

## Chapter Two

### Military Nurses and Civilian Women Go to War: A Brief History

Chapter One focused on military and civilian women as missing from history, missing in war, and misrepresented in fiction. That chapter included both actual women and female characters from novels. Both groups of women are stereotyped by the pens of male authors who write war genre novels. Furthermore, these women are virtually lost as far as history and war are concerned. Three stereotypes—madonna/mother, angel, and whore—are often used when writing about women, especially in fiction. I would argue that those who stereotype military and civilian women are discounting their service to the soldiers, to their country's military, and to those civilian organizations which are an integral part of the war's arena. The male authors are also seemingly unaware of the conflict the military and civilian women have encountered in order to reach their goals—to serve their country, to provide quality care for the soldiers, and to provide civilian organizations which include the United Servicemen's Organization (USO), and the Red Cross, plus other services, for example libraries, which gave the soldiers a place to “forget” the war for a short time.

This chapter will provide a brief overview of the history of nursing as it relates to military nurses to help create an understanding of how, where, and when the three stereotype groupings may have been formed. I am not trying to provide a complete history of nursing, which would be quite lengthy, but to highlight the steps and changes through the centuries that led directly to the establishment of military nursing units, and highlight the service of these women. Additionally, some emphasis will be included to

show how the various civilian organizations that offer relief during wars may have been established.

This chapter, then, will specifically discuss how the idea of having nurses might have first occurred, and how and when nursing was transformed from caricature and “low class status” to a recognized and respected profession. Second, I will present a very brief review of nursing during World Wars I and II, and Korea. Although these three wars are outside the scope of this dissertation, a discussion about them will provide transition information necessary to understand how nursing matured from Florence Nightingale’s experiences, and the founding of training schools for nursing, to the *official* military recognition of nurses in wars *after* the Crimean War. Third, a discussion of Florence Nightingale, with some focus on her Crimean War experiences, is necessary to achieve an understanding of the growth of nursing as a profession as well as the beginnings of civilian organizations which, I would argue, began in the Crimean War. Fourth, the traditional roles of women as military nurses reached their apex during the Vietnam War; therefore, a section on their Vietnam War experiences will be the heart of this chapter on military nurses and civilian women because they represent military nursing, and the apex of the civilian organizations at their best as well as the end of the *traditional* roles of women during wars.

Going back to the beginning of women’s participation in war is necessary to give background as to how military nursing began, and to conjecture as to the growth of civilian women’s participation in wars. The history of civilian and military women’s service during times of war originates with the start of human existence, and continues to the present day. Further, this history is checkered with many differing perceptions as

well as misconceptions about women's "correct" roles at or behind the battle lines. Women have, since wars have been fought, followed armies in order to cook, clean, and care for the wounded—historically their husbands, but later for specific military companies—generally, a group of soldiers usually with a headquarters and two or more platoons. Throughout history, these women followed their husbands through a variety of harsh weather conditions, faced fatal diseases, nursed the sick, and confronted a life cut off from their families and society. These women would face disapprobation from "decent" society, i.e. a society with the expectations that women would fulfill the roles of wife and mother without additional public arena goals because women were not "supposed" to concern themselves with the "man's world." The function served by these women behind or near the battle lines has been given small recognition by society, and they have been granted very little respect by their society even though these "soldiers" deserve more. Therefore, a review of the beginnings of the nursing profession is necessary in order to show how nursing was born, became recognized, went through a dark period, and finally emerged as a medical specialty with dedicated women who also took their expertise to the battlefields.

Returning to the beginnings of civilization helps create an understanding of the thought processes which inspired nursing. Two texts, chosen because of their thoroughness, *The Emergence of Modern Nursing* by Bullough and Bullough, and *Nursing in Society: A Historical Perspective* by Dolan provided most of the early history of nursing. Bullough and Bullough state that "[w]hen and wherever man first began to care for the injured, the sick, the wounded, then nursing began" (1). Further, the authors state that "evidence has been found by paleopathologists of injury and disease

among prehistoric civilizations which required someone to care for those persons” (Bullough and Bullough 1). The Egyptian and Babylonian are the oldest civilizations with specifics in regard to nursing.

The first evidence of medical specialties may be found in ancient Egypt. The Egyptian temples often had a “house of life” where physicians and medical attendants were trained. The “house of life” contained numerous papyrus scrolls that indicated a more or less scientific approach to disease among the Egyptians with careful diagnosis and what prognosis might be made for the patient. The Egyptian documents are also noteworthy because they reveal specific instructions for diet and for providing patient care by either wives or “nursing priests” (Bullough and Bullough 8-9).

The Egyptians preferred order and precision in their patient care whereas, according to Dolan, Babylonian documents show a more casual approach to medicine and the care of the sick (12). Not only did the Babylonian documents describe many “cures” in their efforts to ward off evil spirits or punishment from the gods but also the Code of Hammurabi dictated the exact amount of payment the physician would receive for treating someone of a specific class. A class of physician-priests were responsible to the government for the quality of patient care and occupied a prestigious position. Under the physician was a surgeon who bore the full weight of “the malpractice punishments of the Code” (Dolan 12). However, in the Code of Hammurabi, no specific mention is made of a nurse or someone similar to the modern conception of a nurse.

The Hebrews made the next advance in the development of a nursing specialty. Dolan makes several interesting observations about the Hebrews’ interest in medicine. First, she notes that the Hebrews’ concern for medical care emerged about the same time

as the Babylonians' interest in medicine. Second, the Hebrew civilization was notable for their interest in sanitation and public health, while the extant Hebrew texts, like the Babylonian texts, also reveal a philosophy that considered disease divine retribution. Third, neither the Babylonians' nor the Hebrews' documents show a specific societal role for a nurse or a nurse-like person (Dolan 12-13)

The next step in the development of medicine and medical care occurred in the seventh century B.C. The Greeks made important strides toward developing medical terminology and advances in the field of medicine as a science. Because trade allowed contact with other cultures, the Greeks utilized the better techniques and qualities from the various civilizations that they encountered to compile ideas, treatments, and methods into their own form of medical care. A medical work, *The Art*, by Hippocrates—who may or may not have written the numerous works ascribed to him, but who is called the “Father of Medicine” and author of the Hippocratic Oath—discusses both the profession of the physician and nursing practices. For example, Hippocrates taught accurate observation of the sick, that diseases have natural causes, and laid the foundation for the professional nurse by dismissing slaves, and insisting that medical students care for the patients (Dolan 39).

Additionally, Homer used the term “nurse” (or a form of the word “nurse”) in *The Odyssey* in order to write about Odysseus' wet nurse and in *The Iliad* when Thetis is speaking to her son, Agammon: ““Unhappy son!”/. . . ““Why have I borne thee with a mother's throes,/To fates averse, and nurs'd for future woes?”” (*The Iliad of Homer* 23). Homer's words may indicate that nursing focused only on the mother or women of the family, or that nursing might create a future agony for one involved in the care of the

sick.

Still, specific searches among ancient texts for mentions of women as nurses or anything that might resemble the nursing profession, reveal only oblique and incomplete references (Dolan 37-39). However, Bullough and Bullough concluded that, since women were not considered worthy of literary mention, and since nursing occurred within the household, women did perform such chores (18). I think that the reason women aren't mentioned, specifically, is because caring for the sick was so much a part of day-to-day life that the ancient writers did not see the need to record mundane tasks. The detailed descriptions in the ancient texts concerning proper care of the sick, though, would indicate that someone—trained or semi-trained—would be present to carry out any instructions left by a physician (Bullough and Bullough 18).

As the Greek culture gradually gave way to the Roman culture, Greek physicians were called upon by the Romans who practiced a form of folk medicine in order to learn from Greek expertise. When Rome developed into a world power, consideration was given to training a class of Roman physicians, but the major area of medical care where the Romans excelled was in nursing. Because of the vast empire that Rome controlled, and the constant fighting of the Roman armies, Rome developed the “original portable hospital” (Bullough and Bullough 26). When tents became spread too far from a base of operations, the Romans built “permanent convalescent camps located at strategic points” (26). These hospitals seem advanced when compared to other, earlier, civilizations because they contained wards, recreation areas, baths, pharmacies, and rooms for the attendants (26). The attendants were males who were, probably, the first professional nurses. I would argue that the Romans' portable hospitals were the forerunners of the

Mobile Army Surgical Hospital (MASH) which served in both the Korean and the Vietnam Wars, and the Medical Unit, Self-Contained, Transportable (MUST) units which were specific to the Vietnam War (Kopp 13).

Women, in ancient Rome, were restricted to caring for those in their households and to delivering babies—which the physicians refused to do—basing their refusal on moral or modesty grounds. Later, as Rome became a vast empire, nursing homes—*valetudinaria*—were established to care for sick slaves because slaves nursed the sick and were, therefore, considered valuable (Dolan 42). The Romans also gave much attention to public health and sanitation, but not to developing a “professional” nursing order. The Romans, with their attempts to extend their control over the known world, also spread their medical ideas throughout the same areas.

Dolan notes that when the Romans invaded Britain, the Irish Celts “were [already] advanced in medical treatments, and in the establishment of laws regulating the practice of medicine” (44). The Celts utilized Roman medical knowledge in order to expand their own medical knowledge. Not only did the Irish build hospitals, but they also trained physicians, and educated their women. However, evolution of a professional nursing class did not take place. Women merely aided in the births of babies and tended to the sick in their households but little else (Dolan 44). Possibly the Celts chose not to have women in the hospitals because they were needed at home, or maybe the Celts’ reluctance to have women in the hospitals foreshadows the later Victorian thought, especially among the upper middle class, that women shouldn’t view such disturbing scenes as sickness and death because of potential damage to their *sensitive* natures.

As the ancient civilizations ended, and other, stronger groups succeeded them,

nursing went through the first of its major changes. One of the major factors that influenced these changes was Christianity. Bullough and Bullough as well Dolan ascribe the beginnings of nursing as a profession to the birth and ministry of Christ because his message was to care for the poor, the sick, the homeless, the widows and orphans. In *Nursing: Its History, Trends, Philosophy, Ethics and Ethos*, Pelley defines “the word ‘nurse’ [as] a derivative of the Latin word ‘nutricus,’ meaning to nourish, foster or protect” (5). This definition also became the defining philosophy of the first *official* nurses.

In the first century of the Christian Church, an order of Deaconesses was established. These *visiting nurses* carried lamps in order to find their way from house to house, and became known as the “bearers of the lamp.” The Deaconesses followed a set of vows entitled “Corporeal Works of Mercy” (Dolan 49). These vows included giving food and water to the hungry and thirsty, clothing, visiting, and sheltering the naked, imprisoned, and homeless, and burying their dead, but their focus was care of the sick (Bullough and Bullough 49). These precepts were based on the parable of the Good Samaritan, the Sermon on the Mount, and other words ascribed to Jesus as well as the writings of the early church fathers. One of the first Deaconesses is named by St. Paul in his letter to the Romans. He wrote, “For she [Phoebe] also assisted many and myself also” (*Romans* 16: 1-2). The Deaconesses were not trained to cure or prevent illness, but focused on the relief of suffering. Although the order gradually died out, they laid the foundations for the profession of nursing by their focus on the care of the sick.

Pelley notes that another step in the development of nursing as a profession occurred during the fourth and fifth centuries when a group of noble Roman women

began to care for the poor in Rome. These women were well-educated, intelligent, and wealthy; however, they chose to work mainly in the slums of Rome because the need was so great. Even so, they were so well-respected by everyone that history is aware of who they were, and what they did. Among these women were St. Helena, mother of Constantine, who gave her life to the poor as did St. Fabiola who was eulogized by St. Jerome for her dedication. Additionally, St. Paula and St. Irene were also instrumental in establishing hospitals and monasteries, and in elevating household care to an almost professional level with a strong spiritual base (Pelley 9).

Moving into the Middle Ages, one notes that nursing care which had earlier become connected with the Roman Catholic Church continued to be, predominantly, the purview of monasteries and the Roman Catholic Church: “. . . nursing became one of the primary functions of religious duty within the monastic establishments” (Pelley 11).

Dolan notes that several memorable women came to the forefront in their quest to fulfill their lives’ mission by nursing the sick, and caring for the poor. Among these women are Sts. Brigid, Hilda, Clothilde, and Margaret, who dedicated their entire lives to the sick. Additionally, during the Middle Ages, large hospitals were established, for example, the Hôtel Dieu in Paris.

Another forward step in the development of a professional nursing organization was the founding of medical schools. The School of Salerno, staffed by lay men and women, was founded to train both men and women in the fields of medicine and surgery. Dolan concludes that “[n]ursing at last had developed roots, purpose, direction and leadership” (67). However, a shift in the need for and the types of nurses would soon be created by the Crusades.

Under the auspices of the Roman Catholic Church, hospitals and a few schools had already been established, but the vast numbers of Christians, pilgrims, merchants, and entrepreneurs involved in the Crusades required care; thus, the development of military nursing orders became necessary. The Knights Hospitallers of St. John were organized to provide both soldier and nurse in each individual. This group also founded the Sisters of the Knights Hospitallers whose combined tasks included religion along with caring for the sick and wounded (Pelley 12). These monastic groups gave nursing

established principles and practices of unquestioned obedience and devotion to duty, a disciplinary etiquette, a status with aristocratic trends, and an apprenticeship method of preparation for a service based upon religious motives and ideals of charity and service. (Pelley 12)

Not only would these concepts become the primary philosophy of nursing, but they also would be the foundation for military nursing, and would be among the many goals promulgated by Florence Nightingale in her *Notes on Nursing: What It Is and What It Is Not* which established modern nursing and nursing training.

Shryock in *The History of Nursing: An Interpretation of the Social and Medical Factors Involved* notes that, after the Crusades, St. Francis of Assisi founded a mendicant order whose goal was to aid the sick “in a simple, neighborly way” (106). Inspired by St. Francis, St. Clare, of a rich noble family, was motivated to found a convent focusing on the care of the poor and the sick. The examples of St. Francis and St. Clare inspired other priests and nuns to found their own orders, notably Guy de Montpellier in 1180, and an order of sisters known as Oblates in 1296 (Shryock 106). Other Holy Orders soon followed the examples set by these pioneering priests and nuns.

During the fourteenth century (in Europe), the bubonic plague epidemic created a need for a dedicated group to nurse the sick as well as to care for those who survived.

The task fell mainly to women in holy orders. The role of women in holy orders was characterized by St. Catherine of Siena who devoted herself to the care of the plague victims. Her devotion to these plague victims also transcended time, and inspired A.C. Swinburne's poem, "Siena," which salutes the sacrifices of this early nurse: "[s]he took the sorrows of the lands/with maiden palms she lifted up/the sick time's blood-embittered cup/and in her virgin garment furred/the faint limbs of a wounded world" (*The Poems of Algernon Charles Swinburne* 571). Paintings also exist of St. Catherine walking through the streets carrying a lighted lantern much like the Deaconesses of an earlier time, and Florence Nightingale in the Crimean War.

Nursing, during the Middle Ages, seems to have centered mostly on "individuals of high intellectual and social background" (Dolan 92). Both Pelley and Shryock confirm Dolan's assertion that women of more than average intellect and background enjoyed both the status and recognition provided by the Roman Catholic Church. The religious preparation of the women who cared for the sick as well as their intellectual and social environment could be the source of the madonna/mother and the angel stereotypes that are used by male authors to describe the nurses in their novels. To a group of poor and sick people, these women in their habits with the ability to make people feel better must have seemed like the pictures of the saints in the stained glass windows come to life. Further, the women with their gentle ways, and their focus on the relief of suffering must have been like supernatural mothers to the poor and the ill. Unfortunately, the achievements of the Roman Catholic Church, and people like St. Francis and St. Clare, would be followed by a seemingly "dark period" in medicine, but especially in nursing, which lasted from 1600-1850 (Shryock 153). If the nuns of the Roman Catholic Church

had appeared to be madonnas/mothers, and angels, then this new period would bring the third stereotype, that of the whore, into existence.

The decline in nursing can be correlated to the religious upheaval caused by the Reformation and its corresponding alteration of society's traditional organization. The nurses and hospitals had been under the aegis of monastic orders; however, during the Reformation, those who wished to reform the Church urged dissolution of the monasteries, which resulted in the "Pilgrimage of Grace" in 1536.

The culmination of the closure of the monasteries occurred during Henry VIII's reign. Henry VIII closed the few monasteries that remained in the British Isles in order to provide money for his various wars. The result for the poor and the sick was tragic. Hospitals became places of horror, places to die rather than to get well. A statute of 1414 had declared, "Many hospitals . . . be now for the most part decayed, and the goods and profits of the same . . . spent to the use of others, whereby many men and women have died in great misery for default of aid" (Shryock 154-55). The same situation was true during the time of Henry VIII. Also during this time, training for physicians and nurses became virtually unknown outside of specific groups related to monasticism but always careful not to *appear* monastic especially since the Reformation had created a climate that was hostile to Roman Catholics. One anonymous writer commented that "[d]uring the bubonic plague in London in 1665, [the] attendants ['nurses'] were described as 'dirty, ugly, unwholesome hags'" (Bullough and Bullough 94). The writer's description is a representative example of how the profession of nursing had declined.

This decline in medicine and in medical care changed hospitals not only into places of horror but also into places where the care given was either by convalescent

patients, or by paid servants rather than a group of trained nurses. Shryock notes that the able-bodied patients were forced to work in the hospitals for their own good. In addition, a trend developed whereby the directors of a hospital would hire servants and pay them a small sum (circa 1630). Still, diseases like smallpox and plague ran rampant. Advances in medical science were few and had to counter prevailing “medical” theories which included the idea that diseases were caused by witchcraft. Moreover, methods to cure the sick appear to be more torture than cure; for example, gunshot wounds were generally treated with boiling oil, and the mentally ill were beaten and confined in “hospitals” that would be considered nightmarish by any standards. Medical knowledge seemed to revert not just to primitive levels but to a pre-primitive state where the sick were regarded as being victims of divine retribution, and filled with imbalances in the bodily humours: yellow and black bile, phlegm, and blood (Bevington xxvii).

A few charities were founded to provide care, again, under the patronage of the Roman Catholic Church. During the Reformation, two types of nurses appeared: women in Holy Orders along with lay sisters of the various orders, and a group of untrained, uneducated poor women who were forced to provide a rough “care” for the unfortunates who came within their reach. This last group was supposed to perform the housekeeping chores required and to sit as “night watchers” (Shryock 162). The disparity between these two groups probably reinforced the stereotype ideas that are so widespread in today’s war novel genre.

The “dark period of nursing” (Dolan 101) was lightened by the founding in 1633 of the Sisters or Daughters of Charity Servants of the Poor by St. Vincent and the Venerable Louise de Marillac. Popularly known in France as “the Grey Sisters” because

of their bluish-grey habits, these lay sisters came from all levels of society and reaffirmed their vows annually. The rule which St. Vincent finally gave the organization (25 March 1642) states, in part, that the sisters will have “no grate but the fear of God, no veil but holy modesty” (Randolph 1). Their rule also reinforces the madonna/mother and angel stereotypes because their habits must have looked very much like the Church’s image of the Virgin Mary, and with their care for the poor and the sick, some must have associated these sisters with angels and madonnas.

The Sisters of Charity were trained to relieve suffering anywhere they found people in need, which included the battlefield. The first time that the Sisters of Charity appeared on a battlefield was at the request of the Queen of Poland—a former Lady of Charity. Three Sisters were sent to the field of battle. Their heroism “secured for them the title: ‘Angels of the Battlefield.’ These Sisters not only ministered to soldiers in Poland but were also present in the Napoleonic Wars, the Crimean War, and the United States’ Civil War” (Randolph 3). Because France continued to be a Catholic country, organizations like the Sisters of Charity had the opportunity to develop and grow into mature orders whose purpose was care of the poor and the sick. However, despite these small advances, the poor and the sick desperately needed the establishment of one or more hospitals that could provide more intensive care than home visits could.

In 1538, the people of London petitioned Henry VIII to re-open two hospitals he had closed during the Pilgrimage of Grace (1536). One of the closed hospitals, St. Bartholomew’s in London, became known not only for the quality of its medical care but also for its well-trained nursing staff. These nurses were, like those of the Middle Ages, divided into two categories—sisters and nurses; however, this time both groups were

supervised by a matron instead of the male heads of monasteries. The sisters (the term is a carryover from the monastic orders) generally had charge of a ward, and those under a sister were called nurses. The nurses' work included bedmaking, washing patients' clothes, and assisting in the care of the sick. In addition, a code gradually developed specifying the responsibilities of nurses: to occupy any free time with spinning or other work, and to "avoid scolding, swearing, or drunkenness, and [they] were exhorted to be virtuous, loving, and diligent" (Bullough and Bullough 64-65). Progress toward the development of a professional nursing staff seems, by reading the histories, to have proceeded without retrogression; however, such was not and is not the case.

The seventeenth and eighteenth centuries witnessed surprising advances in medical science and lesser advances in nursing. Most of the day-to-day nursing was still done by mothers in the privacy of their homes. Hospitals were built, but did not maintain the same quality care that the monastic orders had accomplished. The lack of quality care was probably due, in large part, to the paucity of training for those women who were not in a Roman Catholic monastic order. In short, nurses were more housekeepers than caregivers. The pattern of a lack of education, and a lack of incentives, continues to be evident during these two centuries.

In the 1750's, most women who were placed in charge of hospital patients were, in reality, very poor, untrained, dishonest, and given to drunkenness. The condition of the "caregivers" mirrored the appalling conditions in the hospitals, which were overcrowded, unsanitary, and dirty, more like jails of the time period (Shryock 219-20). The generally sad state of nursing would face the activity of numerous reformers, for example, Dr. William Smellie (1740) who introduced French obstetrical practices in

London, and Dr. William Cadogan (1747) who wrote essays on hygiene. Other reformers would encourage better preparation for doctors, for instance, Dr. Thomas Percival, who published (1803) a code of ethics for doctors (Shryock 220). Although the doctors were improving their training and practices, conditions in the hospitals and among the nurses did not improve significantly. Ultimately, the conditions in the hospitals and among nurses would be permanently altered by one upper class English woman during the nineteenth century—Florence Nightingale.

The true origin of the role of the combat nurse owes itself to one singular human and her involvement with a mid-nineteenth century foreign war: Florence Nightingale and the Crimean War. Born into the upper middle class on 12 May 1820, Florence Nightingale would be very well educated by her parents in order to take her place in upper middle class English Victorian society. Her father insisted on an extensive education for both her and her sister; therefore, Nightingale studied Latin, mathematics, philosophy, religion, and modern languages. She was also well traveled, making many visits to Paris and Italy. Nightingale's educational foundation provided her with the background necessary to become a nurse and to establish a training school.

Besides her education and travel, Nightingale accompanied her mother when she visited the poor and ill in the neighborhood. These visits were not the result of her mother's need to care for these people, but rather that Fanny Nightingale considered these undertakings her charitable duties as a member of the upper middle class. However, to a young and impressionable child—she was nine years old when she began accompanying her mother—these visits gave Nightingale insight into poverty and neglect. In fact, Cook writes that Nightingale made a note in her diary that “as early as her sixth year—was the

sense of a *call* [emphasis mine]; of some appointed mission in life; of self-dedication to the service of God” (15). Because of Nightingale’s mother’s insistence that caring for the poor and sick was not a goal that an upper class young woman should have, Nightingale questioned others in order to confirm her own belief in the efficacy of her *call*. In 1844, while visiting Julia Ward Howe and her husband, Dr. Howe, “Nightingale asked this question, ‘If I should determine to study nursing, and to devote my life to that profession, do you think it would be a dreadful thing?’ Dr. Howe replied, ‘Not a dreadful thing at all; I think it would be a very good thing’” (Cook 43).

However, Nightingale’s plan to study nursing was temporarily halted, again, by her mother. In a letter to Nightingale’s cousin, Hilary (11 December 1845), Florence wrote, “But there have been difficulties about my very first step, which terrified Mama. I do not mean the physically revolting parts of a hospital, but things about the surgeons and nurses which you may guess” (Cook 44). Her reference was probably to the generally low state of nursing and of the nurses themselves. Interestingly enough and almost ironically, Florence Nightingale’s own perception of nursing may have been influenced by Dickens’ *Martin Chuzzlewit* (1844) and its strong negative depiction of nurses and nursing that most likely affected Nightingale’s mother, too. That Fanny Nightingale was influenced, negatively, by a popular novel is probably due to the Victorian habit of reading each serial publication aloud after dinner. One can imagine that the popular image of nurses was only reinforced by Dickens’ novel and Fanny Nightingale’s own fears that her oldest daughter wanted to be a nurse. It is interesting to note how the influence of novels, on a particular subject, can impact the way society, in general, feels about a group. Florence Nightingale, on the other hand, was probably made very aware

of the low class view of nurses, in the same novel. She, then, pushed to change that image.

The whore stereotype probably gained momentum as well as confirmation in the popular imagination through novels such as *Martin Chuzzlewit*. Dickens' female character, Sairy Gamp (*Martin Chuzzlewit*), is characterized by her common language and speech patterns, her rough manner, and the neighborhood—a warehouse area—in which she lives:

she was a fat old woman, this Mrs. Gamp, with a husky voice and a moist eye. . . . She wore a very rusty black gown, rather the worse for snuff, and a shawl and bonnet to correspond. The face of Mrs. Gamp—the nose in particular—was somewhat red and swollen, and it was difficult to enjoy her society without becoming conscious of a smell of spirits. (287)

Mrs. Gamp explained her reason for using spirits in conjunction with her services: midwifery, care of the sick, and preparing the dead for burial: “One’s first ways is to find sich [sic] things a trial to the feelings, and so is one’s custom. If it wasn’t for the nerve a little sip of liquor gives me. . . , I never could go through with what I sometimes has to do” (287). Not only did Dickens’ nurse character drink, she would also order food, ostensibly for her patients, and then eat it herself. During her stay with a patient she would spend the time eating and sleeping; if the sick person moaned or asked for anything, Mrs. Gamp would hit and berate the patient for disturbing her: “The bitter and indignant sarcasm which Mrs. Gamp conveyed into these taunts was altogether lost on the unconscious Chuffey, who appeared to be as little cognizant of their delivery as of his havin [sic] given Mrs. Gamp offence [sic]” (644). Although Dickens’ characterizations of nurses must have affected Nightingale’s mother, these same characterizations served to spur Florence Nightingale to action.

In July of 1851, Florence Nightingale had her chance to begin fulfilling her life's work and her calling. Because Parthe, Florence's sister, was ill, Fanny Nightingale took her and Florence to Carlsbad, Germany, because the waters there were considered restorative. Florence Nightingale was allowed (she was only 34 at the time!) to spend that time at Kaiserwerth Institute (close to Carlsbad) rather than with her mother and her sister. She remained there, as a student, from July to 8 October 1851. Nightingale had long believed that she would find, at Kaiserwerth, the source to begin reforming both hospitals and nursing, especially since Theodore Fliedner (founder and director of the Institute) followed the tenets of the Deaconesses (Cook 108-09). However, Nightingale did not find the type of training she would later develop for her treatise—*Notes on Nursing What It Is and What It Is Not* (1860), but she did find “a better life for women, a scope for the exercise of ‘morally active’ powers . . . training which alone could fit women for larger responsibilities elsewhere” (Cook 111). Nightingale was searching for a dedication comparable to nuns, but for protestants. “. . . Miss Nightingale dreamed of trained women dedicated to the care of sick patients. She envisioned a ‘Protestant Sisterhood-without-vows,’ women who would be devoted and dedicated to their calling. . .” (Aynes 7). At Kaiserwerth, Nightingale had not learned the day-to-day medical care of patients, but she did learn the need for dedication and devotion to the sick.

After she returned to England with her mother and sister, Nightingale felt the necessity for more training. However, Fanny Nightingale had hoped that Florence had *gotten over* her nursing ideas. Both Cook and Woodham-Smith's biographies of Florence Nightingale discuss the opposition of Fanny Nightingale to Florence's desire to be a nurse. Florence was not ready to give up; therefore, she sought further instruction at

Maison de la Providence in Paris (June 1853). This French hospital was operated by the Sisters of Charity, whose devotion to the relief of suffering was well known. Nightingale was the equivalent of a postulant although not allowed to eat with or sleep in the same areas as the nuns (Cook 127). While Nightingale remained with the nuns, she became aware that devotion and the practical side of nursing—bathing, feeding, and giving medications were not enough:

she [Nightingale] gave devotion generously, and she did an immense amount of practical nursing in the Institution herself, but she was always aware that its success was impossible without a balanced expenditure and a proper system of keeping accounts. (Woodham-Smith 76)

In July, she returned to London, and on 12 August 1853 became the superintendent of a hospital euphemistically named an “Establishment for Gentlewomen during Illness” (Cook 133). Nightingale set to work reducing “chaos to order, and her management of this hospital won praise in all quarters” (Cook 136) especially from the hospital’s Board of Trustees. Her experiences as a superintendent plus her training at both Kaiserwerth and Maison de la Providence provided a knowledge of systematic bookkeeping, a clean facility, and properly prepared food; Nightingale would incorporate each of these in the Crimea. When Nightingale’s final *call* came to go to the Crimea and nurse the soldiers, what she had learned would be the basis for her combat nursing, the foundation for nurses, and their training for both civilian and military nursing.

Florence Nightingale’s field training took place during a short, but devastating war that the British Army’s officers were not prepared for; nor were any of the officers experienced in fighting a war. However, the Crimean War (1852-1856) was, at first, a popular war with the British public. The Russians were, historically, considered a threat to many western European countries. When the Russians began to move, militarily, into

territory that belonged to the Ottoman Turk Empire, the result was a plea by the Turks for help in order to control what was viewed as empire expansion no matter the cost:

England entered this war between Russia and Turkey on the side of the Turks because Russia was seeking to control the Dardanelles and thus threaten England's Mediterranean sea routes. The country might not have gone to war had it not been so popular, patriotism being inflamed by such works as Charles Kingsley's *Westward Ho!* (Cody 1)

Although the British did not enter the war until 1854, their involvement accelerated the necessity to have medical personnel available who could care for the British soldiers.

This awareness of the need for quality care for the British soldiers, and specifically, the need for females to be sent to the Crimea to nurse the soldiers, came directly from newspaper correspondents whose accounts of the war reached England within two weeks of the actual events. Phillip Knightley writes that when the British people learned of the appalling conditions that the British Army was being forced to endure, they marched in the streets demanding proper care (4). Statistics concerning the numbers of soldiers that were dying, for example, 40-50 percent dying from cholera (Berges 95), combined with vivid descriptions of soldiers dying through exposure and neglect increased the British public's demand for action (Woodham-Smith 83-85). Thomas Chenery—Constantinople correspondent for *The Times*—commented that there was a lack of “sufficient surgeons, dressers and nurses, [and] linen to make bandages. . .” (Knightley 13). Consequently, Sir Sidney Herbert, British Secretary of War, who recognized Nightingale's work as a competent hospital administrator at a private women's hospital as presenting the type of medical care which could aid the British military, requested that she organize a group of about 40 women and go to the Crimea to nurse the soldiers. Herbert wrote,

If this succeeds an enormous amount of good work will be done now to persons deserving everything at our hands, and a prejudice will have been

broken through and a precedent established which will multiply the good to all time. I think she may be regarded as having proved an exception to La Bruyere's dictum 'that men and women seldom agree on the merits of a woman; their interests are too different.' (Page 262)

"Florence Nightingale and the Crimean War" supports both Cook and Woodham-Smith's biographies, all of which record Nightingale's comment when accepting Herbert's invitation that Nightingale go to the Crimea. She asked that "she should be regarded 'not as a lady but as a hospital nurse'" (Page 206). Nightingale's stance shows her as advancing far beyond the Victorian restrictions on the upper middle class woman. She believed that nursing could rise above the prevailing ideas that nurses were low-class drunks, and stereotypically, whores. Therefore, Nightingale carefully selected the women who would go with her. In addition to providing a carefully selected group, Nightingale wished to have them dress in uniforms so that her nurses would be easily recognized, and would not be confused with either the Crimea's female inhabitants or the camp followers near the barracks. A uniform would separate her nurses further from the idea of *all* nurses as drunks, and help create a higher social standing for these women.

Nightingale was aware that nursing orders had always had a specific uniform. During the monastic period, the uniform was the habit of whichever group of nuns were nursing. For example, the Deaconesses wore a stiff white cap, and their dresses were of linen or of stuff—a wool or worsted material. The motives behind the uniform style and fabrics were to promote "humility, cleanliness, practicability, uniformity, and equality" (Flikke 117-118). Nightingale chose a blended uniform which consisted of

a loose wrapping gown of dark grey tweed, worsted jacket, plain linen collar, and thick white cap. Passing over the right shoulder was a broad strip of brown Holland embroidered in red worsted with the words 'Scutari Hospital.' Short grey worsted cloak, brown straw bonnet and veil completed the costume. (Flikke 117-18)

The purpose was, again, to provide a standard that would be easily recognized, serviceable, and warm.

While Florence Nightingale and her nurses were in the Crimea, a further need was recognized for the comfort and care of the soldiers. As the men healed from disease or wounds, they would become bored. With nothing to do, the men often went to the grog shops and the brothels that had sprung up around the Scutari hospital (Berges 98). Nightingale, therefore, undertook the task of rectifying the situation. I would argue that her actions planted the seeds for the civilian organizations that have become so necessary to the various branches of the military. Nightingale opened “reading and recreation rooms, and offered games and theater, singing classes and lectures, football and chess” (Berges 98). She also told the commanders of each unit that “she would receive any money a soldier would give her and forward it to England, arranging for a postal order to be sent to the soldier’s family” (Berges 98). Prior to the Crimean War, nothing other than hardship, death, drunkenness, and visits to brothels had ever existed. Nightingale was determined to ease the soldiers’ time during a war. Her actions would, I think, be the earliest foundations for the Red Cross, the USO, the Service Clubs (which were so valuable in the Vietnam War), and other civilian organizations whose women were dedicated to helping the soldiers find some relief from the devastation of war.

After the war, Nightingale returned to England, where she was acknowledged by Queen Victoria as both a nurse and a hero. The Queen’s approval helped Nightingale further gain the recognition of the British public. While Nightingale was in the Crimea, many legends had already begun in England through the soldiers’ own words in letters sent home to their families. One soldier wrote, ““What a comfort it was to see her pass



Nightingale's work in the Crimea:

The ranks are full, the hospitals are empty. The angel of mercy still lingers to the last on the scene of her labours; but her mission is all but accomplished. Those long arcades of Scutari in which dying men sat up to catch the sound of her footstep or the flutter of her dress, and fell back content to have seen her shadow as it passed, are now comparatively deserted. (Cook 303)

Through these ideas, songs, and poems, the growth of the stereotypes of madonna/mother, and angel flourished. Nurses who had been thought of as whores were, now, through the adulation of Florence Nightingale also thought of as angels of mercy. I would argue that these legends and myths are the source for the use of the three stereotypes that are seen in Victorian novels about the Crimean War as well as the later novels about this war, which will be discussed, in detail, in Chapter Three. Further, I would argue that these three stereotypes are the source for their more graphic use in Vietnam War novels.

Nightingale's next mission, was to found a school that, funded by monies donated by a grateful nation for her work in the Crimean War, would provide trained nurses not only for the British, but would, ultimately, set the pattern for nursing training worldwide (Turner 65). Nightingale not only wanted to maintain the standards for nurses that she had established during the Crimean War, but she also wanted to increase the numbers of trained nurses, which would help end the stereotypes that were, generally, placed on women nurses along with establishing the trained nursing corps that she envisioned.

Nightingale chose St. Thomas's Hospital as the training ground for her nursing school, which had arranged to pay its own way so that there would be no financial obligation to the hospital, and the nurses would be trained and supervised by women not men as the traditional hospital had previously established (Shryock 279). In June 1860,

15 probationers entered the first training class to provide “the foundations of modern nursing and of the Nursing Profession as we know it today” (Hillyers 491).

Florence Nightingale’s school had several basic precepts which can be found in her *Notes on Nursing What It Is And What It Is Not* (1860). She advanced the ideas “that nurses should live in a Home fit to form their moral life and discipline, and that they should receive their practical instruction in the wards of a hospital, under careful supervision” (Hillyers 491-92). Additionally, these “Nightingale Nurses,” as they came to be known, trained for one year, received pay for their training, and spent two to three years gaining hospital experience either at St. Thomas’s Hospital, or in other, nearby hospitals. As the school grew so did the curriculum, which, at first, “embodied” all that a nurse is required to know and do at the bedside of the sick. The probationers were also expected to “keep written records in the form of lecture notes, diaries, and case books” (Turner 65). In 1867, additions made to the curriculum included chemistry and physiology (Hillyers 492). In 1900, the period of training was extended from one year to four years, and divided into a Preliminary School which included “housewifery, sick-room cookery, first aid and bandaging as well as instruction in the elementary principles of anatomy, physiology, and hygiene,” and in the second half, provided an initiation into ward routines (Hillyers 493-94). The last two years were spent gaining clinical experience.

Nightingale’s nurses were trained under a “master plan, steadily pursued, and [which] made the history of pioneer nursing all over the world” (Hillyers 492). Since Nightingale considered nursing a *calling*, the hospital became the equivalent of a “mother house” with those in training treated very much like novice nuns (Shryock 280).

However, because the training produced quality nurses, hospitals began to demand more Nightingale nurses. By 1885, the school had 1500 applications for only 32 vacancies, and between 1860 and 1900 “1,645 candidates were admitted to the Nightingale School” (Hillyers 492-93). Whereas in 1861 nurses were listed in the census under “Domestic,” by 1901 nurses were enumerated under “Medicine.” Nightingale had created an awareness in the public mind that “nursing [is] an art, and must be raised to the status of a trained profession” (Cook 445). Because other nursing schools proliferated with no check on quality, an organization was needed to provide standards that mirrored Nightingale’s own standards for *all* nurses. The growth and development of nursing schools impacted both civilian and military nursing. At this point, in the late Victorian period, several organizations came into being with the single idea that nursing and nurses must adhere to strict standards of behavior. The nurses were still fighting the whore stereotype, and the feeling that all nurses were low class. These women were attempting to be seen not as madonnas/mothers, angels, or whores, but as professionally trained nurses. Consequently, several such organizations were founded in the next few years.

In *American Nursing: History and Interpretation*, Mary Roberts notes that in 1893 the American Society of Superintendents of Training Schools was founded to advance nursing’s interests, to maintain universal standards, and to promote fellowship among the members (25). Other organizations quickly followed: the International Council of Nurses (1899), the National Association of Colored Graduate Nurses (1908), the Canadian Nurses’ Association (1907), the American Nurses’ Association (1911), and many more. Along with the growth of professional organizations came the need for professional publications so nurses could remain aware of new methods and

improvements in their field. Two of these professional publications are *The American Journal of Nursing* (1900), and *Nursing Research* (1952). By 1903 another need arose—the need to require all professional nurses to register so that these women could be recognized. A national examining board was established to test all graduates of approved nursing schools, and grant licenses along with title Registered Nurse (RN) to successful candidates. As with many professions, just graduating from an approved program and gaining the license would soon be considered only part of the process. Next would come continuing education requirements so that the nurses' training would reflect the most advanced ideas and practices in medical science (Dolan 261-63). Nursing, by the time of World War I, was well established *outside* of the military, but only marginally *inside* the military structure. As a result, the lack of *military* nurses caused many women to come forward in order to further Nightingale's work, maintain her high standards, and notably, to help create a professional *military* corps of nurses.

Dr. Anita McGee (vice-president of the Daughters of the American Revolution—DAR) began a push to establish a military nursing group. The DAR had been very active in getting nurses (1200) sent to Cuba during the Spanish-American War. Her actions followed the Spanish-American War, which had given “prestige to the work of graduate nurses and set in motion forces that were to have an important influence on the development of the profession” (Mary Roberts 28). The ultimate result was the Army Reorganization Bill (1901), which established the Army Nurse Corps (ANC) as a branch of the Army Medical Service. Nurses were appointed and served three years, “but their functions and military status were not defined” (Dolan 266). Jane A. Delano organized the American Red Cross Nursing Service whose function was to provide a nursing

reserve both for military service and emergency service. “In order to join this reserve group, it was essential to be a member of the American Nurses’ Association and the Army Nurse Corps (ARC), as well as the American Red Cross Nursing Service” (Dolan 266). The Nurse Corps of the United States Navy was established by an act of Congress (May 1908). As if to provide a path for these new groups to show the world their capabilities, World War I (WWI) created a demand for nurses, opened up new areas of specialization, accelerated educational processes, and awakened the public to the need for good nursing (Dolan 267). With Congress and many strong-willed women working side-by-side, nurses would be ready to participate in their first major war.

The trench warfare of WWI combined with the use of gas and the outbreak of typhus and flu took its toll on the medical and nursing resources. The total number of nurses who served in WWI was 24,000. Of these nurses, 21,000 were members of the ANC (Mary Roberts 144). Nurses served with pride. One of these WWI nurses was Helen Fairchild, who represents the willingness and pride exhibited by the combat nurse. Nurse Fairchild received her orders to France on Monday, 3 May 1917. She wrote her brother, “I am grateful to be one of the ones to go . . .” (Rote 668). In a later letter home, Fairchild wrote about her proximity to the fighting: “I am with an operation team about 100 miles from our own Base Hospital, closer to the fighting lines,” and in another letter she describes her day as being very demanding, “. . . what with the steam, the ether, and the filthy clothes of the men . . . after fourteen hours of this, with freezing feet . . . then [I’m] off to rest if [I] can, in a wet bell tent in a damp bed without sheets” (Rote 670). Such conditions were very similar to those encountered by Nightingale, and indeed, have been the conditions reported by almost all combat nurses throughout nursing history.

Although the total number of nurses seems great, they were insufficient for the 4,000,000 men who served, especially when combined with disease and the pandemic flu outbreak of 1918. Not only did the soldiers in the field suffer from the shortages of nurses and the dearth of quick efficient medical care, but also the drain on civilian service created severe shortages. As in the days of Florence Nightingale, the numbers of nurses were inadequate to meet the ever-increasing needs of both worlds—civilian and military.

Similar to the rapid development of training schools, and nursing organizations after the Crimean and the Spanish-American Wars, nursing underwent another period of rapid growth between World Wars I and II. The following information relies heavily on the Dolan text covering specific military information which concerns the development of American military nursing. This material is not found in other sources, and is vital to understanding how U.S. military nursing developed into recognized professional organizations.

After WWI (1918), the Army School of Nursing was organized with Annie W. Goodrich as dean (Dolan 268). The school was not founded as a temporary measure, but as a permanent means to provide both a military and a civilian nursing reserve. Although the United States was slow to offer nurses military rank, pressure created by other countries who had already consented to granting military rank to their nurses, resulted in the Army Reorganization Act of 1920, which did grant relative rank to nursing personnel. When WWI ended, the nurses who had served felt that they had contributed more than just their expertise to their country. ““Never before had such a thing occurred, the sending across three thousand miles of danger-strewn seas . . . [the] thousands of *soldier-women* [emphasis mine], to be part of a great expeditionary force”” (Dolan 268). When

WWI combat nurses returned home, they, like nurses before them and after, discovered that they had changed from “textbook-trained” nurses to capable, highly motivated nurses who were not content to just empty bed pans. Peacetime nursing made them long for the high intensity nursing of wartime. Adjustments were difficult. For example, one veteran nurse wrote,

The first private duty case, when one returned to the white uniform, brought a certain amount of satisfaction, but soon one’s thoughts turned wistfully back to the days when slithering around in the mud, wearing rubber boots, was the usual method of going on duty. (Mary Roberts 162)

Nursing needed to further its capabilities, and to develop greater responsibilities for the nurses. The next step taken, after WWI, was to further upgrade the profession of nursing. The Rockefeller Foundation “financed a survey of nursing education” in order to discover both the status of nursing and its needs for the future. The resulting report, *Nursing and Nursing Education in the United States* (February 1923), found many weaknesses in the preparation and training of nurses as well as variations in duration of schooling, subjects studied, and the admission process. The report contained ten conclusions. Among these are requirements for basic hospital training, post-graduate work in public health nursing (probably the result of the flu epidemic and the failure of 29% of the draftees to pass the basic military physical due to poor medical care), nursing training was to be intensive and eliminate unnecessary, non-essential, non-educational routines (Dolan 269-70).

The opportunity to test the success of the nursing report’s conclusions would come soon with the beginning of World War II (WWII). In 1940, the Nursing Council of National Defense (renamed in 1942 as the National Nursing Council for War Service) was founded in direct response to WWII in order “to balance military and civilian needs”

(Mary Roberts 310). In the summer of 1941, the U.S. Congress appropriated 1.25 million dollars for nursing education, and in 1942, the amount was increased to 3.5 million dollars. Congresswoman Frances Payne Bolton (Ohio) sponsored the appropriation bill which resulted in the government's recognition of nurses as a group concerned with their advancement. Additionally, Bolton successfully sponsored a bill creating the U.S. Cadet Nurse Corps (1943). The total number to join this group was 179,000 women. In June 1944, "President Roosevelt signed an executive order making the Corps an integral part of the army, its personnel to receive the same pay and prerogatives as other officers" (Dolan 272-73). The Army-Navy Nurse Act (April 1947) "authorized permanent commissioned status for Army nurses. Florence A. Blanchfield became the first woman to be given a permanent commission in the regular Army as 'Colonel'" (Dolan 274). In July of 1949 the Air Force Nurse Corps was established. WWII, again, gave nurses the opportunity to serve in the military. "Over 104,000 nurses had been certified to the Army and Navy by the American Red Cross (ARC) and over 70,000 were then, or had been, in service with the armed forces" (Mary Roberts 343).

These women served with distinction and courage. Although the stereotypes about nurses were probably part of WWII, they were not seen in the same manner that would occur during the Vietnam War. Nurses, during WWII, were generally viewed as "angels of mercy," but rarely as whores. These women also received many citations and decorations—1,619 or 1 out of 40. Many nurses served in areas that were not considered "safe," and did so with excellence and bravery. Second Lieutenant Winifred Cochrane was one of the nurses who served at the hospital on Anzio Beachhead. She and two other nurses received commendation in an Army Memorandum for their bravery by the

Commanding Col. Henry S. Blesse who wrote that . . . these nurses rendered loyal and devoted service, working long hours every day and always presenting a cheerful smile for their patients . . . they adapted themselves to the additional hardships immediately, even under the constant danger of attack from the enemy.

Cochrane wrote “The Trouble Is Triteness” which reflects her memories of Anzio: “The trouble with attending a war is,/One feels so guilty to come back alive./Young death and torn flesh one writes about is/Theirs” (83). Dolan also notes that other male officers also praised the nurses for their outstanding work: “those who know the record of the Army nurses since the days of the Crimea are not surprised that they proved themselves the equal of men under combat conditions” (274). Further, these officers commented, “their untiring service, their professional skill, and their ability to sustain the unparalleled morale of the wounded in their care will always reflect the highest credit to the Nurse Corps, U.S. Navy” (Dolan 274). The officers’ comments would seem to belie the stereotypical view of nurses in war genre novels, and would foster the professional aspect of nurses that Nightingale wanted to establish.

After WWII, the next opportunity for nurses and civilian women to be involved in a military effort came with the Korean Conflict. Like the Vietnam War, very little about nurses or civilian women’s participation can be found, completely, in one or two sources. The majority of the information is scattered through many texts and documents; moreover, only the Dolan text covers the specific military information given concerning the development of military nursing. Holm in *Women in the Military* recounts the shortage of women’s presence during the Korean War (“war” is Holm’s term). “When U.S. forces deployed to Korea . . . military women, with the exception of nurses, were

left behind, even though civilian women (Red Cross workers, USO girls, etc.) were routinely present” (Holm 209). The actual statistics for women in the 1950’s military break down as follows:

. . . 22,000 women on active duty, and a third of these were in the health professions. The roughly 15,000 in the line (WACs, WAVES, WAFs, and Women Marines) actually comprised less than 1 percent of American’s total military force . . . . (Holm 149)

Increasing the number of women in the military met with strong resistance from the American public as well as military leaders. Because of the protracted nature of WWII, the American public was eager to get back to normalcy; therefore, the Korean Conflict was “an unwelcome intrusion into that impetus.” Problems existed because of the “negative social pressures being applied to young women,” the “timing [for recruiting women] was all wrong” because the war’s pace was slowing, the low pay and low standards of living in the military created problems with recruiting the best qualified, and women were required to meet standards that exceeded those required for men” (Holm 154). The requirements for women even included a psychiatric examination in order to rule out “applicants with personality problems and psychoneuroses” (Holm 154-55). Of the total number of women in the military, only 500-600 served in combat zones during the Korean War, and these were nurses. Although the press highly praised the nurses who served in Korea, recruiting nurses into the military was not enhanced because nurses were utilized only for emergencies and not, as some nurses wanted, drafted (Mary Roberts 50). Other women in uniform got no closer to the war zone than the Philippines, Hawaii, or Japan.

The next conflict/war would prove disastrous at the time and would become a war which continues to influence all facets of American society today. The Vietnam War

(1957-1975) is America's longest and most unpopular war. In *Where the Domino Fell America and Vietnam, 1945-1995*, Olsen and Roberts indicate that

[b]ecause of its peculiar nature—so bloody yet undeclared, so efficient yet so unpopular—the Vietnam War has exerted an extraordinary impact on American culture and foreign policy, shaping the way Americans view themselves, their history, and their view of the world. (1)

The dominance of the Vietnam War can be found in literature, music, politics, history, economics, in the men and women who were Incountry (term used by the military and civilians who served at least one tour—a year—in Vietnam), and in those who were on the homefront. Sending military women to Southeast Asia (SEA) created conflicts within the military establishment. Using women in a war zone—all of Vietnam is now considered to have been a war zone with no safe areas—created more than the usual problem for the War Department. According to Fox in *Air Base Defense in the Republic of Vietnam: 1961-1973*, Cam Ranh Bay—a large base with a major hospital—recorded monthly attacks by the Viet Cong (VC) and North Vietnamese Army (NVA). Holm writes that “[m]any military men and some women contended that a combat area, especially in Southeast Asia, was no place for American women” (205). Some believed that “any military woman in a combat zone would be more trouble than she was worth” (205). Karen Offut was a stenographer attached to the Pentagon in 1968. In 1969, she volunteered for service in Vietnam, “I didn’t think it was really fair that only the men were dying” (McCray 1). Still, she had to persevere in order to get there. Karen wrote, “I was ‘lucky’ because I was working at the Pentagon. I had to beg and bug them and go through several people to get assigned to Vietnam. They made me wait several months until I got ‘older’” (Offut 26 Feb 1998). Other women also experienced the reluctance of the military to send women to SEA. Pat Jernigan wrote, “It took a lot of writing back and

forth, transatlantic phone calls, and much gnashing of teeth. For the men, they just got sent. Us gals had to make a federal case out of it” (Jernigan 26 Feb 1998).

Since the Department of Defense kept no records by gender to record service in SEA, estimates range from 5,000-50,000+ women—military and civilian—who were Incountry. One group, out of necessity, became one exception to the rule of not sending military women. This group was the “anomaly”—nurses (Holm 206). The military willingly sent an estimated 7500 nurses to Vietnam. These nurses were

. . . on the average. . . several years older, more educated, overwhelmingly white and middle class—idealistic ‘good girls’ who grew up in Catholic homes, graduated from three-year diploma Catholic nursing schools and had never been more than fifty miles away from their parents. All had volunteered to join the military; many specifically requested assignment to Vietnam. (Mithers 82-83)

Prior to 1965, “Army and Navy nurses had served on a small scale at Saigon, Nha Trang, and Soc Trang, Vietnam, and Korat, Thailand” (Holm 226). These nurses were very similar to the military male advisors. The mission of these nurses was to train the local nationals so that they could care for any wounded U.S. forces that might be in the area. After 1965 and in association with the military build-up of forces in SEA, the Army began to actively deploy nurses. The military first established the 8<sup>th</sup> Field Hospital in Nha Trang, and the 3<sup>rd</sup> Field Hospital in Saigon. The Air Force set-up the 9<sup>th</sup> Aeromedical Evacuation Group, and a hospital at Cam Ranh Bay; other locations throughout Vietnam and Thailand were sites of newly established military hospitals. The Navy utilized the USS *Repose* and the USS *Sanctuary* as hospital ships anchored off the Vietnamese coastline (Holm 226-227). By 1975, Holm estimates that some 5,000-6,000 nurses and medical specialists had served in SEA (228). The numbers are only estimates; each source consulted reveals a different numerical estimate. Before the war’s end,

eighteen hospitals and nine dispensaries were established to care for the sick and wounded (Holm 228).

Because most nurses were barely out of nursing training with most having only six months experience, they were not prepared for the types and severity of the wounds they encountered. One nurse, stationed at Bien Hoa Air Base, described both what she saw and felt during an attack: “[I saw] the maimed bodies of young men scarcely out of their teens, the green pus that oozed out of many of their dressed wounds, the rage and helplessness [I felt] in the face of death” (Allred 306). What this nurse experienced is duplicated by most of the other Incountry nurses. According to Dusty (she changed her name and identity after her two tours—1966-68, and identifies herself only by a nickname) is also representative of the nurses who volunteered to serve. Dusty’s two tours were spent in an evacuation hospital. These hospitals were where the wounded were first brought in order to stabilize their conditions before being sent to other, long-term care facilities. Dusty was asked why she volunteered. Her reply is indicative of other nurses’ reasons for going to Vietnam and then requesting to remain an additional tour: “the wounded kept coming, the war was getting worse, and I was good at what I did” (Palmer 126). One of the poems Dusty wrote about her Incountry experiences reveals the depth of compassion and strong sense of duty that nurses, mostly since Florence Nightingale, exhibit:

Hello, David—my name is Dusty.  
 I’m your night nurse.  
 I will stay with you.  
 I will check your vitals  
     every 15 minutes.  
 I will document  
     inevitability.  
 I will hang more blood

and give you something  
for your pain.  
I will stay with you  
and I will touch your face.

Yes, of course,  
I will write your mother  
and tell her you were brave.  
I will write your mother  
and tell her how much you loved her.

I will write your mother  
and tell her to give your bratty kid sister  
a big kiss and hug.

What I will not tell her  
is that you were wasted.  
I will stay with you  
and I will hold your hand.  
I will stay with you  
and watch your life  
flow through my fingers  
into my soul.  
I will stay with you  
until you stay with me.

Goodbye, David—my name is Dusty.  
I'm the last person  
you will see.  
I'm the last person  
you will touch.  
I'm the last person  
who will love you.

So long, David—my name is Dusty.  
David—who will give me something  
for my pain? (*Visions of War, Dreams of Peace* 43-44)

For the nursing personnel of the Vietnam War in kinship with nurses from the past who went to war, the deaths of the soldiers were taken personally, and never left their memories. These nurses live day-to-day and night-to-night with their memories and their nightmares. What the future holds for military and civilian nurses past the Vietnam War

is being written, and embodies an entirely different form; however, at the core of the nursing profession will always be Florence Nightingale.

The history of the nursing profession extends from the beginnings of humankind to the present. Nurses have, unlike some other professions, had to struggle for recognition and acceptance both from the general population, and especially from the medical profession. The nursing profession has had to grow from home-based care to the earliest hospitals to the beginnings of a profession to the professional nurses today. Nurses have had, and in some cases continue to have, to fight the stereotypes of “madonna”/“mother,” “angel,” and “whore.” In addition to the general public’s attitudes, nurses have had to fight the war genre fiction characterization imagined by male authors. The civilian women who also go to war face the same stereotypical representations in the fiction as do the nurses.

Throughout the profession’s history, the sense of mission and of a *calling* has manifested itself. The structure and quality of nursing training established by Florence Nightingale continues to influence the profession today. Theodora Turner wrote “The Nightingale Training School 1860-1960,” an article that details some of the development of the schools. She concludes her article with the following statement which was true in Nightingale’s day and continues to be true today:

In spite of the tremendous changes that have taken place in the content of nursing we still endeavour to ensure that the student’s character can develop, so that in the midst of the rapid turn-over of patients and the complexity of surgery and medicine the personal relationship between patient and nurse may remain one of confidence and trust and we may never lose sight of the ‘constant watchfulness and kindness’ which were qualities required of our predecessors in 1860. (67)