

# *Civilian Legacies of Military Nursing*

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LOOKING BACK ON NURSING'S LEGACIES, AT FIRST GLANCE IT IS NOT EASY to determine what elements of nursing have been carried on into current practice. Has nursing's previous practice and knowledge base been discarded as of no benefit, the legacies gone? As one thinks back to the Crimean War, the two world wars, the Vietnam and Korean Wars, and the various conflicts of more recent times, there are many lessons that nursing has maintained and enhanced in its current practice.

The nursing profession has not been good at documenting nursing research and evidence-based practice. It has only recently started to record the practice that makes it unique, and to identify the evidence used in practice to support a legacy that will continue on into the future. Whether or not the role of the nurse as the coordinator of patient care in a particular health setting has been fully acknowledged, it has existed over centuries. In many situations the medical officer may be considered the leader of the team responsible for patient care, but it is the nurse who coordinates and ensures such care around the clock. In some settings the nurse is more visible, both as leader and coordinator of patient care. This is, without dispute, particularly so in the community setting.

## Our beginnings of service or military nursing

We will begin to determine our nursing beginnings with the Crimean War (1854–56) and Florence Nightingale, and their acknowledged effect, for good or for bad, on current nursing practice. The lessons learned in the Crimean War spring to mind as the first legacy of military nursing. Of the 25,000 men who made up the first British expeditionary force sent to the Crimea, 18,000 were dead at the end of twelve months—all but a few from dysentery, cholera, scurvy and other unknown fevers. They were victims of dirty camps, dirty hospitals, bad food, and bad nursing. To quieten the outraged British public, the Queen appointed a sanitary commission to go to the Crimea, and charged Florence Nightingale with the task of revolutionising the mil-

itary hospitals. By applying the principles of sanitation and constant care, Nightingale and her nurses were able to reduce the hospital death rate from 42 per cent to 2.2 per cent, thereby highlighting the vital role of nurses to the overall reduction in mortality and morbidity.<sup>1</sup>

Today, the importance of cleanliness, hand washing, hygiene and wound care is paramount in the management of hospitals and other health settings. Infection control guidelines in many hospitals dictate the need for regular environmental rounds, involving infection control nursing staff, nursing managers and cleaning staff to identify any potential issues related to a lack of cleanliness. The emphasis placed on this highlights to the staff the importance of maintaining a clean environment in the overall care of patients.

## Vietnam and Korea

Triage, a term used for the sorting of produce in the coffee bean industry and fruit and vegetable markets from the 1700s, came to have a different meaning during the Vietnam War, 1962–72, when it was used in the medical context to prioritise those patients in most urgent need of medical care. Triage had been utilised in various wars prior to Vietnam, but its use was perfected in this conflict. The term triage in the multi-casualty setting implies that the most good is done for the greatest number of patients with the available resources.<sup>2</sup> Although it was considered more the realm of doctors, nurses did assist when several casualties arrived at the same time.<sup>3</sup> Triage has since been adopted by ambulance officers in the field setting, particularly in multi-casualty incidents, and in earnest by emergency nurses in the hospital setting.

## Gender equity and relationship to nursing in combat settings

Over the years, the proposal that women join the fighting forces has not been well received. In the Millar report of 1974, it was suggested that women posted to field force units should be allowed to use small arms on a voluntary basis, and that the ages for enlistment and retirement should be in line with those for men.

Efficiency grants that ranged up to one hundred dollars were given only to men who attended a minimum number of parades and qualified at range practice. Women were not eligible for these grants because they were prohibited from weapons training. The Millar report of 1974 recommended

that this requirement should be waived for women so they could qualify for the efficiency grant. It also recommended lifting the restriction on married women with dependent children. It stated that the Women's Royal Australian Army Corps (WRAAC) units have a better recruiting and retention rate than most male units, and maintain an 'excellent' attitude.<sup>4</sup>

Although women in the army have indicated that they are willing to perform combat duties overseas, Australian society has little interest in putting women in the front line. Modern warfare is often conducted at a distance rather than as hand-to-hand fighting, and the traditionally demanding physical requirements for combat soldiers are now being reassessed for both men and women. As the annual fitness run was causing unacceptable levels of injuries, there were suggestions that its length be altered to reduce the training required. Personnel must, however, be battle ready and maintain the fitness levels needed for front-line service. Thus, in economic terms the issue of women being 'less useful' for the same dollar arises once more.<sup>5</sup> In 1960, Civilian Military Forces (CMF) women shared the stigma of being part-time soldiers.

During the Vietnam War and the period of National Service, potential draftees could opt to sign on for six years in the CMF in order to obtain exemption from full-time service. This provision did not enhance the reputation of the CMF, giving rise to the old World War II accusations of being a 'choco' force, from 'chocolate soldier', meaning a reluctant soldier who looks good but melts in the heat.<sup>6</sup>

As nurses were mostly female, they were included in these gender issues, enabling this stigma against women to be further reinforced. In the twenty-first century, nursing is no longer a totally female domain. Many males rank high among nursing's prestigious leaders, although nursing is still female dominated. This gender dominance is certainly not one of nursing's military legacies, as medical assistants in the forces were nearly all male. However, there do not appear to be any male nursing sisters evident in writings from earlier military conflicts.

Charles Martin, in an interview with Narelle Biedermann in her book *Tears on my Pillow*, describes what the female nursing sister could do for their patients that the male medic could not: 'There was a softness we [men] could not provide, a feminine side to nurturing that males often have difficulty communicating without themselves appearing effeminate.'<sup>7</sup> The nursing sisters in Vietnam offered something more in this male environment, which is why it is thought that female nurses are so highly sought after in the event of war. 'Their female presence provides the sick and wounded men [with] a reminder of what they are fighting to protect', and puts a perspective on why they are there.<sup>8</sup>

It is unlikely that one can say the same thing today, as male registered nurses contribute greatly towards patient care and capably demonstrate the caring empathetic attitude that their female counterparts have contributed during times of war. It is also doubtful that one can claim only females can provide this ‘softness’. Maybe in times of war, the female approach and special way of caring becomes more evident in such a male environment. It might also encourage the sick and wounded to remember that for which they are fighting—their wives, girlfriends, daughters and mothers—a perspective that may never change.

The annual *Defence Report 1991–92* recorded:

Women in the Australian Defence Force (ADF) do not have to prove anything to their male counterparts and the defence hierarchy. Their capability and effectiveness have already been shown. And in the current economic climate, and with the ADF going through a metamorphosis to become a leaner and more effective force, it makes good sense to draw fully on the talents and abilities of all available members of the Australian community.<sup>9</sup>

Servicewomen have moved from segregated training and restrictions on employment to integrated training and access to increased employment opportunities, with the exception of combat roles. There are still battles for servicewomen to fight because of their gender, as well as problems with sexual harassment. No woman has been promoted beyond the level of colonel in the army or captain in the navy, but there is now a female air commodore in the air force. The form of femininity previously identified is perhaps not held in such high esteem now, but the affirmation of the value of women’s contribution is still vitally important in today’s defence force. The army has held back from opening combat positions to women, but there are now moves to value the multiplicity of skills and select the best person for the job, irrespective of gender. Valuing the skills that individuals can offer in leadership, intelligence and negotiation enhances the operational efficiency of the army and promises more fulfilling careers for both men and women in the future.<sup>10</sup>

## Impact on their lives

Nurses went to Vietnam for a hundred different reasons, many of them personal. Patients needed care, and nurses volunteered to provide it. Nurses were not drafted, they asked to be there. In total, 7500 nurses cared for patients in the Vietnam War, of whom forty-three were Australian. They arrived with ‘some civilian experience, and many delu-

sions of grandeur<sup>11</sup> about what they would be doing, and little understanding of what was ahead them. The military tried to prepare nurses for what they would encounter, but it was impossible to tell how they would feel and how it would impact on their lives. The nurses in Vietnam quickly learned to assess, do and move on—there was no looking back. The decisions made and actions taken were nothing like the civilian nursing world from where they had come. Nurses triaged, proceeded to intubate, inserted chest tubes, amputated limbs, and did whatever else was required for their patients to survive. Nursing was not only helping the men to live, but also helping them to die with dignity.<sup>12</sup>

Nurses in Vietnam cared for patients with tropical diseases, gunshot wounds, burns, and wounds caused by landmines, claymores and grenades.

As a result of short staffing, nurses were taught to perform tasks that were normally performed by doctors—tasks such as inserting a tube through the patient’s mouth into his lungs in order for the patient to breathe (intubate), administer anaesthetics, insert a small tube into the veins of the patient in order to gain access for blood products and drugs directly into the bloodstream (cannulate), and insert tubes into the patient’s lungs through the chest wall to drain fluid from lungs and to assist with keeping the damaged lungs inflated (insert chest drains). Each of these skills are more complicated than what television soap operas would lead viewers to believe, and considering the environment under which these tasks were performed, the nurses, medical assistants and doctors became extremely skilled.

In the Vietnam War, there were no guidelines directing nursing practice, and the nurses did whatever they could to save lives, knowing full well that the skills learned in Vietnam would probably never be used again once they had returned to Australia. Many described working in the triage area as the most terrifying aspect of their nursing work in Vietnam, as they were not trained to triage seriously wounded patients, or undertake advanced procedures such as emergency assessment and resuscitation. Pamela Kelly’s experience of triage came after 24 hours of observing how it was done: assessing who was critical and who wasn’t. Her first hour of triage was done on her own, without a doctor. Fear not for personal safety but that they may know someone who was being evacuated from the battlefield. Fear also that they were clinically unprepared for the work they were to perform. These helicopters became an overwhelming influence on their lives, and not only for their time in Vietnam but for the rest of their lives.<sup>13</sup>

The nurses communicated with the men’s wives, girlfriends and mothers by writing letters home for those who could not write themselves or to let them know their loved one had died. One could say this is a

legacy that still exists, as even in the highly technical world of nursing today it is the small, non-technical aspects of the job that the patient, family and others remember. It is these personal touches that make people's experience of dealing with nurses and other health care gives a memorable experience. Even as nursing becomes more advanced with higher clinical skills demanded as a routine part of every nursing day, it is the holding of a frightened patient's hand during a procedure, or the smile and a touch which makes the patient feel at home, or just sitting quietly beside a wife or a girlfriend who has just lost her partner in an accident. It is about these gestures that thank you letters are written. This legacy of military nursing is proudly continued, as this is the special memory of nursing that the patient recalls.

Nurses who went to Vietnam and to other wars before that time were generally not prepared for war-time nursing. One of the legacies from this lack of preparedness, both clinically and physically, is the acknowledgment that nurses in a military setting need ongoing preparation for nursing in a conflict situation. They need to be trained and prepared physically as soldiers and professionally as nurses, clinically equipped to manage any situation that may arise. When Sister (later Colonel) Jan McCarthy returned from Vietnam, she saw the importance of developing a field nursing course that would prepare nurses for the transition from the civilian to the field military nursing setting.<sup>14</sup> When she later became matron-in-chief, McCarthy was able to visit the United States and Canada to look at field nursing courses. Strategic alliances have since formed with civilian and defence establishments to assist in the professional training of nurses, medical assistants and doctors on an ongoing basis, as clinical preparation is not possible at little or no notice. Recently, nurses in the defence setting have been expected to attend the field nursing course, as well as the early management of severe trauma course, which was previously only the realm of medical officers. Experiences in Rwanda in 1994–95 showed that nursing officers had again been sent to this conflict clinically unprepared for what was expected. Thus, the second rotation included experienced emergency, intensive care and operating room nurses.

Nurses who directly enter as officers into the Australian Defence Force today are accepted with, and because of, their emergency, critical care, intensive care, operating room, and specialty ward nursing skills. Both general reserve and full-time officers are now deployed in the many conflicts in which nursing officers have become a regular part. The reserve or part-time nursing officers bring with them the clinical skills that enable them to make a unique contribution to the Australian Defence Force when looking after our soldiers.

The scope of practice in civilian nursing today has been extended to incorporate the skills needed to care for patients in a more techni-

cal world, where patient expectations of their own healthcare are greater than ever before both in times of war and in the civilian setting. It is now routine practice for nurses, particularly in the specialist areas, to insert intravenous cannulae, to take venous and arterial samples of blood for examination, to assist in complex procedures, and to monitor and be the support for the care of critically ill patients who may be ventilated or non-ventilated on a twenty-four hour basis. The more advanced role of the nurse practitioner—in a growing field that includes emergency, aged care, anaesthesia, mental health, community, primary health care, critical care, trauma care—also involves the ordering of medications, which is currently one of the significant blocks in the smooth transition of this role into usual nursing practice.

It is reasonable to say that, to date, the nurse practitioner role is more advanced elsewhere in the world than in Australia, although it is progressing here. Rural and remote nurses, for example, take on many extended skills in a widened scope of practice, under standardised protocol-driven guidelines, so as to allow care to be administered when no medical officer is directly available. Emergency nurses also take on extended skills to encourage better patient management, to give more timely analgesia and to start some treatments or procedures that previously had to wait until the patients had been seen by a medical officer. The field nursing course teaches the principles of intubation and assumes that this, along with other more extended skills, may be needed and utilised by ADF nurses in the field setting.

This was certainly the case in the Vietnam War where nurses contributed to the Golden Hour concept in the care of patients. The Golden Hour, incorporating the principles of early care and intervention and surgical treatment, is certainly a legacy of military medicine and nursing and is still currently taught as one of the guiding principles for access and equity of care for all. As a result of this approach:

In Vietnam, fewer men died of their battlefield wounds than in any previous war because of dustoff helicopters<sup>15</sup> and well-equipped modern field hospitals. The percentage of those who died of their wounds declined from 29.3 percent in World War 11 to 26.3 percent in the Korean War to 19 percent in Vietnam.<sup>16</sup>

Patient care is always more about care by a team, rather than care by one person or one specialty. In Vietnam, the nurses contributed as part of a team to the care of the patients; however, in those days they were not called patients, they were called casualties.<sup>17</sup>

The Golden Hour concept is utilised today in the emergency setting, with road or air transport accessed to allow the principle to be maintained. In Queensland, ambulance paramedics, with or without

a doctor, participate in air evacuation of patients from the roadside to the hospital setting. And emergency or critical care nurses and doctors retrieve patients by air or road from one hospital or setting to a higher level hospital for further ongoing care.

## Courage and devotion to duty

In the various conflicts throughout the world, courage and devotion to duty have been evident as part of nursing's exemplar. In World War I, almost 23,000 graduate nurses served in army and navy establishments and in hospitals, with 10,000 of them serving overseas. At least three army nurses were awarded the Distinguished Service Cross, the nation's second highest military honour, several received the Distinguished Service Medal, the highest non-combatant award, and more than twenty were awarded the French *Croix de Guerre*.<sup>18</sup>

One British nurse exemplifies the bravery shown by so many of these nurses. In August 1915, Sister Edith Cavell, who was working in a small Belgian hospital at Ixelles, was arrested by the Germans for helping wounded British soldiers escape through Holland. This she freely admitted during her trial; she was later shot dead along with the head of the local resistance group. The fury this caused throughout Britain encouraged 40,000 recruits to join the army in the week following her death.<sup>19</sup>

Another example of nurses' courage and devotion occurred in 1918, when German bombers made a low-level attack on No. 37 General Hospital, which was then attached to the Serbian army. During the bombardment, British Sisters Dewar, Calhoun and Garrett showed total disregard for their own safety by protecting their patients. As Sister Dewar knelt over a wounded soldier, a piece of bomb casing pierced her chest and she died shortly after in the arms of Sister Calhoun. The Crown Prince of Serbia recognised the gallantry of these nurses by awarding the Serbian Military Medal for Valour to Sisters Calhoun and Garrett. Never before had such an honour been bestowed on women. Such self-sacrifice was not only evident in the firing line, but also through nurses' sheer overwork in their effort to devote all to their patients, despite many of these nurses suffering from dysentery.<sup>20</sup> In total, 260 nurses died either from wounds or disease during the four years of World War I.

In World War II, nurses were stationed in more than fifty countries, and 1600 were decorated for meritorious service and bravery under fire. A total of 210 nurses died, sixteen of them from enemy action.<sup>21</sup> Closer to Australian shores, there are memories of nurses like Sisters Ellen Savage and Vivian Bullwinkel, who showed remarkable courage

in adversity. The sinking of the *Centaur* by a Japanese submarine off the Queensland coast, on 14 May 1943, caused the death of 267 people, eleven of them nurses. Sister Savage, the only surviving nurse, kept calm and did her best to help the others by distributing food and water, attending to their medical needs as she could, and leading the men in prayer. She was later awarded the George Medal for bravery, and commended for her conspicuous service, high courage and fortitude. Sister Savage continued her nursing career after the war. She received the Florence Nightingale Scholarship to attend the Royal College of Nursing in London, and later became Matron of the Rankin Park Chest Hospital in Newcastle, New South Wales.<sup>22</sup>

Similarly, Sister Vivian Bullwinkel survived the sinking of the *Vyner Brooke*, one of the ships fleeing the Japanese invasion of Singapore in February 1942. Her bravery and the bravery of the other nurses involved in the subsequent Bangka Island massacre, in which she was the only survivor out of twenty-two nurses machine-gunned by the Japanese, is nothing short of remarkable. Her survival during this, and her internment in a Japanese prisoner of war camp over the next two and a half years, shows the true courage of Sister Bullwinkel and the others interned with her. A memorial at Muntok on the island of Bangka reads:

The memorial honours the heroism and sacrifice of members of the Australian Army Nursing Service who served in the Bangka area in the second world war during the years 1942–1945.<sup>23</sup>

Sister Bullwinkel rose steadily to the pinnacle of her profession following her repatriation to Australia.<sup>24</sup> Between 1950–55 she worked in St Mary's Hospital and Australia House, London, completed a diploma in nursing administration in 1959, and in 1947 was the charge sister, and from 1959 to 1961 the assistant matron, at the Heidelberg Repatriation Hospital, Melbourne. From 1961 to 1977, she was the director of nursing at Fairfield Infectious Diseases Hospital in Victoria. The legacies of Sister Bullwinkel's determination and strength, so obvious during her military service, became evident in her post-war nursing. She became a reserve nursing officer and lieutenant-colonel in 3 Royal Australian Nursing Corps Training Unit Southern Command from 1955–70, and contributed in a large way to nursing organisations like the Red Cross, the Nurses Memorial Centre Victoria and the College of Nursing Australia. Her awards include the AO, MBE, FRCNA (Fellow of the Royal College of Nursing Australia), and the Florence Nightingale Medal. Sister Bullwinkel's legacy has made nursing, particularly Australian nursing, all the richer.

Can civilian nursing claim to have this same degree of commitment and determination to meet the needs of a changing world and deliver the care needed to patients in whatever the setting demands? Do today's nurses exhibit this same bravery and determination to succeed? The answer one may expect is 'no'. However, is that too harsh a critique of modern nurses?

There are many nurses today who are totally committed to their profession and determined to succeed as nurses, value adding and contributing within their career and the health setting. They have certainly not been asked to demonstrate the same bravery that Vivian Bullwinkel or many others have, but that does not mean they would decline the offer if called upon to demonstrate such a commitment. One can assume they would readily take up the challenge to give service to the standard required or beyond. When Jan Bassett undertook some interviews with ADF nurses—both newly appointed and longer serving officers—she recorded the author of this paper, then one of the more recent nurse appointees to the ADF, as believing '...in a commitment to the need to defend Australia if required'.<sup>25</sup> Part-time nursing officers in the ADF do willingly offer to be part of the contingent in the various conflicts around the globe and in the defence of Australia, performing the role of a nurse in whatever setting it demands. Nursing's esprit de corps is as strong today as it ever was.

In no way do any of these comments above undermine the bravery Vivian Bullwinkel displayed, which would be hard to surpass. She was, and still is in our memories, an incredibly wonderful woman whom the world will not forget. At the opening of the Australian Service Nurses National Memorial on Anzac Parade, Canberra on 2 October 1999, a beautiful day with magically clear blue skies, the author recalls Vivian Bullwinkel's wonderful smile and hearty laugh, as she stood surrounded by the proudest service nurses past and present. When she died on 3 July 2000 in Perth, the world celebrated her life and mourned her loss. However, it is just likely that, in time, others like Vivian Bullwinkel may present themselves.

## The legacies

The strong legacy of military nursing left by Sisters Ellen Savage and Vivian Bullwinkel led into the ongoing contribution and commitment each made to civilian nursing post-war, and nursing is the richer for their input. Respect for nursing, and particularly nurses, in war-time has been acknowledged earlier, but this respect was not just from soldiers but also from medical colleagues. This may have had something to do with nurses' aloofness from other staff, as god-like figures who

always looked so perfect, in their white starched and stiffened uniform. After World War II, this image of nurses carried into civilian hospitals. This was particularly so for matrons, who not only resembled their war-time counterparts but also demanded the same respect from staff. When Matron Sage took over at the Women's Hospital, Melbourne in 1947, she expected to have the same level of respect shown to her as she had become accustomed to in the army. However, this was not how civilian hospitals worked, and junior doctors at this time believed themselves to be more senior to the matron.<sup>26</sup> The respect that Matron Sage expected was not forthcoming from medical staff, even if it was from nursing staff.

For close to fifty years, matrons continued to wield great power over the nurses in their charge. Nurses during this time had trained in the hospital setting, and it was easier to maintain a hierarchical structure within nursing ranks. More recently this hierarchy no longer appears to be acceptable. Nursing is not unique in this; it is a sign of our changing societal expectations. People no longer accept that a hierarchical structure is reasonable, and nurses no longer accept the past status quo. They want to be equal partners in health decisions and in their management structure at the local unit and hospital level. Perhaps along with this change in management structure, some of the aloofness—and perhaps some of the recognised respect for nursing and nurses—also disappeared, or at least, altered over time. The changes to nurses' uniforms may also have taken away some of the mystique surrounding nursing. Maybe that has been a good thing, but perhaps in the wider community there is a belief that nurses have lost something. At some level, they may also have lost the respect of their medical counterparts. In their desire to be more equal they have discarded those things that set them apart, which may yet prove detrimental to the profession. Nurses believe themselves to be equal partners in healthcare, but perhaps other sectors of the industry do not have that same belief.

Assistants in nursing are becoming more popular in today's health care system as the limited resources for nurses are stretched to breaking point. Assistants in nursing support nurses in giving care to their patients in a variety of settings. When one looks back to World Wars I and II, administrative and cleaning roles were handed on to other groups, like the Voluntary Aid Detachments, to allow nurses time to carry out specific nursing tasks. A similar concept has been adopted in civilian hospitals today. This legacy has been further embraced, as limited resources force nurses to identify those aspects of nursing that need to be maintained and kept safe, and those that can be delegated to less skilled staff.<sup>27</sup>

In World War I, Sister Tilton wrote home saying that, over a twenty-four hour period, two casualty clearing stations in France saw 3000

casualties in one and 2800 in the second.<sup>28</sup> It is hard to believe that those same numbers of casualties could be seen in today's treatment areas. Even if every bed was empty and every sister was on duty, it would be unlikely that we could cope with this today. However, this is exactly what the world may face.<sup>29</sup> During the recent sarin gas attack in Tokyo, for example, thousands of patients presented themselves to the local hospital—the first presentation of that number of patients to any hospital setting since World War I. Hospital staff did manage to get through it, but the types of casualties today are most likely to be very different from those at the casualty clearing stations of World War I.

Wound care principles utilised in World War II and in the Vietnam War are still in use today. Baths were popular for wound care then—as they reduced the pain and bleeding caused by the removal of dressings without soaking—with kerosene tins making excellent baths for arms. When grafts were applied it was considered necessary to have a specialist team of sisters, masseuses and orderlies to assist in the gentle handling, observation and intelligent application of the general principles of this work. Now, even though the dressings are more cleverly produced, they achieve the same outcome. The trained team is still evident especially in dealing with patients who have more complex wounds.<sup>30</sup>

In the emergency department setting, nurses are now trained in triage, and supported through the process of learning to assess both critically ill and less acute patients so as to determine the priority of need for each patient's medical care. This determination of triage category then establishes the priority of patient care and sets the emergency team in motion. The lessons from Vietnam began this process in earnest. Triage categories are also used to explore workload issues and, in certain areas, funding arrangements for emergency departments. The simple process of triage—or was it ever simple—has certainly gathered some more angles.

One of our permanent legacies that stands as a fitting tribute to the sacrifice of Australian service nurses is the Australian Service Nurses Memorial on Anzac Parade, Canberra. The memorial in glass and light honours the memory of those nurses who have served and died in past wars and conflicts. The concept for the memorial is horizontal, feminine and nurturing, and echoes the essential, supportive role and inner strength of service nurses. Glass is a timeless material, as old as the custom of women caring for men in war-time. It is familiar, fragile in appearance and yet deceptively strong. Glass reflects the continual changes in light and movement of the surrounding world, thereby emphasising that life continues.<sup>31</sup>

## Conclusion

Nurses have been there throughout the past century, responding to the needs of the nation. They have followed Australia's troops around the world during times of war and distress; climbed on horseback to meet the needs of rural families; walked to migrant camps to care for workers; delivered babies in homes, in elevators and on the lawn; run clinics in storefronts, churches and community centres; and responded to the needs of the ill or injured by learning to operate all sorts of equipment. They have advocated over and over on behalf of those in their care and have learned to finagle [*sic*] the system to help individuals and families get their health care needs met. Nurses have the privilege of being with patients and families during times of vulnerability as well as times of great joy.<sup>32</sup> This legacy has been continued in war-time and peace-time, and is something that nurses cherish. Finally, and indeed most importantly, nurses have continued throughout the twentieth and now the twenty-first century to care, to share joy and sadness, and to hold the hands and touch the hearts of all those for whom they have provided care.<sup>33</sup>

### Brisbane

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