Toronto and Montreal training schools took advantage of their professional networks, new educational opportunities and emerging fields of work to launch successful and satisfying postwar careers.[4] This article considers a cohort of nurse veterans whose lives took a different turn: women for whom poor health or financial need brought them into the sphere of the Department of Soldiers' Civil Re-establishment (DSCR) and later the Department of Pensions and National Health (DPNH). An analysis of the pension records of forty nurse veterans with ties to Southwestern Ontario makes it clear that Mary Mason's struggle reflects larger trends. Nurse veterans facing health challenges after

[2] Mary Mason, CPC 212513, reel 945, Veterans Affairs Canada [VAC] pension files, Laurier Military History Archive [LMHA].

[3] Cynthia Toman, *Sister Soldiers of the Great War: The Nurses of the Canadian Army Medical Corps* (Vancouver: University of British Columbia Press, 2016), 218.

[4] Mélanie Morin-Pelletier, "At Peace with the Germans, but at War with the Germs': Canadian Nurse Veterans after the First World War," in *Canada 1919: A Nation Shaped by War*, eds. Tim Cook and J.L. Granatstein (Vancouver: University of British Columbia Press, 2020), 190-203; and Mélanie Morin-Pelletier, "Héritières de la Grande Guerre. Les infirmières militaires canadiennes durant l'entre-deux-guerres" (PhD thesis, University of Ottawa, 2010).

the war mobilised their medical knowledge and their professional networks to self-advocate and/or self-treat; they engaged in a wide range of postwar employment strategies and financial arrangements, often involving family members; and they grappled with the long-term legacies of war service on their health, careers and family relationships.

NURSING SISTERS OF SOUTHWESTERN ONTARIO: THE SAMPLE

This study focuses on the files of forty nursing sister veterans with ties to the region of Southwestern Ontario,[5] a triangular peninsula bounded on two sides by the Great Lakes waterway system and on the third side stopping shy of the Niagara Escarpment and the Golden Horseshoe region at the western end of Lake Ontario. The counties therein (Essex, Kent, Lambton, Huron, Perth, Middlesex, Elgin, Oxford, Norfolk, Brant and Waterloo) enjoy a moderate climate, fertile farmland and a large number of small-to-medium-sized urban centres. The sample therefore includes women who trained in smaller places like St. Thomas or London and broadens the picture that emerges from Morin-Pelletier's research.[6] However, since being born in, or enlisting in, Southwestern Ontario does not necessarily correlate to a deep or lifelong connection to the region, no argument is made for a distinctive Southwestern Ontario nursing veteran experience. Instead, the demographic similarities between the women in the sample and the larger body of Canadian Army Medical Corps (CAMC) nursing sisters suggests that these

[5] With the help of Cynthia Toman's comprehensive database of First World War Canadian Army Medical Corps (CAMC) nursing sisters, a preliminary pool of 735 nursing sisters who were born in *and* enlisted in Ontario was identified. This pool was searched for women who were born in *and/or* enlisted in the Southwestern Ontario counties listed in the text above. Of the 171 women thus identified, 40 (23 per cent) have pension records with Veterans Affairs Canada, a number reasonably in line with the roughly 28 per cent of all Canadian First World War nursing sister veterans who have pension files.

[6] Morin-Pelletier, "At Peace with the Germans;" and Morin-Pelletier, "Héritières de la Grande Guerre." See also Mélanie Morin-Pelletier, "Les Bâtisseuses de l'Est: Les vétéranes des Maritimes et la santé publique, 1919-1939," *Acadiensis* 42, 1 (2013): 127-49, and Mélanie Morin-Pelletier, "Des Oiseaux Bleus chez les Poilus," *Bulletin d'histoire politique* 17, 2 (2009): 57-74.

Southwestern Ontario nurse veterans' experiences may be similar to those of nurse veterans across the country.

In keeping with wartime CAMC requirements, all nurses in this sample were British subjects, graduates of three-year nurse training programmes and deemed physically fit at the time of enlistment. They were also universally white and English-speaking, although there were some francophone nurses in the CAMC. They had an average age at enlistment of 28.8 years—versus 29.9 years in the whole contingent—with the most frequently reported age in both cases being 27. The youngest—a twenty-year-old—aged herself up a few years to enlist, while the oldest openly enlisted at forty-three. Falsified ages and exceptions were common (including overage Matron-in-Chief Margaret Macdonald!), so here, too, the sample is representative.[7] It more or less proportionately reflects CAMC nursing sisters' religious backgrounds, being "overwhelmingly Protestant," although it contains twice as many Methodists (24.4 per cent versus 12.2 per cent) and dramatically fewer Catholics (2.4 per cent versus 13.8 per cent) as compared to the larger body of CAMC nursing sisters.[8] One woman in the sample was married during her overseas service and another's status is unknown, but the rest reportedly met the requirement to be unmarried as did 95.8 per cent of CAMC nurses who reported their marital status.[9]

The women in this sample also largely came from small and mid-size places like most Canadian nursing sisters and many moved back

[7] CAMC nurses were supposed to be between twenty-one and thirty-eight years old on enlistment. Toman, *Sister Soldiers,* 47; Susan Mann, *Margaret Macdonald: Imperial Daughter* (Montreal and Kingston: McGill-Queen's University Press, 2005), 75.

[8] Statistics and trends for the entire CAMC nursing sister contingent come from Toman, *Sister Soldiers*, 50-51. Proportions for Church of England/Anglican, Presbyterian and Baptist/Congregational affiliations in the sample are very close to those within the entire contingent.

[9] Toman, *Sister Soldiers*, 50-51. Toman explains that marital status was difficult to track and was not always inquired about. Some nurses' marriages before or during the war therefore went quietly unreported.

to smaller places after the war.[10] Southwestern Ontario's many small urban centres—including Windsor, Chatham, London, St. Thomas, Woodstock, Brantford, Sarnia, Kitchener and Waterloo—offered many pre- and postwar employment options for nurses including hospitals, industry and eventually public health organisations. However, the region retained a strongly rural character throughout the first half of the twentieth century and private duty nursing in patients' homes (the least preferred option for most nurses) would have been the principal venue for nursing work.[11]

One striking but likely coincidental feature of this Southwestern Ontario sample is that although it includes only 1.4 per cent of the total number of CAMC nursing sisters, it contains 10 per cent of the sixty-one nursing sisters identified by Dianne Dodd as having died for reasons directly attributable to their military service.[12] All six women were deceased by 1922: Katherine Maud MacDonald was killed in action during the German bombing of Étaples, while four others (Caroline Graham Green, Bessie Maud Hanna, Agnes MacDougall and Mary Geraldine McGinnis) all died of diseases contracted or exacerbated on service. The sixth, Alice Trusdale, is on Dodd's list, but the pension board deemed the polio that killed her not attributable to service.[13]

[10] Of the 735 nursing sisters identified who were both born in and enlisted in Ontario, for instance, 52 were born in Toronto, 90 were born in the mid-size cities of Ottawa, Kingston, London and Hamilton and 586 were born in small communities ranging from towns like Ingersoll and Orillia to rural townships like Sydenham and West Gwillimbury. The trend continued during the 1920s and 1930s, with anywhere from 54 to 85 per cent of nurse trainees coming from rural towns, according to Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (1996; Toronto: University of Toronto Press, 2003), 123-24.

[11] Private duty nurses were independent contractors who worked in the patient's own home – a cheaper and more accessible option than a hospital convalescence. These nurses experienced intermittent unemployment and many families could not afford to pay their fees in a timely manner.

[12] Dianne Dodd, "Canadian Military Nurse Deaths in the First World War," *Canadian Bulletin of Medical History* 34, 2 (2017): 327-363.

[13] Katherine Maud Macdonald, BPC 39952, reel 131, VAC pension files, LMHA; Caroline Graham Green, BPC 205581, reel 453, VAC pension files, LMHA; Bessie Maud Hanna, BPC 60783, reel 548, VAC pension files, LMHA; Agnes MacDougall, BPC 107671, reel 133, VAC pension files, LMHA; Mary Geraldine McGinnis, [no pension number], reel 137, VAC pension files, LMHA; and Alice Trusdale, [no pension number], reel 655, VAC pension files, LMHA.

NURSE VETERANS AND THEIR HEALTH

From a list of 171 CAMC nurses with ties to Southwestern Ontario, forty were found to have pension records. Of these forty women, thirty-two (78 per cent) applied for personal pension support on medical grounds and nineteen of them (59.4 per cent) were successful—although not necessarily right away or to the extent they desired. Some women were reassessed (anywhere from once to six more times) in subsequent years and awarded different levels of support at each point. If we count each assessment as a separate event, there were thirty-six assignments of pensionable disability: the average amount assigned was 30 per cent. However, this figure makes the pension commissioners sound more generous than they were. In keeping with trends for all Canadian military pensioners, the majority of the applications in this sample (twenty-one of the thirty-six assessments) were assigned 20 per cent or less and the most frequently awarded amount was 10 per cent.[14] In the higher categories, nine applications were awarded between 25 and 50 per cent disability, three were awarded between 55 and 95 per cent and three were awarded 100 per cent. All but one of the six applications awarded between 60 and 100 per cent were either second or third assessments, indicative of these women's dramatically worsening health. The sole exception was a 100 per cent disability awarded upon first assessment to a woman diagnosed with tuberculosis of the lungs and cystitis in 1919, who spent five years in hospitals and sanatoria before applying for a pension in 1924.

Of the thirteen women whose pension applications were unsuccessful, twelve were told their conditions were unattributable to service and the thirteenth was twice deemed not to be in financial need. In two instances, physicians could not decide whether the women's problems pre-dated or post-dated their service, but the absence of any mention in their military health records meant the Department was not on the hook either way. Some applicants sought specific medical services (including physician examinations, hospitalisations,

[14] Morton and Wright explain that "barely 5 per cent of Canadian pensioners collected the full rate; 80 per cent received under 50 per cent of the maximum, and most received 20 per cent or less." Desmond Morton and Glenn Wright, *Winning the Second Battle: Canadian Veterans and the Return to Civilian Life, 1915-1930* (Toronto: University of Toronto Press, 1987), 155.

prescriptions and orthopaedic devices) rather than, or in addition to, pensions. Only twice in this sample did women request treatment that was not granted—in both cases because their condition was deemed unrelated to their military service.

Figure 1 outlines the wide array of health conditions reported by nurse veterans in their pension records. Not all were deemed pensionable, but the overwhelming majority were attributed to military service by the women themselves. A few trends are apparent. Since nursing sisters did not engage in combat, it is no surprise that the pensionable conditions found in the Southwestern Ontario sample exclude shrapnel wounds, the effects of being gassed, trench foot and so on. Conversely, nurse veterans were diagnosed with a number of gynaecological conditions that could not affect servicemen. Nurses were especially vulnerable to lung conditions, particularly bronchitis and tuberculosis—the latter of which emerged as "the most acute military medical problem" for the wartime CAMC.[15] The nature of nursing work routinely exposed military nurses to a variety of infectious diseases, including the so-called 'Spanish Flu' strain of influenza that circulated in 1918-1919, and over time long hours and heavy lifting took a toll on nurses' feet, legs and lower backs. Other conditions listed here—those related to cancer or heart trouble, for instance—may have developed *during* military service without being *caused* by it. A final point of interest comes from three cases in which a minor injury to a hand (the skin broken while changing a bed, for instance) turned into a debilitating, systemic infection—a real threat in this era prior to the development of antibiotics.

As Mark Humphries notes, "research tells us that in their quest to be heard and have suffering taken seriously, patients intuitively and unconsciously exhibit the symptoms that they anticipate physicians will perceive as 'real' illness."[16] However, this did not guarantee a veteran's encounter with a medical board would be favourable. Morton and Wright argue that male veterans' pension claims were hampered

[15] Morton and Wright, *Winning the Second Battle,* 25. Tuberculosis, a deadly lung disease also known as "TB," "consumption" or "the White Plague," was endemic before the rise of antibiotic treatments in the 1940s. See Stacie Burke, *Building Resistance: Children, Tuberculosis and the Toronto Sanatorium* (Montreal and Kingston: McGill-Queen's University Press, 2018), 5. On alarming rates of TB affecting nurses, see McPherson, *Bedside Matters*, 141.

[16] Mark Osborne Humphries, *A Weary Road: Shell Shock in the Canadian Expeditionary Force, 1914-1918* (Toronto: University of Toronto Press, 2018), 15.

Figure 1. Health Conditions Revealed in Nurse Veterans' Pension Files

Condition	**Nurse Veterans Diagnosed**	**Conditions Included**
Respiratory	*16*	bronchitis (x6); pulmonary tuberculosis (x6); possible tuberculosis (x2); pleurisy (x3); dyspnoea; hydrothorax; lung abnormality; pulmonary abscess; pulmonary collapse; unspecified respiratory issues; shortness of breath
Infectious (excluding TB and bronchitis)	*9*	influenza (x6); diphtheria (x2); polio myelitis; scarlet fever; septic [strep] throat; tonsillitis
Musculoskeletal	*9*	myalgia (x4); arthritis (x3); sore feet (x2); defective gait; fibrositis; flat feet; fractured ankle; lumbago; Potts disease; sciatica
Digestive	*8*	appendicitis (x3); cholecystitis; cholelithiasis; cystitis; gastric ulcer; nephritis; pyelitis; ulcerative colitis
Miscellaneous	*7*	severe systemic infections arising from minor hand injuries (x3); sinusitis (x2); fatigue (x2); poor eyesight (x2); migraine; abscessed teeth; corneal ulcer
Cardiac and Circulatory	*6*	valvular and myocardial disease; myocarditis; hypertrophy of heart; hypertension; stroke; myocardial infarction; cardiac arrest; cardiovascular-renal disorder; unspecified cardiac issue; varicose veins
Mental	*5*	nervous debility (x2); neurasthenia; functional neurosis; anxiety; difficulty readjusting
Cancerous	*3*	ovarian cancer; uterine cancer; breast cancer; retroperitoneal sarcoma
Gynaecological (excluding cancers)	*2*	septic endometritis; unspecified uterine issues
Glandular	*2*	toxic goitre (x2); enlarged thyroid; hyperthyroidism
Entirely Unspecified	*2*	(n/a)

Data drawn from documents in nurse pension files. Due to the overexposure and/or other illegibility of some of the original microfilmed documents, the list is likely incomplete. Categories created and applied by the author.

because few "felt at ease in the military formality of a medical board or in wrestling with a remote bureaucracy."[17] In this respect, nurse veterans were at a distinct advantage: they may have felt equally ill at ease, but their training and clinical experience had taught them what symptoms held most weight with diagnosing physicians, as well as the precise medical terminology to identify them. Although a number of nurse veterans employed the services of veterans' advocate Harry Bray, from a medical perspective many of them appear to have been their own best advocates. Some went beyond self-advocacy to diagnose and/or treat their own ailments if they disagreed with physicians' offerings.

Not all nurse veterans started out as strong self-advocates. Florence H. (later Mrs. F.) blamed what she considered a persistent misdiagnosis of her condition upon her own lack of confidence in her medical knowledge when she originally reported her medical history in 1920. She grew more vocal over the years, however, earning special note in later life for her exceptional ability to articulate her symptoms and history. Her persistence paid off in 1930 when her pension—discontinued a decade earlier—was reinstated.[18]

Like Florence H., Mary Mason was troubled by the disconnection between her self-diagnosis and the diagnoses of DSCR/DPNH physicians. Much of her so-called neurotic behaviour—explained by physicians in 1933 as "in part due to her economic and environmental position"—could alternately be attributed to the frustration of having her personal *and* professional knowledge disregarded by (male) physicians and officials.[19] A century later, clinical studies repeatedly show that women's pain is not taken as seriously as men's, nor treated as quickly or effectively.[20] Mary's belief that her ailments were not being taken seriously therefore may have been entirely valid. Undeterred, she mobilised her nursing skills and professional

[17] Morton and Wright, *Winning the Second Battle*, 76.
[18] Florence H., CPC 182376, reel 1225, VAC pension files, LMHA.
[19] Mary Mason, CPC 212513, reel 945, VAC pension files, LMHA.
[20] Laura Kiesel, "Women and pain: disparities in experience and treatment," Harvard Health Blog, Harvard Medical School, 9 October 2017, https://www.health.harvard.edu/blog/women-and-pain-disparities-in-experience-and-treatment-2017100912562; Rachael Rettner, "Women Feel Pain More Intensely Than Men Do," MyHealthNewsDaily, *Scientific American*, 23 January 2012, https://www.scientificamerican.com/article/women-feel-pain-more-intensely/#; and Lanlan Zhang et al., "Gender Biases in Estimation of Others' Pain," *The Journal of Pain* 22, 9 (2021): 1048-59.

networks to support her claims, soliciting letters of support from former nurse and physician colleagues and providing lengthy "case notes" describing her health problems since 1917. When a physician's examination in 1932 suggested there was nothing wrong with her, she protested by refusing to leave her hospital bed.

Of particular distress to Mary was her official diagnosis of pulmonary tuberculosis; despite the department's later admission that it was a misdiagnosis, the vagaries of bureaucratic procedure meant the tuberculosis diagnosis was locked in as her only pensionable disability. By 1935, she was dealing with arthritis and/or myalgia (causing chronic pain), sinusitis, eye problems, varicose veins and myocarditis, some of which she linked to her military service. But since none could be tied to her official diagnosis of tuberculosis (which, to repeat, she did not have), none were pensionable. No wonder she was frustrated to the point of threatening violence to herself or pension officials. Mary may have derived some retrospective satisfaction, however, from the memory of having acquired orthopaedic devices to which she was not officially entitled when she nursed for the DSCR in Burlington's Brant Hospital and Hamilton's Scott Barracks Hut Hospital in 1922.[21]

Another staunch self-advocate was nurse veteran Norma Harper. One of the few nurse veterans able to make a career of nursing in veterans' hospitals,[22] forty-year-old Norma received a 20 per cent pension beginning in 1928 for gastric hemorrhage and gastric ulcer. By 1939, she was forced to retire because of worsening health and when she was hospitalised in 1948 she had very definite ideas about what was wrong with her. Physicians diagnosed her variously with ulcerative colitis, peptic ulcer, gastric ulcer and undetermined lung and heart troubles, but Norma herself was reportedly "obsessed" with her colon and had devised a treatment regimen at home that included frequent enemas and self-prescribed painkillers. Dismissing her self-diagnosis, hospital staff classified her as "difficult to manage" because she refused certain treatments, demanded others, removed intravenous tubes and undid dressings herself. Her death in October 1948 was largely a result of her recently acquired lung conditions,

[21] Mary Mason, CPC 212513, reel 945, VAC pension files, LMHA.

[22] During the 1920s, about 125 nurse veterans worked in eight DSCR hospitals. Morin-Pelletier, "At Peace with the Germans," 192. Norma Harper worked at the Dominion Orthopaedic Institute ("Christie Street Hospital") in Toronto.

but she may not have been wrong about colon trouble. Her desire for frequent enemas and refusal to eat dairy while in hospital suggest she may have suffered from irritable bowel syndrome (IBS), the cramped, bloated, blocked-up sensations of which can sometimes be minimised with a dairy- or lactose-free diet.[23]

Minnie Misner attributed the chronic pain and stiffness that left her unable to nurse by 1935 to a systemic infection sustained on service. Like Mary and Florence, she sent the DPNH highly detailed accounts of her 1917 illness, convinced the salient points were being lost in official accounts. At the same time, she gathered further evidence from medical colleagues and specialists. Her efforts resulted in a 25 per cent pensionable disability assessment in 1936. And, like Norma, she was proactive about her own treatment, lobbying the DPNH in 1941 (successfully) and 1946 (unsuccessfully) to pay for newly emerging treatments that might ease the pain from her chronic myalgia and fibrositis.[24] Despite the professional networks and nursing knowledge that brought her partial success, Minnie's case illustrates the fact that nurse veterans faced the same challenges as male veterans when confronting a pension bureaucracy intent on minimising costs.[25] Her initial 1935 pension application was turned down because, to her shock, her wartime medical record only listed bunions. Minnie was an extremely skilled nurse whose dedication had seen her mentioned in dispatches and honoured by King George IV and she was unwilling to accept this omission. Instead, she explained (complete with supportive testimony) that she had spent time in the Buxton rest home for nurses after a hand injury in 1917 led to a serious systemic infection. This infection left her permanently weakened and, in the opinion of five separate physicians, was directly responsible for the postwar conditions that left her unable to nurse. She further explained that she had stayed on duty in 1917 and did not report her pain and other symptoms until the infection completely felled her because her hospital (No. 7 Canadian General Hospital, in

[23] Norma Louise Harper, BPC 218955, reel 552, VAC pension files, LMHA; and "Irritable Bowel Syndrome," Mayo Foundation for Medical Education and Research, 2 November 2022, https://www.mayoclinic.org/diseases-conditions/irritable-bowel-syndrome/symptoms-causes/syc-20360016.

[24] Minnie Ethel Misner, CPC 228414, reel 370, VAC pension files, LMHA.

[25] As Morton and Wright note, "The goal of civil re-establishment had always been to reduce Canada's responsibility for her returned soldiers." *Winning the Second Battle*, 202.

France) had no orderlies and only one nurse per ward. So many other sisters were off sick that "those who could keep going were expected to do so," she claimed.[26] This is a clear example of what Toman describes as CAMC nursing sisters' determination to "soldier on" in wartime: "to push themselves physically, to accept dangers and risks and to refrain from complaining."[27] Although admirable, this dedication likely led some nurse veterans to lose postwar pension support to which they may have been entitled.

In Minnie's case, her commendable military record and forceful assertion of medical evidence helped overcome the absence of a wartime medical record; she was explicitly given "the benefit of the doubt."[28] Others in a similar situation were unsuccessful. Mabel M.'s original 10 per cent pension for war-related fatigue (1919-1921) was discontinued on the grounds that she had improved, so in 1922 she took similar steps as Minnie, self-advocating and securing diagnoses from specialists who strongly concurred that her lung condition was "definitely attributable to service." DSCR officials, however, pointed to the absence of evidence in her wartime medical record and did not reinstate her pension.[29] By and large, if a condition was not recorded in a nurse's wartime medical records, it effectively never existed—a fact which turned the sisters' determination to soldier on uncomplainingly for the good of their patients against their own long-term best interests.

Significantly, not one nurse veteran in this sample received any pension money or treatment for mental health conditions. Even when they reported symptoms tied to mental health, physicians focused on the presence of physical ailments to explain them. When none could be found, the patient was deemed undiagnosable and therefore unpensionable. While this certainly aligns with a broader postwar disinclination to take war trauma seriously, a particularly gendered element seems likely in the case of nurse veterans. Mark Humphries argues that the First World War saw the decline and ultimately the systematic delegitimisation of "the concept of nervous suffering" as an explanation for war-related trauma, which was often diagnosed under the terms "neurasthenia" or "shell shock." By war's end, experts

[26] Minnie Ethel Misner, CPC 228414, reel 370, VAC pension files, LMHA.
[27] Toman, *Sister Soldiers*, 110.
[28] Minnie Ethel Misner, CPC 228414, reel 370, VAC pension files, LMHA.
[29] Mabel M., BPC 154101, reel 670, VAC pension files, LMHA.

emphasised "hereditary and morale defects rather than the traumas of war, a pattern that lay the groundwork for later approaches to pensioning."[30] But the term "neurasthenia" also had a deep history of feminine connotations by the early twentieth century, tied to the same set of symptoms that had previously been diagnosed in women as migratory womb, hysteria, demonic possession, nervousness and more. Initially linked to uterine disorder, it was later associated simply with "'feminine' personality traits and behavior."[31]

Florence H. (later Mrs. F.) may very well have suffered from long-term war trauma. Already in receipt of a 10 per cent pension for minor physical ailments resulting from influenza, she petitioned for further support in the 1920s. The doctors focussed their search on physical causes (ultimately attributing the symptoms to thyroid and gall bladder issues) and ascribed the more obviously mental aspects of her symptoms to family anxieties, hypochondria or simply "emotionalism." By contrast, twenty-first century health professionals might recognise Florence's extreme nervousness, restlessness, shaking and heart palpitations as signs of hypervigilance (often described as "feeling on edge"). When this hypervigilance is combined with her additional symptoms of fatigue, poor sleep, vivid dreams and nervous attacks (which Florence described as a panicky feeling that she "simply couldn't stand anything anymore"), her symptoms are strongly suggestive of war-related trauma.[32] On top of her own struggles, Florence had a war-disabled husband to look after. But instead of receiving compassionate treatment, she was accused by one official of trying to scam the system.[33]

The term "neurasthenia" was explicitly applied to Dorothy H. in October 1918 in connection with her symptoms of nervousness, insomnia, lack of appetite and a nervous tremor in her hand. However, when the same symptoms cropped up in March 1919—now augmented by headaches, poor concentration, loss of memory

[30] Humphries, *A Weary Road*, 326, 11.

[31] Susan A. Cayleff, "'Prisoners of their own feebleness': Women, Nerves and Western Medicine – A Historical Overview," *Social Science and Medicine* 26, 12 (1988): 1199-1200. As early as 1844, women were being described by anthropologists as particularly susceptible to their nerves. This became engrained in medicine and psychology.

[32] "Signs and Symptoms" and "Conditions," Make the Connection, U.S. Department of Veterans Affairs, accessed 3 November 2021, https://www.maketheconnection.net/.

[33] Florence H., CPC 182376, reel 1225, VAC pension files, LMHA.

and heart palpitations—the examining neurologist dismissed the possibility of war trauma because Dorothy did not report any dreams and appeared well-fed. He instead attributed her headaches to dental issues and advised the out-of-work veteran to "undertake some useful occupation."[34] While meaningful work has its merits, it is difficult not to read this prescription as both dismissive and patronising—especially in light of the fact that longstanding cultural stereotypes painted unmarried women of a certain age as "self-absorbed hypochondriacs."[35] A similar dismissiveness is briefly visible in the file of Ruth H., who left nursing to be a full-time housewife on an Albertan farm after the war. Ruth's file contains extensive correspondence and reports throughout the 1920s and 1930s relating to her ongoing battles with sciatica, lumbago, myalgia and arthritis, but officials clearly did not consider Ruth's health issues as debilitating as she did. One medical director wrote in 1922: "It has been discovered that this woman is a marked neurasthenic and is very prone to exaggerate her symptoms." Her neurasthenia itself received no further consideration and her pension for physical ailments remained at or below 20 per cent.[36]

NURSE VETERANS, WORK AND FAMILY

Nurse veterans' postwar health was closely entwined with their ability to work and the presence or absence of family connections. Simply put, most unmarried nurses' single status made paid work an economic necessity, while some nurses' work supported dependant relatives. In these case studies, we catch glimpses of the financial strategies nurse veterans used to sustain themselves and vulnerable loved ones through challenging economic times and occasionally of their relationships to the work itself.

The nursing profession gave nurse veterans opportunities for postwar geographic mobility, opening employment options even in a

[34] Dorothy H., BPC 92774, reel 552, VAC pension files, LMHA.
[35] Gwendolyn Davies, "'Old Maidism Itself': Spinsterhood in Eighteenth and Nineteenth Century Literary and Life-Writing Texts from Maritime Canada," in *Mapping the Margins: The Family and Social Discipline in Canada, 1700-1975*, eds. Nancy Christie and Michael Gauvreau (Montreal and Kingston: McGill-Queen's University Press, 2004), 240.
[36] Ruth H., CPC 120735, reel 1231, VAC pension files, LMHA.

challenging interwar economic context.[37] Many nurse veterans in the sample stayed within Southwestern Ontario after the war or repeatedly returned to it after sojourns elsewhere. A few settled in Toronto, where they may have trained or had professional contacts, and others ventured further afield, perhaps as a result of what Toman describes as the restlessness of many nurse veterans who found it "difficult to stay in one place for very long."[38] At least five lived in other provinces at some point, including British Columbia, Alberta and Quebec, and one worked in Northern Ontario, which would have felt like a different province to someone raised in Southwestern Ontario. At least three worked for a time in cities on the American side of the lower Great Lakes (including Detroit, Michigan and Buffalo, New York) and three moved to California (with one subsequently relocating to Arizona) for the health benefits of a warmer climate. Although some of these moves were related to marriage or health, the vast majority of nurse veterans relocated—or stayed put—for work.

Pension records offer valuable insights into the postwar careers of ordinary nurses whose accomplishments were unlikely to be celebrated in the pages of alumni or professional publications. Some took up marriage as a career option and a few moved into other employment, but most seem to have remained in nursing. Of the twenty women whose files reveal evidence of postwar employment, seventeen nursed after the war, many of them moving between employers or types of nursing over the years. Nine of the women are known to have worked in Canadian veterans' hospitals (usually immediately after the war), four of them in regular civilian hospitals[39] and one woman provided unpaid nursing care for her disabled veteran husband. Two women practised industrial nursing within businesses, six did private duty nursing and one pursued public health (school) nursing. Two women became social workers and of those who nursed or did social work, three are known to have taken up supervisory positions. Four women

[37] Nursing leaders feared a nurse surplus in Canada when over 2,800 military nurses returned to a country which had expanded its training programmes to account for the loss of civilian nurses in the interim. However, the real problem turned out to be the erosion of the private duty nursing market in the face of more patients choosing hospital care (where student nurses attended them) from the 1920s onward and fewer patients being able to afford private nursing during the Great Depression of the 1930s. Toman, *Sister Soldiers*, 195; and McPherson, *Bedside Matters*, 115.

[38] Toman, *Sister Soldiers*, 197.

[39] These may have been supervisory positions since hospitals primarily used the labour of nurse trainees.

who at some point found themselves unable to nurse but in need of income took up a variety of other "women's" work of the period: domestic service, office work, running a boarding house and running a tearoom. Four women reported themselves as full-time housewives and an additional four who were married likely also filled this role.

Marriage was a viable career option for nurse veterans: interwar Canadians looked to marriage as a means to acquire both affection and economic benefits for both partners.[40] However, the odds were stacked against CAMC nurses: nearly half were aged thirty or over when they enlisted—already past their prime marriageable years—and they were even older by the time they were demobilised. The war also removed many men from the pool of marriage candidates. Nonetheless, some nurse veterans walked down the aisle after the end of the war. Of the forty women in this sample, more than half were over age thirty in 1919, yet nine are known to have married from 1918 onward, some of them quite late in life. Olive Clarke married Gordon Scott in 1946 when she was fifty-nine, taking up the life of a housewife in Stratford after leaving her seventeen-year career of nursing veterans in London, Ontario's Westminster Hospital. While the marriage likely offered economic benefits to an aging Olive, a sorrowful letter from Gordon following her death from cancer in 1949 suggests it was also a love match.[41] Pension files for the Southwestern Ontario sample shed little light on postwar nurse veteran marriages, but the presence of married nurse veterans in the files at all suggests that marriage did not always bring financial security, especially during the Great Depression.

Ten nurses in the sample are known to have died single and it seems reasonable to assume that a majority of those whose postwar marital status is unknown—half of the sample—also remained single. It also seems reasonable to assume that for most of them—given the predominance of working- and middle-class origins in the profession—unemployment was not a viable option. Early-twentieth-century nursing was a physically taxing profession, requiring the ability to lift and move patients of all shapes and sizes and the stamina to endure long hours of work, often on one's feet. It also involved a great deal of laborious cleaning and scrubbing by hand to ensure a hygienic

[40] Veronica Strong-Boag, *"Janey Canuck": Women in Canada, 1919-1939,* CHA Historical Booklet No. 53 (Ottawa: Canadian Historical Association, 1994), 14.
[41] Olive Louise Clarke, BPC 169568, reel 1017, VAC pension files, LMHA.

environment that would deter infection in an age before antibiotics.[42] A wide array of ailments could therefore critically endanger a nurse's ability to perform her work and send her into economic crisis.

Immediately following the war, the DSCR paid for four newly demobilised nurse veterans in the sample to retrain because they were already deemed unable to do traditional nursing. As early as 1916, retraining programmes were seen as an important pillar of Canada's civil re-establishment programme. Those unable to resume their pre-war employment were guided toward related occupations, to minimise the retraining period.[43] The burgeoning field of public health nursing was inherently less physical than hospital or private duty nursing, so two nurse veterans joined many of their CAMC colleagues in that field[44] and enrolled in the new Public Health Nursing course at the University of Toronto. A third took a Social Work course at the same institution while the fourth, who had done secretarial work before her nurse training, chose to brush up on her typing and stenography at Toronto's Remington Business College. Department officials assessing their prospects for employment in these fields noted approvingly of a variety of qualities that had also been valued in them as nurses: a pleasant and ladylike demeanour, intelligence, precision and neatness. Maud Hanna had to discontinue her secretarial course because of declining health, but the others appear (at least in the short term) to have been successfully employed in their new fields.[45]

A nurse veteran's inability to find paid work that was meaningful to her could have harmful effects on her mental health. Hesse L.'s struggles both sprang from, and affected, her employability. Hesse nursed in Vancouver and Montreal during the 1920s but lost her savings in the 1929 stock market crash. As the Great Depression set in, she "found it difficult to make her way." She tried but failed to

[42] McPherson, *Bedside Matters,* 78-81.

[43] Morton and Wright, *Winning the Second Battle*, 202, 33.

[44] For instance, the significant roles played by nurse veterans (in both paid and volunteer capacities) in Prince Edward Island's nascent public health system is particularly well traced in Katherine Dewar, *Those Splendid Girls: The Heroic Service of Prince Edward Island Nurses in the Great War, 1914-1918* (Charlottetown, PEI: Island Studies Press, 2014), 171-73. See also Morin-Pelletier, "Les Bâtisseuses de l'Est" and Toman, *Sister Soldiers*, 197-98.

[45] Maud died in September 1921. Bessie Maud Hanna, BPC 60783, reel 548, VAC pension files, LMHA; Minerva M., CPC 169833, reel 670, VAC pension files, LMHA; Mabel M., BPC 154101, reel 670, VAC pension files, LMHA; and Claire Denelda Tye, CPC 204495, reel 659, VAC pension files, LMHA.

secure nursing positions with the Grenfell Mission in Newfoundland and the Ontario Hospital Service, so she traded the bright lights of Montreal for the lower cost of living in London, Ontario, where she was lodging in the YWCA in December 1933 at age fifty. With no immediate family, few friends and a reportedly "anti-social" personality, Hesse had few resources and no network of support to draw upon. The YWCA found her several housework jobs, but she failed to keep any of them because she refused to do a variety of standard tasks expected of domestic help, considering them beneath the dignity of a trained nurse. While this attitude was unwise from a purely economic standpoint, it hints at a woman clinging to her professional identity in the face of hard times.[46] Nursing was a skilled and respectable profession; domestic service was a menial occupation for those without options.[47]

While a professionally-trained woman's desire to find satisfying work should not be discounted, the search for postwar employment among unmarried nurse veterans was likely *also* (and probably predominantly) driven by financial need—particularly as the decades passed and they or their loved ones faced the prospect of aging in poverty.[48] Some nurse veterans, such as Mabel M., were dependent on the financial support of family members. Mabel's long-term disability kept her from working but was not considered pensionable and the 1921 census captures her serving as head of household in an apartment shared with three unmarried nurses who worked at Toronto General Hospital—one of them her sister, Myrtle.[49] Shared housekeeping was a sound economic strategy for single women.

Although nursing offered women a potential path to economic self-sufficiency, for many interwar nurses this did not extend to an

[46] Hesse L., [no pension number], reel 288, VAC pension files, LMHA. Since Hesse was deemed medically fit on discharge from the CAMC, the Department offered no help.

[47] On the status of nursing, see McPherson, *Bedside Matters*, 168, 125. On women's experiences of domestic labour in this period, see Linda Kealey, "Outport 'Girls in Service': Newfoundland in the 1920s and 1930s," *Acadiensis* 43, 2 (2014): 79-98.

[48] Strong-Boag notes that in this period "old age often meant poverty," with older women lacking sufficient income "for good health or peace of mind." Living with relatives was a common strategy to combat this. *"Janey Canuck,"* 24.

[49] Mabel M., BPC 154101, reel 670, VAC pension files, LMHA; and "M—., Mabel," Toronto, Ontario, district 130, subdistrict 37, 1921 Census of Canada, Library and Archives Canada [LAC], https://central.bac-lac.gc.ca/.item/?app=Census1921&op=img&id=e003037568.

ability to save for emergencies or old age.[50] Even those nurses who earned a bit more might see their meagre savings wiped out by a personal health crisis or expensive household repair. Nor did being unmarried necessarily mean freedom from financial obligations to family members. Several women in the sample supported dependant relatives—even after they died. In most cases, their role as chief breadwinner predated their military service. This was in keeping with prevailing expectations for working-class children of all ages to contribute to the household economy, but was more unusual for middle-class daughters.[51] The Southwestern Ontario sample includes six pension applications for dependant relatives of nurse veterans, of which five were approved.[52] Three were for widowed mothers, one for the school-aged child of a single-parenting nurse and another for the invalid sister of a nurse on partial disability. These cases offer insights into the vulnerability of many interwar Canadians, as well as the strategies families used to collectively keep body and soul together.

Through the entire decade of the 1920s, nurse veteran Claire Tye shared with her sister and fellow nurse Edith the role of financially supporting their widowed mother—a task considerably aided by a successful application for a dependant pension. By 1929, Claire was at 100 per cent disability, receiving $75 each month, plus $20 for her mother—who was in turn supporting another unmarried sister, Wilma, a lifelong invalid. When Mrs. Tye died, her son petitioned the DPNH to transfer her dependant pension to Wilma. The department did so, although at only half the previous rate. Claire continued to support her sister by sending a portion of her own pension each

[50] McPherson, *Bedside Matters*, 137-40. A 1932 survey of nursing education in Canada found the estimated cost of living for a nurse in Canada, 1929-1930, was in the neighbourhood of $1,400-$1,600 (with the lower figure representing a nurse who could live rent-free with family members) while, in the same period, private duty nurses earned an average of $1,022 per year, hospital nurses (not trainees) $1,385, and public health nurses $1,574. Nurse superintendents averaged $2,000 per year. McPherson, *Bedside Matters*, 135-36.

[51] Lara Campbell, *Respectable Citizens: Gender, Family and Unemployment in Ontario's Great Depression* (Toronto: University of Toronto Press, 2009), 85. Campbell notes that the 1930s saw a transition away from this long-time working-class family survival strategy and toward a sole male breadwinner model but adds that it was still common through to the end of the Second World War.

[52] No details are available to explain the unsuccessful sixth application for a dependant pension. Mary Mason supported an orphaned invalid nephew but did not apply for a dependant pension.

month and paying for taxes, fuel, groceries and doctors' bills. When Claire died in 1933, at the height of the Great Depression, Wilma was swiftly thrown into financial crisis, her few savings gone by the end of the first year as her surviving siblings essentially abandoned her. She had inherited their mother's small cottage and supplemented her income by fostering an infant for some months and taking in a little sewing. However, the cottage was in disrepair and a DPNH investigator reported in 1934 that Wilma had outstanding debts for taxes, fuel, groceries and medical care and "looks hungry." Claire once again proved Wilma's salvation—this time from beyond the grave—when the DPNH agreed to pay the $1,600 balance on Claire's pension account to her sister, in monthly installments of $20-30. A stroke in 1936 brought more medical bills and decreased Wilma's ability to take care of herself, but further help (again, because of Claire's history of providing for her sister) came in 1939 when Wilma was awarded a dependant's pension at the maximum rate of $30 per month. This new pension, awarded under Section 34-5 of the *Pension Act*, was specifically geared toward adult siblings unable to take care of themselves. Nevertheless, Claire would no doubt have been dismayed by the bleak picture painted by a 1941 investigator's report: the aging Wilma was permanently debilitated by her stroke, her cottage was falling to pieces around her and her inability to keep her fires lit meant she was forced to board with their brother (at the cost of $20 per month!) each winter until her death in 1946.[53]

Katherine Macdonald, whose wages had provided for her widowed mother and younger sister both before and during the war, continued to support her mother via a dependant's pension even after her death on service in 1918. This income appears to have been crucial: the 1921 census captures Mary Maud MacDonald (then sixty-two) serving as head of household and sole income-earner for an extended family consisting of her unmarried sister and brother and an unmarried adult niece, residing in a seven-room brick home. When Mrs. MacDonald died in 1940, aged eighty-one, her estate was insufficient to cover her

[53] Claire Denelda Tye, CPC 294495, reel 659, VAC pension files, LMHA.

final expenses, suggesting that her Depression-era old age was lived perilously close to the financial edge.[54]

Mary Mason's long and colourful pension fight only ever netted her a 10 per cent pensionable disability, leaving her dependent by the mid-1930s on her savings and her sister—also a nurse—as they tried to support themselves and a sickly, orphaned teenaged nephew who was totally dependent on them. When she received a War Veterans Allowance beginning in 1937, the financial relief it provided seems to have eased her depression considerably: having believed herself "permanently unemployable" for years, she bounced back sufficiently to buy a house in Hamilton and take in boarders for a time and from there to take up private duty nursing again by 1945. Her record ends with her 1951 decision to up stakes at age seventy and move to California with her sister, where she died six years later.[55]

Another nurse veteran, Ruth M., tried on multiple occasions in the early 1920s to return to nursing, first in veterans' hospitals and then in tuberculosis sanatoria. Unhappily, she found her ability to do heavy nursing was repeatedly derailed by her own health condition, later diagnosed as tuberculosis. Ruth's ability to earn was important as she was the sole financial support for her widowed mother. Her initial decision to train as a nurse may even have been tied to the death of her father in 1913. Ruth enlisted in 1917 at age twenty, at which point she began providing her mother $70 a month. With one sister dead of tuberculosis and the other eventually heading to New York City to train in commercial art, Ruth—still only in her mid-twenties—was left to support her mother alone. She was assessed at 100 per cent disability by 1929 (90 per cent of it pensionable) and with her father's $5,000 life insurance payout already exhausted, there were no family savings or investments to draw upon. Ruth's $75 per month pension did not go far for two adult women and by 1931 mother and daughter were paying $10 per month to store their furniture so they could live more cheaply in two rented rooms in a yellow brick house on London's Colborne Street, doing light

[54] Katherine Maud MacDonald, BPC 39952, reel 131, VAC pension files, LMHA; and "MacDonald, Mary Maud," Brantford, Ontario, district 68, sub-district 20, 1921 Census of Canada, LAC, https://central.bac-lac.gc.ca/.item/?app=Census1921&op=img&id=e002917186.

[55] Mary Mason, CPC 212513, reel 945, VAC pension files, LMHA; and "Mary Jane Mason," 14 December 1957, Department of Public Health Services, Sacramento, California Death Index, 1940-1997.

housework to earn a little extra cash. Their meagre expenses ate up their entire income, leaving them trapped in their precarious financial situation. A dependant's pension for Mrs. M. ($13.50 per month) in 1932 provided a bit of breathing space, allowing them to reclaim their furniture and move into a four-room apartment of their own. The file ends in 1937: Ruth's younger sister was married but still not contributing to her mother's maintenance, Ruth was in and out of sanitoria for her "far advanced" tuberculosis and she and her mother still had no savings.[56] It is difficult to imagine that either Ruth or her mother's circumstances improved much over the next decade.

The most uplifting case in this sample of a nurse veteran supporting dependants—also the most scandalous by early-twentieth-century standards—is that of Elizabeth Orme. Born Elizabeth Brinsmead in the village of St. Mary's, Ontario in 1878, at the age of four she was unofficially adopted by her maternal aunt and uncle, the Ormes, and grew up in London, Ontario. She spent her twenties and thirties working as a milliner and contributing the sole income to her family's household (which lost her uncle and gained another aunt by 1911). She began her three years of nurse training around 1913 and in 1916 rounded her age down by five years in order to enlist in the CAMC. While serving overseas, she had some sort of sexual encounter with a fellow member of the Canadian Expeditionary Force, a St. Thomas, Ontario salesman five years her junior named David L. There is no way to know whether the encounter was consensual or not, nor whether, if consensual, Elizabeth knew David was married. But either way, conceiving a child while still actively nursing overseas was always going to cause difficulties for Elizabeth. When she was discharged in April 1919, she was seven months pregnant and no doubt desperately trying to conceal it. She remained in England and gave birth to her son (whom she officially registered under his father's surname) in mid-June, then returned to Canada sometime before the end of the year.[57]

[56] Ruth M., BPC 219826, reel 1464, VAC pension files, LMHA.

[57] Elizabeth Orme, BPC 220794, reel 615, VAC pension files, LMHA; "Brinsmead, Elizabeth," London, Ontario, district 87, subdistrict 4, 1901 Census of Canada, LAC, https://central.bac-lac.gc.ca/.item/?app=Census1901&op=&img&id=z000081349; and "Brinsmed [*sic*], Elizabeth," London, Ontario, district 94, subdistrict 1, 1911 Census of Canada, LAC https://central.bac-lac.gc.ca/.item/?app=Census1911&op=&img&id=e002001648.

Already accustomed to going by a surname that was not legally her own, Elizabeth reinvented herself as the war widow "Mrs. Elizabeth Orme" and moved to the small town of Wallaceburg, Ontario, where she took up private duty nursing and boarded her young son with a Baptist minister and his family during periods in which she was working in others' homes.[58] Some version of this arrangement likely continued through the 1920s until tuberculosis and bronchitis incurred on service in 1917 caught up with Elizabeth. By 1929, she was unable to nurse and a brief stint as proprietor of a tearoom similarly had to be given up. She secured a pension (50 per cent in 1930, raised to 100 per cent in 1931), but her application for a dependant's pension for her son opened the question of his paternity and her marital status. Elizabeth stalled but they needed the income if her son was to complete high school instead of leaving to take a job, so in 1934 she admitted he was illegitimate. The Pension Board granted the additional stipend and when Elizabeth died in 1938, aged fifty-nine, her then eighteen-year-old son had finished school and started a job at the Dominion Glass Factory. She had only $33 in the bank but left her son their $2,400 home in Wallaceburg, $500 worth of furniture and $600 worth of federal government bonds.[59] With determination, deception, some government support and her nursing skills, single working mother Elizabeth Orme had launched her son into young adulthood with a small nest egg, despite her own dramatically deteriorating health and the deprivations of the Great Depression.

The portrait of ordinary nurse veterans' experiences that emerges from the pension files of this Southwestern Ontario sample is fragmentary and incomplete; many of the postwar lives the files reveal are small and circumscribed. Yet the stories of women like Mary Mason, Florence H., Elizabeth Orme and their peers provide valuable insights into the ways that health, work and family shaped the lives of Canada's First World War nurse veterans. The knowledge and experience they gained through nursing informed their interactions

[58] Elizabeth Orme, BPC 220794, reel 615, VAC pension files, LMHA; "Orme, Elizabeth," Wallaceburg, Ontario, district 93, subdistrict 91, 1921 Census of Canada, LAC, https://central.bac-lac.gc.ca/.item/?app=Census1921&op=img&id=e002936107; and "Leslie, John," Wallaceburg, Ontario, district 93, subdistrict 91, 1921 Census of Canada, LAC, https://central.bac-lac.gc.ca/.item/?app=Census1921&op=img&id=e002936125.

[59] Elizabeth Orme, BPC 220794, reel 615, VAC pension files, LMHA.

with the DSCR and DPNH as well as their efforts (and sometimes their failures) to transition into other forms of employment. Armed with nursing knowledge, contacts and professional confidence, they self-advocated and sometimes self-treated with moderate success, but like male veterans they and their dependants could be reduced to economic desperation by health problems that kept them from working and a pension bureaucracy often unmoved by moral claims. Still, and despite the harrowing circumstances revealed in many files, most nurse veterans soldiered on through postwar life as they had soldiered on through the war years. The same intelligence, skill and pluck that had carried them through the rigours of the war sustained them through the changing postwar society it birthed as well.

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ABOUT THE AUTHOR

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