Caring Under Fire: A Grounded Theory of Contemporary Australian Army Nursing Officers in Armed Conflict

Submitted by

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Statement of the Contribution of Others

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Abstract

Over the 160 years since Nightingale marched to the Crimea, Australian Army nurses have practised in war zones in support of military personnel. The relatively little known of their experience is largely historical analysis. Despite progressive militarisation and recent conflicts to which they deploy, the challenges and personal consequences of contemporary Australian Army Nursing Officers (NO) working in a combat environment has not been explicated.

To establish a foundation for understanding the experience of Army NO in international armed conflict, a grounded theory study explored NO who deployed to Iraq or Afghanistan between 2005 and 2021. The focus was on identifying how they prepared for, practised in and survived their deployment—to elucidate challenges and how NO managed them.

This thesis describes the findings and substantive theory that emerged from the data. Caring under fire is the core category around which a need to be prepared, respond to surrounding threats, work with the military organisation, identify as an Army NO, cope with challenge and reintegrate on return home revolved. The final theory is one in which being an Army NO is more than a story about the places they go and what they see. It is about how NO must be prepared to respond to and cope with the complex clinical, moral, military and personal demands of both the organisation and the environment. It is these capacities that allowed them to return home with a sense of achievement that supports learning to live with a new sense of self.

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List of Diagrams

Glossary of Military Terms

Army Health	The modern focus of Army health support is to prevent or cure disease, ameliorate the effects of injuries caused by weapons and to protect the ability of the force to fight, by preserving fighting power (Australian Army, 2015). For further detail, see description on page 12.
De-conflict	A term used in the military to describe the need to manage any conflict existing between two high contrasting situations, such as warrior and nurse. The purpose is to find a point of reconciliation (Oxford Dictionary, 2023a).
Dependency	A term referring to the soldiers for whom a nurse or other health care provider is responsible. A trait of the hierarchical Army structure.
Deployment cycle	The force generation cycle (FORGEN) provides a defined timeframe and action for readying troops for armed conflict and involves three phases: readying, ready, reset. For further detail, see description on page 12.
'Green on Blue'	A threat situation in the form of an unexpected attack by supposedly friendly forces. The colour terms relate to the colours the Army used to designate forces when creating pictorial maps in conflict zones. Blue referred to Australians and allied forces such as the US. Green forces included local soldiers working with the Australians, who had access inside the security perimeter. For further detail, see description on page 114.

Insurgent/Enemy	In Iraq and Afghanistan adversaries were called ‘insurgents’. The traditional term is ‘enemy’. For further detail, see description on page 114.
Medical Technician	Commonly known as a ‘medic’, medical technicians are trained by the Army and hold such qualifications as an Enrolled Nurse and Diploma of Paramedicine.
Mission	The military mission, herewith known as the ‘mission’. An operation assigned by higher command, with clearly defined parameters on activity that can be undertaken and objectives to be met (Oxford Dictionary, 2023b). Within each mission, subset areas such as health, have a discrete mission, nested within the higher Commander’s intent.
Nursing Officer	A registered nurse employed as a specialist officer.
Platoon Commander	A person employed to command a platoon, which is a small group of varying size, depending on the purpose of the platoon.
Refit to fight	A colloquial term used to describe the time when personnel regroup, physically and mentally, in preparation for future action.
Staff Officer	An officer able to undertake the general administrative duties of an Army officer, regardless of their corps (field of specialty).
TriService	A reference to the three services of Army, Navy and Airforce.

List of Abbreviations

AANS	Australian Army Nursing Service
ACU	Australian Catholic University
ADF	Australian Defence Force
ADHREC	Australian Defence human research ethics committee
AHPRA	Australian Health Practitioner Registration Authority
AIF	Australian Imperial Force
ANZAC	Australian and New Zealand Army Corps
ARA	Australian Regular Army
ARES	Australian Army Reserve
BSP	Basic social process
BSPP	Basic social psychological processes
BSSP	Basic social structural processes
COA	Course of action
COVID 19	Coronavirus 2019
DAH	Directorate of Army Health
DDVAHREC	Department of Defence and Veterans Affairs human resource ethics committee
DFAC	Defence Force Area Canteen

DVA	Department of Veterans Affairs
ED	Emergency Department
EI	Emotional intelligence
FORCOMD	Forces Command
FORGEN	Force generation cycle
GT	Grounded theory
IAC	International armed conflict
ICN	International Council of Nurses
ICU	Intensive Care Unit
IED	Improvised explosive device
IHL	International humanitarian law
JCU	James Cook University
MASCAS	Mass casualty (Incident)
MBI	Maslach Burnout Inventory
MED ROE	Medical rules of engagement
MRE	Mission rehearsal exercise
NO	Nursing Officer (used as both singular and plural)
OT	Operating theatre
PG	Postgraduate
POW	Prisoner of war

PTG	Post-traumatic growth
PTSD	Post-traumatic stress disorder
RAANC	Royal Australian Army Nursing Corps
RN	Registered Nurse
SERCAT	Service Category
UK	United Kingdom
UN	United Nations
US	United States (of America)
WWI	World War One
WWII	World War Two

Chapter 1: Introduction and Historical Background

1.1 Introduction

Despite being essential contributors to the survival process, the documented record about military nurses' experience in war is light and knowledge of this subject is limited. The dominant discourse in documented history concerns the 'military' aspects of war—of battles won and lost, strategies and tactics used. Health research has focused on medical lessons of war. Existing literature on military nursing is predominantly historical narrative recollection and description, with an emphasis on the two world wars. As a result, the military nurse's experience in war is provided through an historical lens, often extrapolated from and secondary to the predominant experience of soldiers.

Beginning with an explanation for the inception of this study, and then using a chronological approach, this chapter provides a short history of Australian Army nursing from the Boer to Gulf Wars. This is followed by a brief explanation of recent wars and a few key military terms, concluding with an outline of the chapter structure for this thesis. This sets the scene for Chapter Two, which provides additional background to this study, in the form of a review of contemporary literature on the experiences of military nurses.

1.2 Motivation for the Study

I joined the Australian Army Reserve (ARES) as a Nursing Officer (NO), two years after graduating as a Registered Nurse (RN). At that time, I found that Australian Regular Army (ARA) forces did not view ARES as part of the 'real Army'; nurses were not viewed as 'real officers' and gender was an overt barrier. There was no clear direction on how to develop in the role of NO. The implicit expectation was that I would understand my job in the Army without additional direction on its nursing aspects or any significant training on how to be an officer. Despite these impediments to transitioning into the Army, I embarked on a self-driven journey of discovery, focused on developing knowledge of the Army along with civilian clinical and leadership capacity. Because the system overtly emphasised the 'officer', I had little involvement in clinical aspects of military care. After many years of commitment,

determination and frustration, I eventually reached a point where I felt I understood the interaction and reciprocity between the Army and nursing.

After a tour of Timor Leste in 2004, I deployed in 2005 to armed conflict in Balad, Iraq. I found myself negotiating and navigating some very difficult terrain to ensure my patients received the best care I was able to provide in very austere circumstances. This required every bit of clinical acumen, ingenuity, courage and sheer determination to do what I considered the 'right thing' (in nursing professional terms) in the face of the significant ethical and clinical challenges that arose from the complex interplay between two sides fighting a war and the people caught in the middle. The magnitude of the trauma was appalling; I was caring for large numbers of patients with minimal support and witnessing behaviours towards patients I had never expected to see and never really understood. I found my own vague sense of peace in caring for the large number of dying and deceased soldiers and civilians, and in focusing on getting the job done.

At the end, I simply went home and returned to my civilian work. I discovered that going home was more than returning to Australia; there were unexpected consequences from deploying to a war. With minimal active guidance on how to be an NO or how to go to war and return home, I used a reflexive retrospective process to examine my deployment and career, realising that it was up to me to make sense of the Army and my role in it. I was irritated and frustrated: it did not need to be like that. I worked my way through my concerns and decided to do something about improving the future for Army nurses. I wanted to discover what others had experienced—thus this research project was born. I wanted to illuminate what being in the Army is about and to key identify considerations for navigating the path to NO: how to prepare for, survive and transition home from war. Finally, what to think about when, as the infantry would put it, 'refitting to fight' the next round—both for our profession and ourselves. Thus, this study is about Army NO and their journeys into, through and out of war.

1.3 Origins of Army Nursing: 1854–1991

Trained nurses have practised in war zones for over 150 years, yet relatively little documentation exists about their experiences in these austere, intense and dangerous practice

settings. Modern nursing began in 1854, in a British field hospital during the Crimean War, when Florence Nightingale went against the social mores of the time to lead an expedition of female nurses to the frontline (Bostridge, 2008). Using her acumen and social position to engage the military, she countered healthcare mismanagement to improve survival rates and overall care (Figes, 2010).

Nightingale and her colleagues were 'wartime' nurses, nurses who went to war to nurse, but who were not military members (Bassett, 1992). They served alongside but were not 'in' or 'of' the military. This conferred a degree of autonomy in a quintessentially male world; offsetting the vicissitudes of women operating in a man's domain—the military paradigm of the time (Bostridge, 2008; MacQueen, 2007). As a synthesis of social conservatism, military style discipline and Nightingale's approach, civilian nursing training gained a distinctly militaristic tone, which would dominate from the 1890s until at least the 1970s (Bassett, 1992; Vining & Hacker, 2001).

1.3.1 Boer War

In 1899, Australia sent a contingent of 'wartime' nurses to South Africa to work in British military hospitals. The Boer War acted as a catalyst for the establishment after federation of the Australian Army Nursing Service (AANS), a national organisation designed to provide a ready group of nurses for deployment to war (Bassett, 1992). Every nurse who went to war represented civilian nursing training requirements: unmarried, well-educated, advocates of the nursing discipline (Bassett, 1992). For deployment, they had to be clinically experienced (Harris, 2011). Many paid their own way to join the war effort. The first Army nursing death on foreign soil occurred during the Boer War (Bassett, 1992).

1.3.2 World War One (WWI)

In 1914, civilian nurses became the reservoir for 'wartime' nurses, with large numbers signing up to join the war effort (Bassett, 1992). Nurses continued to sign up until 1918, to join or find their brothers, do their duty and, as Tilton would comment, go on the 'trail with the warriors' (1933, p. 7). Approximately 2250 nurses deployed from Gallipoli to the Western Front and outposts such as Salonika (Australian Government, 2021a; Bassett, 1992).

Serving beside the Australian Imperial Force (AIF) until 1916, when nurses received an honorary rank to bring them 'into' the Army, nurses were the only women to serve with the force and near the frontline (Bassett, 1992). Honorary rank was designed to control the all-female nurses and permit the all-male Army Medical Services dominion over the nurses' practice and behaviour (Bassett, 1992). However, nurses consciously managed to avoid full militarisation, perceiving it would hamper their autonomy and success in delivering quality nursing care (Bassett, 1992). Moreover, nurses wanted to remain impartial and nurse both allies and enemy without distinction (Arthur, 2011; Souhami, 2010). Thus, they resisted military external trappings by creating their own uniform and acknowledging each other as 'sister' rather than rank.

Notwithstanding their efforts to keep separate from the armed forces, 33 nurses died in service and several hundred received decorations—including for courage under fire (Bassett, 1992). Until relatively recently, regardless of their frontline service and sacrifices, Army nurses were not viewed as part of the Australian New Zealand Army Corp (ANZAC) (Rees, 2009). On ANZAC Day, nurses would undertake their own march, such as to the Edith Cavell memorial in Melbourne ('Returned Nurses', 1952). In the official WWI histories (Bean, 1920, 1942), and subsequent analyses of war, nurses are more commonly referred to in footnotes, or appear as occasional whispers in the background (Hallett, 2009).

1.3.3 World War Two (WWII)

During the inter-war years, a reserve list of nurses was established and maintained. By 1940, a third of the Australian nursing population had signed up to join WWII, with 3477 deployed over the war's duration (Bassett, 1992). Deploying with only their civilian skills and continuing to refuse khaki dress, nurses, by 1943, wore an insignia indicating permanent military rank for the duration of deployment. This strategy was most likely because the extent and breadth of WWII brought other women into the Army; the behaviour of women could be controlled if they were subsumed into military structure, where rank, position and area of service allowed military rule to predominate (Bassett, 1992).

Thus, nurses became both 'in' and 'of' the military, albeit with distinctly different treatment to male colleagues. As true non-combatants, nurses did not carry weapons. However, a

number of them would handle them in desperation when their non-combatant status offered, ultimately, no protection. Many nurses were prisoners of war (POW), tortured, died in enemy action or survived to return home to recover physically and deal with the experiences (Bassett, 1992; Jeffrey, 1954; Kenny, 1984; Manners, 1999; Shaw, 2010).

An inherent discipline and *esprit de corps* at the heart of the nursing profession became evident after the fall of Singapore, when nurses as POW fought to survive as a whole. Where possible they maintained a 'leave no one behind' approach (Manners, 1999), reflecting a theme that continues in modern war, where an injured soldier is always retrieved. The transition of nurses to 'warrior' started in WWI because of proximity to the frontline. However, when the line between combatant and non-combatant blurred during WWII, many nurses found themselves undertaking activities more commonly associated with soldiers (Bassett, 1992).

1.3.4 Korea and Vietnam

The militarisation of nursing advanced by 1951. The AANS became part of the regular Army (ARA) force, transitioning to the Royal Australian Army Nursing Corps (RAANC) (Bassett, 1992). Permanently serving Army nurses supported post-war reconstruction. As fully-fledged Army (Nursing) officers, at least by external appearance, nurses became obligated to behave in accordance with military policy, albeit without having to undertake military duties. Nurses could no longer refuse to wear khaki or deny acknowledgement by rank (Australian Army, 2019). Only the official rule of not being required to carry a weapon remained.

From 1945–1971, during what is commonly referred to as the Cold War period, NO served in Korea and Vietnam. The Korean War, now described by many as the 'forgotten war', remains largely obscure for soldiers, with even less known about the nurses who served. O'Neill's (1985) official history of the Korean War, 1950–1953, has a section on medical services, but fails to acknowledge nurses adequately.

The nursing contribution to the war in Vietnam, 1967–1971, resulted in both military and 'wartime' civilian nurses serving (Australian Government, 2021b). In keeping with the past, pre-deployment training was minimal and nurses were required to run wards, but had no

authority over male orderlies (Bassett, 1992; Biedermann & Harvey, 2001). The military expected NO would be able to adapt to the clinical demands of war using civilian experience (of any sort) and consequently mismatched professional experience against clinical appointments in the war zone. In addition, nurses ultimately felt clinically unprepared for practising in a war zone given a lack of resources and the nature of the trauma they saw—high numbers of young, critically compromised personnel with complex contaminated blast injuries survived to hospital because of advances in aeromedical retrieval (Biedermann & Harvey, 2001; Biedermann, Usher, Williams, & Hayes, 2001; Brayley, 2016).

NO believed they had to adapt rapidly to cope with and survive their clinical challenges, and subsequently found themselves operating beyond the scope of practice with which they deployed. This, in turn, influenced how they perceived the role and identity of the Army NO. The situation they found themselves in, resulted in challenges with transitioning from war (Biedermann et al., 2001). On their return home from Vietnam, most nurses simply went back to work, either civilian or military. Exposed to anti-war sentiment on returning home, nurses suffered similar psychological and physical effects to Vietnam veteran soldiers (Bassett, 1992; Biedermann et al., 2001). Although better known than the war in Korea, as Brayley (2016) argues, nurses who served in Vietnam have been largely ignored, and their contribution disregarded, in post-war explorations of the conflict.

By the 1970s, Army NO had gained 'equality' by rank, pay and uniform, but on men's terms (Bassett, 1992), which meant restrictions in terms of conditions of service, including where nurses could work. Nurses were still non-combatants in a combatant organisation. In 1972, the first male joined the RAANC (Bassett, 1992).

1.3.5 Gulf Wars

NO deployed to the first Gulf War in 1991, by which time they were wearing camouflage uniforms, carrying personal weapons and expected to meet the same fitness, weapon readiness and general military standards of all Australian Army personnel (Australian Army, 2019). They were more 'of' the Army than they had ever been before. Gender was no longer an official barrier, despite military traditions still reflecting inbuilt gender prejudice (Bassett, 1992)—such as what roles a female (not the male NO) could fill.

Nurses had two distinct roles: Army officer and nurse, one a combatant and the other, not. These produced a conflicting duality. The nursing role had not changed, but expectations of the individual in the Army had. Thus, as a consequence of the organisation they worked with, the wars they battled through and changing social expectations, the process of militarising nurses—which began in the Boer War and accelerated through WWII—was almost completed by 1991 (Bassett, 1992).

Apart from work by Biedermann et al. (2001), on the war in Vietnam, knowledge of Army nursing prior to 1992 is drawn predominantly from Bassett's (1992) seminal historical inquiry covering the Boer War to the first Gulf War. A source of original facts, iteration of nurses' personal experience and socio-political circumstances up to and including 1991, Bassett (1992) articulated the general experience, challenges and personal consequences of war, and generated an insightful and valuable understanding of the progressive militarisation of nurses. However, while establishing a history upon which to add a story of modern Army nursing, Bassett's narrative stopped in 1991. There has not been an examination of the longitudinal effects of fully militarising nurses. Nor has there been an evaluation of which themes regarding the nursing experience in war persist into the twenty-first century.

1.4 Army Nursing After 1991

What is known of Army NO after 1991 derives from the grey literature and publication of personal stories (McCullagh, 2010). Army nurses became increasingly involved in military activities beyond their nursing practice insofar as they were expected to display the qualities and capabilities of the Staff Officer—an officer able to undertake the general administrative duties of an Army officer, regardless of their corps (field of specialty). The Australian Defence Force (ADF) deployed nurses to conflicts in Rwanda, 1994–1995, Timor Leste 1999–2004, 2006–2013, Iraq and Afghanistan, in various clinical and administrative roles. NO also deployed to a range of humanitarian operations (Australian Army, 2021; McCullagh, 2010).

1.4.1 Rwanda

In 1994, the security situation in Rwanda deteriorated into a civil war, resulting in a United Nations (UN) security response. As part of this military effort, Australian medical teams provided support to military personnel (Operation TAMAR), with a secondary requirement to provide humanitarian relief to Rwandans (O'Halloran, 2012).

Australian Army NO, wearing the same uniform as soldiers and carrying weapons, worked in a variety of settings, from primary health to intensive care, and had the opportunity to work relatively autonomously in refugee camps (McCullagh, 2010). In April 1995, just before ANZAC Day, a contingent of Australian health personnel, including NO, were in the Kibeho refugee camp where a massacre of 4000 Rwandans occurred, the worst genocide in recent history.

The Australians struggled to deal with an overwhelming volume of injured humanitarian victims, including the many young children orphaned when their parents were killed (Australian War Memorial, 2021). Although many NO went home feeling they had done what they could and left behind an enduring legacy, others left with a sense of hopelessness (McCullagh, 2010), reflecting the different ways NO perceived and processed their experience after returning to Australia.

1.4.2 Timor Leste

From 1999 to 2004, Australia deployed military personnel to Timor Leste as part of a peace-making mission that involved significant armed violence in its early stages. NO on deployment arrived to scenes of widespread physical devastation of the local infrastructure, including the healthcare system. The purpose of NO started with the provision of primary health care to soldiers plus a secondary resuscitation capability, then progressed to a significant role in humanitarian aid support (McCullagh, 2010). Some worked with UN medical personnel, and the general sense on coming home was one of having helped a fledgling nation by supporting its healthcare system (McCullagh, 2010).

1.4.3 Iraq

During 2005, Operation CATALYST included an Australian contingent of nurses from the TriService, embedded in a United States (US) military hospital based in Balad, Iraq. This was the first time since Vietnam Australian military nurses had worked with the US in armed conflict. Considered the most bombed piece of real estate in Iraq given the high incidence of ground mortar attacks (A Way with Words, 2019), the casualty numbers presenting to Balad were very high, with many deaths, to which Australian NO were exposed. At the same time, these nurses were relatively isolated from other Australians deployed to Iraq, primarily located further south. Compared with Afghanistan, where locals viewed allied forces as liberators, in Iraq the allied forces were viewed as occupiers (Scannell-Desch & Doherty, 2010), thus altering the political dynamic within which these NO operated.

From 2014 to 2021, Australia deployed nurses to Taji, Iraq (Operation OKRA), where they worked in support of an Australian Defence training mission, which focused on capacity building for local security forces (Australian Army, 2020). The role of NO in this context included primary health care support to Australians and training of local health personnel (Australian Government, 2015).

1.4.4 Afghanistan

From 2001 to 2021, Australian soldiers deployed to Afghanistan on Operations SLIPPER or HIGH ROAD. NO began deploying to Tarin Kowt during this time, ceasing when Australia formally pulled out of the war in Afghanistan. Specialist NO started deploying in support of US health services in Kandahar from 2007 and continued to do so until 2021 (Australian Army, 2021). Whether an NO went to Tarin Kowt or Kandahar determined the range of situations they experienced, including the risk of armed attack and injury to Australian military colleagues.

Despite these deployments, after 1991, there has been no formal exploration of the involvement of Australian military nurses in contemporary conflict and thus there is almost nothing in documented history about their experiences.

1.5 Military Terminology

As this study is about Army NO, I felt it was important to allow the nature of the military to permeate the language used—enabling the non-military reader to gain a sense of the culture nurses encounter when they join the Army and begin militarising. Moreover, I believed that trying to describe military terms in non-military parlance would result in some loss of meaning in the narrative. Therefore, I decided to use a small selection of the military terms referred to by participants throughout the thesis and describe their essential meaning in a glossary, as a reference for the reader. I also explain the militarisation process and provide additional detail on the terms 'deployment cycle' and 'Army health'.

1.5.1 Military and Militarised Products

To create a distinction with regard to how someone is militarised, I have chosen to describe personnel in the Army as being either a 'military product' or a 'militarised' product. A 'military product' is someone who joins the Army and has a purpose-built Army job, such as an infantry soldier, that would not exist or fit neatly into another organisation. Through an extensive training process, the Army ensures inculcation to the organisation, general military objectives, Army culture and language.

RN are an example of 'militarised' personnel; people with a qualification and practice that the Army chooses to import, rather than create. They undertake initial civilian training and practice and then enter the Army to commence a process of militarisation in order to understand and work within the system. They take with them a view of nursing formed outside the organisation and not influenced by military factors until they enter the Army. This view continues to be important as they remain registered by a civilian organisation (in this case the Australian Health Practitioner Registration Agency [AHPRA]), which places extant obligations on the nurse for the standard of their practice, including their ethical stance. The extent to which an NO uses Army language and demonstrates Army-oriented attitudes and behaviour is variable, dependent on exposure to the Army, duration of service and personality.

There is a small subset of NO who begin their career as a military medic, meaning that they are, initially, a military product. They undertake a Bachelor of Nursing and the obligatory two years graduate experience in a civilian hospital before re-entering the Army as an NO. Militarised in advance of becoming an NO, this group subsequently develop an understanding of civilian (non-military) perceptions of nursing, before re-focusing on the military organisation.

The militarisation process is a combination of skills-based training and socialisation of the individual to the structure, culture and language of the Army. This socialisation occurs through interaction with the Army over time, through a variety of training activities and postings. The Army is a highly structured hierarchical organisation that trains to operate in dangerous, austere environments. Structure is important to ensuring standards are maintained, particularly those of discipline in behaviour. This is essential to ensuring people respond, as the Army needs them to, to facilitate safety. Thus, a nurse's preparation for the military aspects of working with the Army is similar to the baseline training given to all other personnel.

After completing baseline military training, a nurse prepares for their unique role within the organisation. Through military socialisation, there are varying degrees of transformation in person and practice. For instance, once nurses join the Army, they become more than a nurse working in the military—they are an officer in the Army, an NO. The title of Army officer encompasses expectations of behaviour and capability, which supports the military organisation. To maximise their clinical effect, and to navigate and negotiate organisational relationships and power structures, NO need to develop an understanding of how demands made by the organisation can influence clinical decision-making.

1.5.2 Deployment Cycle

If armed conflict breaks out, the Army needs to be ready to fight; thus, they need to generate the capability to do so. The force generation cycle (FORGEN) provides a defined timeframe and action for readying troops for armed conflict and involves three phases: readying, ready, reset. 'Readying' occurs through training. Being 'ready' means individuals or groups are ready to go and, before deploying, are likely to need only last-minute training focused on a

particular deployment environment. Ready also implies an individual has the requisite experience in their role for what they are likely to experience in armed conflict.

'Resetting' occurs after return to Australia, where a responsive approach takes lessons learned on a deployment and integrates them into future training (Australian Army, 2014). This is also the period colloquially described as 'refitting to fight', where personnel regroup physically and mentally in preparation for future action.

FORGEN essentially reflects the deployment cycle of preparation, deployment and redeployment home. However, in practice, while combat units may operate clearly on a three yearly cycle, health personnel are concentrated in health units from which selection for deployment occurs at any time. Thus, they ultimately fall outside of FORGEN, meaning that an NO may not receive the benefits of being embedded in a cycle that facilitates the gaining of relevant professional experience required to be 'ready'. In the case of NO, this equates to ongoing clinical practice aimed at both maintenance and development of skill.

1.5.3 Army Health

To enable the Army to raise, train and sustain a fighting force, a hierarchical structure exists with associated cultural values. Although, over time, the purpose and structure of the Army has essentially remained unchanged, weapons and retrieval systems have evolved and expectations of healthcare have shifted. The modern focus of health support is to prevent or cure disease, ameliorate the effects of injuries caused by weapons and to protect the ability of the force to fight, this latter by preserving fighting power (Australian Army, 2015).

Military members are viewed as existing in a dependent relationship with their employer (Australian Government, 2018); soldiers rely on the system for their healthcare, both proactively and reactively. A commander has legal authority over personnel in their command and there are unique requirements for the select sharing of information with a commander. This requires that those who share that information, such as NO, understand why and how they should liaise with combat personnel and higher rank. This, in turn, requires a good working knowledge of the structure, culture and function of the Army.

1.6 Significance of the Research

Australian Army NO deploy to war zones where they function in dual roles (as both nurse and officer) and are potentially faced with treating colleagues, civilians or enemy using whatever scope of practice is required by the situation. They experience the harrowing nature of armed conflict, potentially time-critical or morally challenging situations and sometimes risk their lives in the line of duty. Then they return to Australia, where they resume their non-wartime nursing practice, with no apparent consideration for how they or their practice may have changed in response to their armed conflict experience.

Although a small amount of knowledge exists concerning historical Army nurse experiences, very little is known about the modern Australian Army NO. It is important to understand their experiences because the survival of those who sustain injury is in the hands of those tasked with their care, which includes NO. Thus, soldiers rely on the preparedness and capacity of NO to provide care and to do so while under potential duress in armed conflict.

With no available literature that theorises how modern Army NO prepare for, practise in and survive the armed conflict experience, the inquiry into their activities during conflict as described in this thesis will provide knowledge about an under-researched area of nursing. The findings from this study have been formulated into a theory that makes sense of participants' experience by explaining who they are (identity), what they do (role and scope of practice), the challenges they encounter deploying to and practising in war zones and how they find resolution. This knowledge is intended to inform the preparation of nurses for deployment regarding the challenges they may face in delivering optimum care; thus, potentially improving outcomes that benefit the nurse, nursing profession, patients, Army and government.

A substantive grounded theory (GT) of Australian Army nursing—as developed through this study—may provide a way to navigate and negotiate the challenge of being both a nurse and officer, rather than NO being expected to understand the job and how to do it. Such a theory will explain potential tensions between nursing priorities and the Army and offer recommendations that might assist NO in resolving them, particularly for the benefit of patient care in the difficult terrain of armed conflict. Thus, the intent of this research is to

improve the future for Army NO, by illuminating what being in the Army is about, how being both officer and nurse can be complementary and how to prepare for, survive and transition home from war.

1.7 Thesis Overview

There are eight chapters in this thesis, reflecting the study's progression from inception to theory. This first chapter has introduced the study, discussed relevant historical background and described the significance of the research. It has demonstrated that although Army nursing formed the basis for the profession of modern nursing, little historical research exists beyond personal stories and occasional research. There is no research on Army nursing after 1991, and therefore this chapter outlined the significance of exploring the experience of contemporary Army NO and the effects of militarisation on their clinical practice.

Chapter Two describes the literature review process, followed by analysis of the knowledge found. Identified key themes include transition and transformation, clinical and moral readiness and coping strategies. Despite increasing contemporary understanding of war and its associated challenges, this chapter demonstrates how researchers have tended to ignore military nurses working in war as a study population. Chapter Three describes the methodology underpinning this study, gives a brief discourse on the origins of GT and the methods utilised, including the ethical challenges of the study and why Glaserian GT was chosen.

The study findings are described in Chapters Four to Six. Chapter Four begins with a description of the participants, followed by an explanation of the preparation NO experienced before deploying. Chapter Five describes the findings through the deployment phase and return to Australia, identifying not only what NO experienced but how they dealt with those experiences. Chapter Six explicates the theory that emerged from the data, providing the frame, context and pattern of relationships evident in the findings. A case study is used as a working exemplar to provide the reader clarity around how the theory applies.

Chapter Seven is a discussion of the findings in the context of existing knowledge and elaborates on how the findings address the research question. Chapter Eight concludes this

thesis, summarising the implications of the findings, examining the strengths and limitations of the study and providing recommendations for future practice and research.

1.8 Conclusion

As this chapter has revealed, there are long historical roots to healthcare in support of troops, with modern nursing conceived on a nineteenth century battlefield. Prevailing social conditions influenced the organisational treatment of nurses and the extent to which nursing practice was controlled. Over time, NO have become integral to ensuring the health of the fighting force, while simultaneously experiencing progressive inculcation to the expectations and practices of the Army.

Now fully militarised, nurses are more controlled in the twenty-first century than they were when they existed alongside the Army in WWI. The findings of this research, as described in later chapters, explore the implications of this evolution in socialisation to the Army in the context of themes relevant to the modern Australian Army NO and their practice. With this chapter having concluded with a summary of the structure of this thesis, the following chapter provides additional background for the study. More specifically, a review of literature regarding the contemporary military nursing experience provides a basis for articulating the problem statement underpinning this study.

Chapter 2: Review of Research Literature

2.1 Introduction

Chapter One introduced the motivation for this study and provided a summary of the historical antecedents to modern Australian Army nursing, identifying that the documented research narrative ceased to develop after 1991. Chapter One also set the scene for understanding the context of Army nursing by describing key elements, such as the deployment cycle. This chapter presents a review of contemporary research in the substantive area of this study. Specifically, it commences with a brief consideration of the literature review in the context of GT before describing the process employed in conducting this review. Thereafter, the thematic framework used to describe and analyse the findings of the literature review is presented. The chapter concludes with the problem statement underpinning this study.

2.2 Literature Review and Glaserian Grounded Theory

In the contemporary research environment, especially for student researchers, a literature review is a condition to be met when formulating a research proposal. Moreover, to obtain funding requires evidence that a study will contribute to new knowledge (Dunne, 2011). However, when undertaking GT research, the conduct and timing of a literature review can be problematic. In purist Glaserian terms, exposure to the literature introduces the risk of partisanship, in the form of preconception, to the natural emergence of a theory (Artinian, Giske, & Cone, 2009; Fernandez, 2004; Glaser, 1978, 1998; Glaser & Strauss, 1967). In essence, there would be no pre-study literature review undertaken in such studies, allowing researchers to be open, through a form of naiveté, to the literature, to discovering the concerns of a particular group (Holton, 2008; Thornberg, 2012). Glaser (1992) took this further, stating the researcher should not read in the area of research at all and instead attend to literature only from outside the study area. Rather than act as a source of context and stimulus to guide research design and theory development (Strauss & Corbin, 1998), literature is used later during analysis, to clarify and direct emerging theoretical ideas. The irony is that to maintain pre-study naiveté would mean not undertaking additional studies on the same topic.

Moreover, as Thornberg (2012) has argued—problematising the requirement to delay a literature review to avoid preconception—if researchers are to explore their own fields of interest, they are likely to have varying degrees of awareness of pre-existing literature.

To address the problem of how to manage the expectation of GT versus institutional demand, while also ensuring a researcher is not trying to cover old ground, a review of the literature is now considered acceptable as long as researcher thinking is not theoretically prejudiced (Artinian et al., 2009; Luckerhoff & Guillemette, 2011; Thornberg, 2012). In acknowledgement of proposal and thesis requirements, Glaser (1998) has advised treating the literature reviewed as data—there is discussion on both this and how researchers avoid tainting their analysis in Chapter Three. In practical terms, to achieve the minimum to meet institutional demand, Birks and Mills (2015) have suggested undertaking a limited and purposive literature review. Therefore, to find a balance between Glaser's dictum and modern research requirements, in this study a review of the literature occurred for the specific purpose of formulating the initial proposal, identifying a gap in the literature and providing context and justification for the research.

2.3 Literature Search Process

The intent of the search process was to identify peer-reviewed research that could help explain the experience of contemporary Australian Army NO in armed conflict, with the most recent Australian military involvement being Iraq and Afghanistan. In the context of this study, which commenced as a Master of Philosophy (MPhil) and then transferred to a Doctor of Philosophy (PhD), and which involved a change in universities, two literature searches were ultimately required. The first provided context for the MPhil proposal and the second addressed the requirement for a student researcher to revisit their initial literature review prior to thesis submission.

To facilitate a search for literature relevant to this study, a range of primary and secondary sources were utilised. Primary sources were research articles about the military nursing experience. Secondary sources involved information located in the grey literature, which related to this group of nurses. An online search process with no language restrictions utilised electronic databases, engaging the following keywords: 'Army nurses', 'nursing', 'military',

'war', 'armed conflict', 'Iraq', 'Afghanistan' and 'Australian'. The searches utilised library search engines at Australian Catholic University, Royal Melbourne Institute of Technology and Google Scholar. Databases accessed included: CINAHL, Science Direct, Proquest Research Library, Expanded Academic, Political Science—SAGE, Ingenta, Wiley Online, PubMed, Scirus—Elsevier (Scopus). Potential new material was also identified by viewing the reference list of relevant articles. Grey literature was included to address the government and international context and identify archived non-research material and documents. Resources included the Australian War Memorial, Australian National Archives, Australian Army Homepage, National Library of Australia, Kings Centre for Military Health Research and the TriService Nursing Research Program (US).

An initial search of the literature occurred in February 2014, with an open publication time limit. This revealed the majority of literature on military nursing related to international historical narratives about war in the twentieth century prior to the first Gulf War. A small body of work covered Australian nurses from WWI to Vietnam. The majority of all literature found was about Army nursing. The search was re-run from 1 March to 3 April 2014, with a publication time limit of 1 June 2004 to 2014, to narrow search findings to war after Australia's military involvement in the Iraq and Afghanistan conflicts commenced in the twenty-first century. This revealed a very small percentage of literature related to international TriService nursing in Iraq and in Afghanistan. In total, the search identified seven relevant peer-reviewed international studies, none of which were about Australian nurses in war since 1991. A second search occurred in October 2021, using the same keywords and an extended time limit of 2004 to 2021, with the purpose of identifying literature published since the first search. This search identified two additional studies on the experience of non-Australian TriService military nurses.

The nine identified studies included six qualitative studies examining war-based deployments of US and United Kingdom (UK) nurses (Finnegan et al., 2015; Griffiths & Jasper, 2008; Rivers, Gordon, Speraw, & Reese, 2013; Rushton, Scott, & Callister, 2008; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). The wars covered by these six qualitative studies included four examining the recent wars in the Middle East (Second Gulf War [Iraq] and Afghanistan); one evaluated the first Gulf War and another, the war in

Vietnam. A further qualitative study investigated the humanitarian deployment of US Navy nurses (Almonte, 2009). Two quantitative studies used cross-sectional design to examine burnout phenomena, already well described in the literature (Ayala & Carnero, 2013; Lang, Patrician, & Steele, 2012). Of the nine studies, some were exclusively about Army nurses and others examined nurses in the TriService.

2.4 Discussion of Review Findings

Generation of international literature on the topic under exploration has predominantly occurred in the US, encouraged by the TriService Nursing Research Program (1957). The amount of literature generated increased after 2003, in alignment with US involvement in the Second Gulf War. Over time, there was a shift from storytelling to a greater focus on clinical practice challenges amidst conflict and associated preparation prior to deployment (Currie & Chipps, 2015). Six of the studies used in this review were from the US, two were from the UK and one from Peru. Using an Excel spreadsheet, evaluation of each study focused on design, sample, research question, military service, armed conflict and key findings. This review discusses the main themes identified from the studies, which included processes of *transition*, *transformation and coping*, *clinical and moral readiness* and *burnout*.

The term 'war' is predominant when referring to military activity in the international literature. However, in the modern international environment, the term 'war' has specific usage and the term 'armed conflict' permits the enforcement of international humanitarian law [IHL] (Chelimo, 2011). Therefore, for the purpose of this study, from Chapter Three onwards the term 'armed conflict' will be utilised instead of war.

2.4.1 Transition, Transformation and Coping

The experience of entering the military and deploying to armed conflict involves processes of change and transition that may also lead to personal and professional transformation for nurses (Griffiths & Jasper, 2008; Rushton et al., 2008; Scannell-Desch & Doherty, 2010). According to Meleis (2010), transition is a move triggered by change from one stable state to another stable state; within the transition, there can be milestones and turning points. In studies such as Rushton et al. (2008), transition has been described as the passage nurses take

after enlistment and then to, through and home from war. This passage reflects the deployment cycle. Transition can be both a physical and psychological response involving a process of adjustment to a new environment. Transformation describes a marked change of form, nature or appearance (Oxford Dictionary, 2023c). It is not simply a move from one point to the next; it is a physical or psychological metamorphosis.

The notion of transition was central to the core category of 'caring for war: transition to warrior' as exposed in a GT study by Griffiths and Jasper (2008). This study used interviews to examine the wartime experiences of 23 British nurses recruited from the TriService. The core category represented the realities of conflict and the identity of the military nurse, with the term 'warrior-nurse' used to encapsulate the dual role of caring and bearing arms (Griffiths & Jasper, 2008). This poses the questions of how effectively these nurses embraced this new identity, what challenges they faced and how they would de-conflict the high contrast between concepts of warrior and nurse.

Griffiths and Jasper (2008) partly answered these questions by identifying a range of strategies they argued nurses used to cope and adjust with their change to 'warrior-nurse'. Specifically, nurses strived to create a psychological comfort zone from which they could embrace their dual roles and effectively transition from the civilian to military environment and armed conflict. Strategies for managing change and establishing a comfort zone included dealing with the perceived threat in the war environment by using knowledge of how far they were from the frontline. Thus, part of their transition to war was developing an awareness of where they were in relation to the frontline and learning to live with the threat.

The nurses in Griffiths and Jasper's (2008) study identified a potential conflict between caring and military practice, establishing their own mental boundaries between roles and responsibility to manage this conflict. They believed this strategy ensured they maintained awareness of both caring and military codes of practice, enabling them to remain answerable to both the military and civilian nursing professions (Griffiths & Jasper, 2008). It was also suggested that the use of these transitional strategies led to a symbiotic relationship between the warrior and nurse roles, which in turn produced a new identity. Nurses in the study apparently found ways to seamlessly flex from warrior to nurse, dictated by casualty rhythms and threats (Griffiths & Jasper, 2008). A direct threat could trigger transition to warrior, with

the nurse becoming a combatant to survive, thus disengaging from the role of the non-combatant nurse. While referred to as singular new entity, the warrior-nurse description entailed two discretely separate roles, suggesting that the new identity was actually a case of moving from one role to the next according to circumstance. There is a lingering sense that the legal difference between the nurse's non-combatant status under law and their combatant status as a 'warrior' was not reconciled. Moreover, Griffiths and Jasper (2008) acknowledged that reconciliation with the warrior role required nurses to gain specific socialisation and training directed at guiding the transition to 'warrior-nurse'; training that had not been given to the nurses participating in the study. However, at the same time, they did not articulate what the consequences of not gaining this socialisation were.

The study by Griffiths and Jasper (2008) provided insight into the use of GT for exploring the experience of military nurses, in particular their transition to war, identity shift and mental strategies, while also highlighting further areas for exploration. There was a service representation disparity in the participant group, with 14 representing the Army, seven the Airforce and two from the Navy. This may mean that the core category was more reflective of Army nurses. Moreover, the experience level between participants varied significantly, with Army nurses, who were the larger cohort, having the least nursing experience on average (Griffiths & Jasper, 2008). This is important because there was no evidence from the findings that participants were asked about their prior experience and if they perceived whether this made a difference to their overall deployment, where nursing required application of skill. Prior experience, both clinical and of armed conflict, may influence a nurse's transition and adjustment to war (Griffiths & Jasper, 2008). As discussed in Chapter One, transition to conflict was an issue for Australian nurses in Vietnam. The concept of prior experience and readiness for armed conflict is therefore one that requires exploration in the context of the transitional experiences of Australian Army NO.

Other researchers have also shown nurses used psychological strategies in their transitions to war (Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). Scannell-Desch and Anderson (2005) conducted a phenomenological study to explore the lived experience of nurses deployed to the war in Vietnam. Using a purposive sample of 24 female nurses who had served across the US TriService, they distilled lessons that were then shared as guidance

for contemporary US military nurses. The findings highlighted how nurses coped, showing they relied on social support systems, inner strength, humour and diversional activities as strategies to cope with their transition to war (Scannell-Desch & Anderson, 2005). The study also demonstrated that nurses believed better preparation for the influence that armed conflict would have on nursing—such as the environmental, cultural, technological and psychosocial circumstances of nursing in this context—was needed before deploying. This, they thought, would have helped them cope more effectively with the transition.

In their phenomenological study using a sample of 37 US military nurses who served across the TriService, Scannell-Desch and Doherty (2010) explored the experience of deployment to Iraq and Afghanistan between 2003 and 2009. The authors investigated how nurses responded to the challenges they encountered and what happened to them because of their war service. Although nurses coped with their transition through kinship and bonding, they experienced changes in their person and profession, and subsequently faced a difficult challenge of transitioning home (Scannell-Desch & Doherty, 2010).

Nurses in the two studies (Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010) thought they would have benefited from learning the lessons of the past before they deployed. They were keen for future nurses to listen to them to avoid the pitfalls they had faced and thus be better prepared. Lessons from nurses who went to Vietnam focused on coping—including caring for yourself, using support systems, talking about experiences, understanding the mission and being prepared—because they found themselves unprepared (Scannell-Desch & Anderson, 2005). Nurses who deployed to the Middle East shared lessons on the experience of deploying, being in harm's way, kinship and bonding, their war stress, professional growth and wanting to be able to give advice to those who went after them (Scannell-Desch & Doherty, 2010). This suggests that identifying the lessons learned from Australian NO deployed to Iraq and Afghanistan would potentially provide invaluable support for NO who may deploy in the future, while also allowing for the comparison of Australian with US experience.

Compared with nurses in Vietnam, the Scannell-Desch and Doherty (2010) study of Iraq and Afghanistan included nurses who were members of the full-time or part-time (reserve) military and the National Guard (Scannell-Desch & Doherty, 2010). These inclusions were

valuable because of the role part-time military nurses play in modern wars. However, although these studies add to current knowledge regarding the experiences of US military nurses deployed to Iraq and Afghanistan, little is known about the Australian military NO who served in these wars and in US hospitals. This is because there have been no identified studies exploring their experience.

Personal and professional transformations were identified as important influences on transitioning through war. Rushton et al. (2008) undertook an historical inquiry to examine the experience of US Navy nurses deployed during the Persian Gulf Wars, using a purposive sample of 11 naval nurses who, at the time of study recruitment, worked in the same medical centre. The authors found that, as a consequence of the challenges they faced, nurses underwent a process of transformation to their military nursing role and identity (Rushton et al., 2008). The nurses accepted they were military nurses, but established an enhanced understanding of what this meant in terms of role and identity when they deployed and experienced the hardships of war, an experience that required courage and resilience to survive. Nurses articulated a theme of 'it's what we're here for' to describe their belief that military nursing means doing whatever is necessary to accomplish their mission (Rushton et al., 2008, p. 179). The nurses' experience of humanitarian service, supply challenges, patient movement processes, sacrifice of physical safety and caring for the sick and injured influenced their transformation, both on and off the battlefield, with positive or negative consequences (Rushton et al., 2008). An ability to transform role and identity improved their military nursing practice, which required time-critical, concise and effective decisions, while accounting for limited resources.

Conversely, nurses experienced negative effects after redeployment home, where they encountered the need to reintegrate into and re-adjust to an environment that had become foreign to them (Rushton et al., 2008). Despite providing useful explanations about the nursing experience in war, participation was limited to US Navy nurses working in a single military health facility and, as a result, caution is required when interpreting the transferability of any findings. Moreover, given social, political and professional differences between US and Australian nurses, whether Australian Army NO experience similar

transformations can only be determined by examining the experience of those who have worked in conflict zones.

The experience of reintegration on returning home was the focus of an existential phenomenological research study by Rivers et al. (2013). Using a purposive sample of 22 US Army nurses who served at one of two military posts in Iraq and Afghanistan, this study identified themes around the challenges entailed in going home. A key theme in this study related to the responses to the nurse, when they returned to the US, from the organisation and from family and friends. Nurses believed Army Command did not care once they returned, beyond a need to 'check the blocks' (tick the boxes) in the completion of post-deployment psychological evaluations (Rivers et al., 2013, p. 169). Frustration at what they saw as a formulaic process designed to protect the establishment left the nurse with a sense of being insignificant, aggravated by a lack of guidance on how to reintegrate. In addition, nurses felt that Command expectations that reintegration could occur according to a pre-set timeline were unrealistic because they found themselves coping with change and adapting over longer timeframes.

The authors found nurses needed to re-evaluate how they fitted into a civilian environment, compared to the military one they had been in (Rivers et al., 2013). At the same time as they faced challenges at work, nurses found themselves trying to reconnect with their pre-war life, including family and friends. They realised family were frequently unable to appreciate the ways in which going to war 'changes you', with family and friends expecting the nurse to slip back into their pre-war life (Rivers et al., 2013, p. 169). This produced a point of tension between the nurse and their support network, which the nurse inherently relied on to enable reintegration; the onus was therefore on the nurse to work out how to fit in. At the same time, with their experience in conflict altering their perception of the world, they described being unable to put their life back together in the way it was before they left.

Nurses in the study by Rivers et al. (2013) appeared to view the main barrier to reintegration as a failure by Command and personal support networks to realise a person can change in response to deployment, meaning that they may not be able to fit neatly back into their pre-deployment life without additional support. To cope with the gap created by inadequate organisational and family networks, nurses adapted using faith and talking to other nurses

who had deployed (Rivers et al., 2013). In addition, this study suggested that the effects of armed conflict on a nurse are most apparent when they return home, suggesting a delayed action phenomenon. Scannell-Desch and Anderson (2005) found a similar challenge among nurses who returned from Vietnam. In spite of differences between the Australian and US military, Rivers et al.'s (2013) study offers valuable insight into potential challenges faced by Australian Army nurses on their return home from service in Iraq and Afghanistan.

Although many nurses successfully transitioned to war and transformed their practice, others faced psychological barriers to transition and coping effectively, including a lack of understanding about the purpose of the mission (military assignment) and their reason for deployment, and the image of military nurses held by other personnel (Griffiths & Jasper, 2008). Nurses in Griffiths and Jasper's (2008) study believed a value-laden image associated with nursing negatively affected their military credibility within the Army, which in turn affected their military identity. It is unclear as to how the nursing identity influenced military identity, but there is the implication that the desire for a credible military identity negatively influenced the nurse and their ability to practise. This suggests a tension between the primary purpose of the military and nursing practice, which nurses must resolve to be as effective as possible. Identifying the extent to which nursing identity may be subsumed by the military hierarchy, and considering both whether this may reduce the positive influence a nurse may have on patient care and how nurses find resolution, are issues worthy of further examination.

In addition, the participants in Griffiths and Jasper's (2008) study considered that the purpose of the military mission, particularly in the field of humanitarian aid, restricted their spheres of nursing practice. This suggests nurses viewed the mission as inhibiting what they should be doing. In comparison to these British nurses, US nurses who served in Vietnam, Iraq and Afghanistan believed it was their own failure to understand the military mission and a lack of preparation for the carnage and death they faced that created seemingly insurmountable challenges (Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). Rather than viewing the military mission as inhibiting practice, the US nurses felt they were simply unprepared for what the military expected of them. Whereas British nurses perceived barriers, the US nurses saw fault in themselves. It is unclear to what extent the surrounding military culture influenced these differing perceptions, what degree of encouragement nurses

received to engage with the military purpose and how far they could evolve their military nursing identity and practice.

In a study by Finnegan et al. (2015), described as constructivist GT, the authors examined a purposive sample of 18 British military nurses deployed to Camp Bastion in Afghanistan in 2013. This study identified the intrinsic characteristics and values nurses believed were required to be a military nurse. Framed in terms of Nightingale's 'focus on the triad of the person, health and the environment' (Finnegan et al., 2015, p. 86), this study examined the characteristics that nurses used to deal with and counteract the influence of the war environment. Participants told the authors that a nurse needed to be flexible, clinically able to respond to significant trauma and paediatric care requirements, caring, compassionate, patient-centred, diverse, trustworthy and ethical. These characteristics—combined with clinical leadership, team-building and military skills—were all considered essential for the military nurse, playing a significant role in managing the demands imposed by the war environment. The study also examined ideas of professional identity in response to the work environment, similar to Griffiths and Jasper's (2008) findings when examining the new identity of warrior-nurse. Although there are differences between the Australian and UK military in terms of structure and employment of RNs, and the sample involved a single group of nurses in one location, the study by Finnegan et al. (2015) offers a useful guide to the characteristics of a military nurse that may be relevant to Australian NO.

In the study by Rushton et al. (2008), nurses felt that if they had known they would be caring for enemy personnel, they would not have gone to war. These findings support the suggestion that military nurses may deploy with limited preparation and understanding of the mission, both as part of the military and as nurses, leading to a tension between expectation and practice. There may also be implications for returning home, if the individual is dissatisfied with the role they played in the war. To maximise lessons for the benefit of Australian Army NO, it would be useful to identify how armed conflict influences processes of transition and transformation, and how they relate to each other.

In summary, although researchers identified transition and transformation as processes experienced by military nurses, the literature provides no clear understanding of the factors that influence these processes, or how they relate to each other. Furthermore, this literature

does not clearly distinguish the two terms, appearing to use them interchangeably throughout the articles reviewed. This conflation could be problematic because whereas transition is essentially about movement into and out of a situation, transformation implies a significant change in thought or practice, representing a response to transition or other experience. There was some suggestion positive adjustment led to transformation, implying good coping skills; whereas unpreparedness could result in negative experiences that constrained the capacity for transformation.

2.4.2 Clinical and Moral Readiness

A lack of clinical readiness for armed conflict was a repetitive theme in the literature and a challenge to effective transition (Almonte, 2009; Griffiths & Jasper, 2008; Rushton et al., 2008; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). One study demonstrated, for instance, that on arrival to armed conflict, nurses were required to work beyond the scope of practice for which they prepared (Griffiths & Jasper, 2008). This was especially true of the nature of trauma experienced in Vietnam, Iraq and Afghanistan (Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). However, to meet this challenge and achieve the military mission, some nurses were able to utilise prior experience to apply adaptive mindsets to expand their knowledge and skill.

The identification of constructive coping strategies to negotiate and navigate through roles and relationships appears intrinsically linked to issues such as clinical and moral readiness. Those nurses who were able to adapt and cope effectively with clinical demands, identified and implemented strategies such as social support and debriefing, using these to feel positive about their new scope of practice being beneficial to both their patients and them (Almonte, 2009; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). However, unprepared nurses experienced distress and conflict, with some failing to adjust to the stress associated with their work (Almonte, 2009).

Through a GT examination of the deployment cycle of 11 US Navy nurses who had undertaken a ship-based humanitarian mission, Almonte (2009) described a non-armed conflict deployment experience that produced a number of challenges nurses found difficult to manage. This is relevant because Army NO who practise on or near the battlefield may

face the challenge of caring for humanitarian victims. The main clinical readiness challenge was the nurse's paediatric skills, which they believed were inadequate to deal clinically with children (Almonte, 2009). Moreover, the care process involved making decisions on which children to admit in accordance with strict mission criteria (boundaries for what will be achieved and how) or risk coming into conflict with military policy. The basis of the decision to admit a patient included considerations such as the time available to provide care, the number of people a ship could manage and restrictions imposed by the infrastructure of the host nation to which the ship travelled (Almonte, 2009). As the countries who received humanitarian aid were unable to provide high dependency support to patients after initial surgery, health personnel on the mission were unable to perform surgery unless the patient could recover without critical care support (Almonte, 2009).

Subsequently, nurses in the study by Almonte (2009) denied care to some children, a situation they found difficult and distressing, and in conflict with their patient advocate role. The practice reality of watching children die heightened their distress. Although these children would have likely died had the humanitarian mission not taken place, there appears to have been an assumption that the military policy, which prevented care provision, led to poor outcomes. The result for these nurses was moral distress, a condition in which an individual feels distress at making a moral judgement upon which they do not act (Savel & Munro, 2015). In this case, they felt they should have admitted the patient. Moreover, according to Almonte (2009), nurses experienced a sense of disconnectedness from the military mission. These findings suggests that if a nurse is not aware of what a mission will entail in terms of restrictions on healthcare delivery, they are ultimately not prepared for deployment.

Other studies have identified two additional causes of psychological and moral distress: seeing soldiers die and caring for POW (Rushton et al., 2008; Scannell-Desch & Doherty, 2010). The stress that arose from the experience of seeing soldiers die was managed through coping strategies mentioned earlier, but also linked by nurses to their experience of adjusting after they came home—specifically, with regard to managing ongoing thoughts of the war (Rushton et al., 2008; Scannell-Desch & Doherty, 2010). This suggests that military nurses may have a delayed response to the effects of war, one that did not inhibit their ability to care during war. These studies did not clearly articulate the stress of dealing with the enemy

(POW) and the discussion did not explore the influence of any prior experience of dealing with prisoners in a non-war setting.

Thus, although the literature examined indicated that clinical readiness for armed conflict was an issue, few contemporary examples were articulated, with no understanding provided of the challenges Australian nurses face when preparing for practise in war. Moreover, whereas challenges to being prepared for how to advocate as a nurse were identified in a humanitarian environment, little is known about what challenges nurses face when advocating for their patients during armed conflict.

2.4.3 Burnout

Burnout was an identified issue for military nurses (Ayala & Carnero, 2013; Lang et al., 2012). Lang et al. (2012) used a convenience sample of 257 US Army nursing personnel to conduct a non-experimental cross-sectional design study, applying the Maslach Burnout Inventory (MBI) and Practice Environment Scale, to compare burnout rates between nurses deployed to Iraq with a second non-deployed group. They found that, compared with nurses caring for the long-term injured in the US, deployed nurses were challenged by a perceived lack of support and long work hours and had higher levels of cynicism towards their patients (Lang et al., 2012). Deployed nurses also cared for POW, a situation previously identified as producing psychological and moral stress (Rushton et al., 2008; Scannell-Desch & Doherty, 2010). All of these findings imply that deployed nurses require preparation and support to deal with prisoners in an armed conflict setting.

Although data collection in the Lang et al. (2012) study used a validated tool, the use of convenience sampling was a less rigorous approach in targeting easily accessible subjects. Moreover, the total numbers of RN per site varied between 45 and 63 per cent, meaning the rest of the 'nursing personnel' participants were licensed practical nurses and medical technicians, supervised by RN. Thus, the pre-existing differences in role and practice between groups in the sample demonstrate a threat to research internal validity and prevent generalisation of the findings to the Australian Army NO. In addition, the use of a quantitative survey may have restricted respondents' answers, with a potential consequential loss of richness and complexity inherent in events (Borbasi & Jackson, 2012).

Personal and work-related factors can ameliorate burnout among military nurses (Ayala & Carnero, 2013). Using a convenience sample from the critical care nursing staff of a non-deployed tertiary military facility, Ayala and Carnero (2013) used the MBI to examine determinants of burnout among military nursing personnel (RN and Enrolled Nurses) in critical care settings in Peru. The authors found clinical inexperience aggravated emotional exhaustion and depersonalisation was more of an issue in younger nurses and those who worked in critical care (Ayala & Carnero, 2013). Those who were parents had a higher sense of personal accomplishment. The findings suggest that age and experience may contribute to better coping.

In the Ayala and Carnero (2013) study, the original tool did not cater for cultural dimensions specific to the Peruvian population; therefore, the researchers included additional questions. Analysing the constructs of the MBI as continuous variables corrected a lack of reference scores for the Peruvian population, obviating the need to introduce cut-off scores and potentially over or underestimate the prevalence of burnout (Ayala & Carnero, 2013). However, despite an 85 per cent response rate, this study has similar sample selection limitations to Lang et al. (2012), meaning that the findings cannot be generalised to Australian NO.

In summary, burnout is a potential issue for military nurses, especially those deployed to armed conflict. Whereas clinical and life experience appears to ameliorate the risk of burnout, caring for POW may require specific preparation to reduce the risk.

2.5 Problem Statement

The literature reviewed identified a range of issues experienced by nurses working in the unique contexts of the military and armed conflict. However, despite acknowledging a suspected tension between the roles of nurse and military officer, accentuated by the militarisation of nursing, there is little on what strategies nurses might use to ameliorate this tension or reconcile duality, and nothing about how a nurse's dual role affects their capacity to practise. Discussion around clinical readiness infers challenges to a nurse's capacity to manage the patients they see and their scope of practice. Despite potential implications for both patients and nurses, these issues have not received exploration. Nor is there any

contemporary study exploring the Australian Army NO experience of preparing for, practising in and surviving armed conflict, despite suggestions that interaction with this environment challenges how an individual functions.

Specifically, there remains a lack of knowledge about the identity and role of contemporary Australian Army NO—specifically, how they manage the professional and personal consequences of their armed conflict experience, resolve tensions and manage their nursing practice. There is also no exploration of the effects of militarising nurses and how these effects have influenced practice. Thus, the Army NO's capacity to practise during and following an armed conflict deployment remains poorly understood and largely under-theorised. Furthermore, there is no formal system of principles that articulate how Army NO should be prepared to practise in and survive armed conflict.

2.6 Conclusion

International researchers used a variety of methodologies in their pursuit of knowledge about military nurse experiences during and since the war in Vietnam. They have revealed issues, many occurring over time and space, such as transition to and transformation in response to armed conflict, coping strategies, clinical readiness and moral challenges. There is the suggestion of tension between the nurse and their role as a military officer, albeit with limited detail on what this means in practice. The one Australian study identified similar themes and challenges. These arose from a lack of clinical preparation for what is experienced in armed conflict, including potential effects on scope of practice.

Although all of these studies provide useful insight into potential issues arising from military nursing and deployment, there is a lack of detail on the processes and consequences of transition and transformation, including coping mechanisms. There is limited exploration of scope of practice—a tenet of nursing—and no study examined the Australian Army NO identity or roles serving in a modern combat environment. The effects of the sociocultural context within which modern Army NO work and find meaning, and the consequences of increasing militarisation, have not been considered. Thus, despite elucidating themes, there is a lack of detail and application to contemporary Australian Army NO, whose stories are largely silent and whose professional attributes remain unexamined. This study addresses

this omission. The next chapter explains the aim of this study and the methodology chosen to undertake an exploration of Australian Army NO and their experiences.

Chapter 3: Methodology

3.1 Introduction

The previous chapter identified a lack of knowledge and understanding about contemporary Australian Army Nursing Officers (NO), what they do, what happens when they enter an international armed conflict (IAC) zone and the consequences of their involvement in IAC. Challenges these nurses may encounter as a result of working for the Army, particularly in armed conflict, were not acknowledged or understood. The purpose of this chapter is to clarify the aim of the study and associated research questions, as well as describe the methodological design and process that guided data collection, analysis and theory development. With a GT research design selected to achieve the intent of the study, the focus of this chapter is on why GT was utilised for this study, what GT is, the Glaserian view and the methods used when applying this methodology.

3.1.1 The Aim of this Study

The aim of this study was to investigate and theorise the experience of being an Australian Army NO deployed to an IAC zone. This included identifying the social processes and main challenges entailed in an NO's interaction with the Army and conflict environment, illuminating how they prepared for, practised in, survived armed conflict and 'refitted to fight' again.

3.1.2 Research Questions

Given this aim, this study investigated the following research question: How do Australian Army NO prepare for practise in IAC zones and what challenges do they face on deployment? Associated sub questions included, how do NO practise with the dual identities of 'RN' and 'Officer', address scope of practice issues and manage their experience of an IAC zone? Does the experience of IAC affect their return to a non-armed conflict zone practice and home life?

3.2 Methodology

The methodology chosen for this study was GT. Specifically, GT is utilised when there is inadequate explication of an area of interest in the extant literature and the researcher, through exploration and discovery, wants to generate a theory to illuminate the unknown (Artinian et al., 2009; Gasson, 2009; Glaser, 1978, 2011; Glaser & Strauss, 1967). Although descriptive elements reveal a story, the main objective is conceptualisation through theory development (Glaser, 1978). The creation of a theoretical end state explaining the involvement of Army NO in armed conflict was the primary reason for pursuing GT over phenomenology. I wanted to encapsulate the main influences on these nurses, and the challenges they may experience and manage, with a theory that provides a reference for how they might prepare to practise in, survive and return home from armed conflict. The subsequent challenge was selecting a GT stream—for this study, Glaserian GT.

3.2.1 GT: A Brief Discourse on Origins, Philosophy and Structure

GT is a highly debated methodology, with differing opinions on its philosophical underpinnings, the cogency of more recent methodological evolutions and the challenge of how to navigate GT approaches to reach a decision on which method to use (Breckenridge, Jones, Elliott, & Nicol, 2012; Cutcliffe, 2004; Gibson & Hartman, 2014). It has been suggested that the problems entailed in arriving at an informed decision as to which GT approach to utilise have ultimately resulted in researchers opting for a combination of versions despite inherent incompatibilities (Breckenridge et al., 2012; Cutcliffe, 2004). This poses potential practical challenges to delivering a well-constructed GT study (Breckenridge & Jones, 2009). The purpose of this section is to provide a brief discourse on the origins, philosophy and structure of GT, before explaining why I chose to pursue Glaser's version.

In 1965, Glaser and Strauss created GT as a new approach to theory generation, with the aim of producing contemporary theory responsive to social change (Gibson & Hartman, 2014; Glaser & Strauss, 1967; Grbich, 2013). Often referred to as 'classic' GT, this approach represented a dynamic merge of contrasting research traditions, combining quantitative systematic analysis with qualitative study of human behaviour. The result was a methodology

for generating theory from observation—using outcomes to explain and anticipate behaviour within a given social microcosm (Glaser & Strauss, 1967).

Ideally, behaviour would be studied using field naturalistic observation; however, risks inherent in investigating during armed conflict made entering the environment unrealistic for this study. Alternately, exploration of behaviour can occur indirectly through interview, with other information sources used to augment a line of inquiry (Artinian et al., 2009). Using direct or indirect means, behaviour is 'observed' for latent patterns of group behaviour exhibited in response to resolving a problem (Artinian et al., 2009; Glaser, 1978, 1992, 2011; Glaser & Strauss, 1967; Holloway, 1997; Malterud, 2001). Although individual perspective is a fundamental input to conceptualising behaviour, the focus is on social process—that is, interaction with others (Fernandez, 2004; Glaser, 2001, 2002a). Thus, a pattern of group behaviour reflects the extent to which members of a group coalesce to resolve a shared issue. This potentially demonstrates socialisation to a given context, showing degrees of shared commonality in thought and collective notions of truth.

As a realist who believed that 'truth' was waiting to emerge from data, Glaser introduced quantitative influences into GT, such as empiricism (Glaser, 1995; M. Kenny & Fourie, 2014; Mills, Bonner, & Francis, 2006). Empiricism is the process of verifying facts about the world through what we can sense and observe via experience, rather than through logic, and is commonly associated with traditional quantitative scientific research (Alvesson & Skoldberg, 2009). Realists accept what they see as real, believing there are social and natural structures that exist outside of the individual mind (Kilminster, as cited in Haralambos, 1992). Glaser's contribution to the codification methods used in GT added quantitative terminology to the GT lexicon, a situation that has become a position of discomfort for some contemporary qualitative GT researchers and a source of tension in the GT debate (Bryant & Charmaz, 2007; Lawrence & Tar, 2013).

Compared with Glaser, Strauss was a relativist, meaning that he saw beliefs, values and theories as societal constructs that were only relevant in the time they existed (Abercrombie, Hill, & Turner, 2006). This is an interpretivist view, with proponents arguing that structures exist because we think they do. According to relativists, there is no absolute truth; the only truth is what we believe and construct within a specific cultural paradigm (Abercrombie et

al., 2006). The ultimate polarity of this position in contrast to Glaser contributes to the GT debate.

Through engaging pragmatism and symbolic interactionism, Strauss introduced an emphasis on social interaction and the structures humans create as a result (Corbin & Strauss, 2008). Pragmatism is a utilitarian approach, first defined by Charles Sanders Peirce in 1878, where knowledge derives from interaction, decisions made about an object reflect its perceived practicality and acknowledgement of outcomes is for their usefulness, rather than attractiveness (Halton, 2004; Peirce, 1992). In other words, what do we think an object might do for us? And how might we use it for best effect? Using the normal constraints of logic, Peirce clarified ideas about an object at a given point in time, believing time and changing need may alter the potential value an object may have for an individual (as cited in Halton, 2004).

Symbolic interactionism originates from the study of human group life and the role of symbols in social organisation (Blumer, 1969). For Blumer (1969), there were three premises: we act towards objects in accordance with what they mean to us; meaning arises from our social interaction with others; and, as individuals, we interpret objects through our handling of them. Handling an object or situation in the context of a group thus produces a feedback loop in thought and interpretation—the group can influence the meaning given to something. Thus, symbolic interactionism considers human action as interpretive, with humans creating and changing meaning about self, society and reality from their interaction with objects (Blumer, 1969; Charmaz, 2006; Corbin & Strauss, 2008).

The endpoint of GT is a theory. Inductive reasoning allows concepts to emerge from data; thus, facts do not prove a GT, rather, the theory arises from data (Alvesson & Skoldberg, 2009; Gibson & Hartman, 2014; Glaser, 1978, 2001). A theory is legitimate if it is faithful to and 'fits' the data it arose from. A theory is *grounded* in the data it emerges from, offering a way to understand complex underlying processes through pragmatic explanations (Artinian et al., 2009; Breckenridge et al., 2012; Glaser & Strauss, 1967; Lawrence & Tar, 2013).

A common characteristic is elicited using abstract conceptualisation through constant data comparison (Glaser, 2002b; Glaser & Strauss, 1967; Hernandez, 2009)—such a

characteristic referred to in this study as the *core category*. This is the main concern explaining predominant behaviour, not necessarily the only concern. Conceptualisation transcends description to take an emerging theory beyond people, time and space (Alvesson & Skoldberg, 2009; Fernandez, 2004; Glaser, 1978, 2005, 2011; Glaser & Strauss, 1967). An emerging storyline is a byproduct, not the primary intent.

A well-produced GT should be logical, plausible, clear, adequately detailed yet parsimonious (Artinian et al., 2009; Glaser, 1978, 1992; Glaser & Strauss, 1967). The simplest explanation with the fewest underlying assumptions is the most practical choice; fewer assumptions mean the explanation is more likely and defensible. Rather than entailing a static authoritative truth, the final theory is transient and open to modification if exposed to new data (Breckenridge et al., 2012).

There are two challenges that need to be met when retrospectively attempting to identify a philosophical stance. These are, first, to understand the social context of a previous time and how people viewed their world and, second, to avoid imbuing analysis of the past with contemporary opinion and ways of thinking. Failure to achieve either can lead to misinterpretation and unnecessary criticism of past approaches, on the assumption current ways of thinking and social research are more correct, rather than simply different. Glaser and Strauss (1967) did not clearly articulate a philosophical position (Birks & Mills, 2015), producing significant problems for the contemporary researcher expected to understand the philosophical underpinnings and genealogy of a selected methodology, and align this with their personal perspective.

Since 1967, much has been written about GT, Glaser and Strauss, their similarities and differences. Always to some extent fundamental opposites in their views, with time inherent tensions between Glaser's and Strauss's perspectives led to disagreement on how to apply GT. Subsequently they diverged, taking different paths in pursuit of GT, evolving a split between their philosophical and practical approaches (Birks & Mills, 2015; Grbich, 2013). Glaser (2008) remained a realist and maintained a position congruent with classic GT, arguing GT is a general inductive methodology for use with any data (Glaser, 1978, 2002a, 2008, 2011; Rosenbaum, 2008; Walker & Myrick, 2006). This aligns with recent arguments

that focus on GT design as a middle ground methodology (Breckenridge et al., 2012; Gibson & Hartman, 2014; Glaser, 2008; Holton, 2008).

The relativist path taken by Strauss merged with a perceived modernisation of GT, where qualitative information has predominated as a source of data and its use gives the illusion of rigour. Subsequently, because the contemporary propensity to use qualitative data has eroded understanding of the original intent of GT, the suggestion arose that the perspective of GT as a middle ground methodology may have been lost. That is, that there has been a quiet *remodelling* of GT toward a territorial focus on qualitative inputs (Breckenridge et al., 2012; Glaser & Holton, 2004; Holton, 2008; Walker & Myrick, 2006). In return, Glaser (2008) has argued that qualitative data does not define GT just because its use predominates. Specifically, he suggested the perceptual shift in GT theoretical orientation to qualitative territory occurred through a process of symbolic interactionism, resulting from a sustained use of qualitative data.

In summary, contentious opinions about GT appear to fluctuate across the quantitative versus qualitative divide, with contemporary evolutions in GT in juxtaposition to a recent revival of Glaserian GT. Understanding of what each GT type stands for may have blurred (Age, 2011; Gibson & Hartman, 2014; Walker & Myrick, 2006), with the quantitative influences in classic GT engendering an ongoing sense of discomfort when compared with contemporary qualitative sensibilities and perspectives concerning GT. Ultimately, GT can use either quantitative or qualitative data, depending on the aim and focus of the study. In the case of the research presented in this thesis, qualitative data were most appropriate to achieve the study purpose.

Despite questions about GT remodelling (Breckenridge et al., 2012; Cutcliffe, 2004; Gibson & Hartman, 2014), both classic (Glaserian) and contemporary (Straussian) approaches offer valuable methods and considerations when determining which angle to approach a GT study. Ultimately, each version poses challenges that require careful management.

3.2.2 Choosing Glaserian GT

Having chosen GT, the subsequent decision was to choose Glaser, for the reasons outlined below. However, the choice came with some unexpected challenges, largely around how to reconcile Glaserian GT with current research expectations and an, at times, contentious opinion as to what Glaserian GT represents. I persisted because Glaser's philosophy resonates with my own. To paraphrase Evans (2013), I trusted the GT process, was able to tolerate an initial sense of confusion, was in no rush to find the answer and always believed the 'truth' would arise from the data—whatever that turned out to be.

Glaserian GT provided a version of GT that allowed for an emerging theory not consumed by overly technical rendering as well as a parsimonious focus, enabling establishment of a simple yet detailed theory, and one able to make a practical difference (Breckenridge et al., 2012; Gibson & Hartman, 2014; Glaser, 1992; Heath & Cowley, 2004). A parsimonious and pragmatic theory is more likely to gain acceptance by NO and the Army, where healthcare is an attachment, not the main purpose, and the collective function predominates. It is essential non-nursing personnel, who may make decisions about NO, their preparation and selection for deployment, could understand a theory on the intricacies of nursing in the Army.

Glaser adheres to a theory providing foundation for adaptation as events change, arguing this allows for changing times and promotes usefulness over time (Glaser, 2002b, 2005, 2011). This is an important consideration when a theory represents processes related to the ever-evolving situation of armed conflict. Further, as the Army utilises standardised approaches to training and promotes a military persona, this methodology provides the capacity to distil common purposes for behaviour and collective notions of the NO identity from the breadth and depth of individual experience (Glaser, 1978, 2002b). Solutions gained by explaining the surrounding socioecological network and evaluating how a particular socio-political and cultural environment—for this study, the Army and armed conflict—may influence behaviours, offer a form of legitimacy.

Ongoing tensions between classic and contemporary approaches to GT also produced a lingering sense of confusion about how the end product should appear (Breckenridge et al., 2012; Cutcliffe, 2004; Gibson & Hartman, 2014). Although Hood, as cited in Bryant and

Charmaz (2006, p. 163), argued that as long as a GT study includes the 'troublesome trinity' of theoretical sampling, constant comparison and theoretical saturation, a study can claim to be GT, albeit with differing opinions on versions of GT. For this study, Glaserian methodology (Glaser, 1978) offered this researcher a clear view as to what the product should look like when it was finished. In keeping with the call for a return to appreciating Glaser and the intent of the classic form (Age, 2011; Artinian et al., 2009; Breckenridge et al., 2012; Duncan & Nicol, 2004; Jones & Alony, 2011), Glaserian GT seems well suited to exploring experience within the nexus of nursing, the Army and conflict.

3.3 GT Methods

3.3.1 Overall Study Design

This was a two-phase GT study. Phase 1 occurred during an MPhil, from 2015 to 2019. Utilising all GT methods articulated in the following sections, the purpose was data collection, analysis and theory production. From 2020 to 2022, Phase 2 occurred after the MPhil was transferred to a PhD and focused on strengthening the theoretical concepts developed in Phase 1.

3.3.2 Phase One

3.3.2.1 Recruitment: Sample

Two methods of sampling are utilised in GT, an initial purposive sample and, subsequently, a theoretical sample (Chun Tie, Birks, & Francis, 2019). The *purposive sample* initiates data collection, with participant selection focused on identifying a group who can contribute to developing knowledge in the area of research interest. For this study, Australian Army NO deployed to an IAC. To address contemporary IAC experience, the two most recent IAC zones were included in the selection criteria. Therefore, participants had to be current (at the time of recruitment and participation) members of the RAANC who served on either of two specified operations, in an NO role. This included operations CATALYST, Iraq (from 2004 to 2005) and SLIPPER, Afghanistan (from 2007 to 2014). Participants needed to be willing to reflect on and share their knowledge (Brink, 1998; Creswell, 2014).

To generate an initial sample, distribution of a plain language flyer explaining the study and inviting participation occurred via email from a non-nursing officer not in the chain of command of any RAANC NO. This approach helped limit the perception of command control over who should participate. The flyer asked NO who met the selection criteria and wished to participate, to initiate contact with the researcher by email or phone. Participants then received a plain language information sheet and consent form by email. Copies of the flyer and plain language document are located in Appendices A and B, respectively. Given specific requirements for Defence personnel, as outlined in the section on ethics, the researcher, after receiving signed consent forms, waited 24 hours before contacting potential participants to arrange an interview time.

After initial data analysis, the subsequent sampling method used in GT is *theoretical*. Theoretical concepts emerging from initial analysis dictate participant selection, as the researcher follows and clarifies ideas and clues and tests interpretations (Alvesson & Skoldberg, 2009; Birks & Mills, 2015; Chun Tie et al., 2019). Theoretical sampling is essential to grounding a theory in the data and fully evolving theoretical concepts and continues until the researcher achieves a sense of closure by reaching theoretical saturation (Birks & Mills, 2015; Corbin & Strauss, 2008). This is the point at which no further information arises to enrich a concept and is an important aspect of data analysis. In total, eight participants were interviewed: two had served in Iraq and six in Afghanistan, two were male and six were female.

3.3.2.2 Data Collection

Traditionally, when seeking qualitative data for GT, the preference was for use of field observation and notes over taped interviews, because interviews and recording were considered limiting to the researcher (Artinian et al., 2009; Fernandez, 2004; Glaser, 1978). However, field observation was not possible as the study area was an armed conflict zone. Therefore, primary data collection was through open-ended interviews that allowed participants to describe experiences in their own words (Streubert & Carpenter, 2011).

Glaser argued against recording interviews, because he saw recording as producing quantities of data without simultaneous distillation of ideas; he preferred a post-interview written record

by the researcher (Artinian et al., 2009; Glaser, 1992). This created the record as a recollection of what was heard and remembered, with memos reflecting ideas the researcher had as they wrote—thus ensuring the beginning of analysis during the collection process. Notwithstanding this stance on recording, for this study I chose to record interviews and make interview notes, leading to a comprehensive account I could revisit at any time (and did regularly). This became particularly important when sifting through the range of complex issues made visible in each interview.

Notes provided a way to start working with data, as well as a backup source of information in the event of technological failure. In addition, rather than relying on memory to gather quality data relevant to the interview questions, these notes provided a guide for me when considering, in the midst of an interview, which direction to take the data collection process. That is, by offering a way to revisit the text to review codes in light of new information, a recording can be reviewed multiple times to validate data analysis, thus promoting constant comparison and potentially revealing previously unidentified codes (Fernandez, 2004). Artinian et al. (2009) argue that even the experienced researcher can gain from listening to a recording again to understand all the nuances of an interview and identify new ideas not previously considered. Going back over a recording can assist in maximising the breadth and depth of concepts a researcher can draw from an interview.

Each interview began by briefly exploring personal and professional demographics, insofar as this information may have later explanatory relevance to the evolving theory. For example, differences in employment status, such as ARA compared with ARES, may help explain findings. According to Glaser (1978), demographic data essentially distracts the researcher from abstract analysis by limiting information to time and place. However, it may have a limited role if something in the demographic data emerges as relevant to the evolving theory (Glaser, 1992). Artinian et al. (2009) point out that demographic data may be useful in meeting modern research requirements and provide guidance on the direction of future research. In this study, once demographic data were obtained, participants were asked to describe their experience of deployment, starting with their experience of preparing to go.

Glaserian GT emphasises not forcing data and, for this reason, an interview guide is problematic (Glaser, 1978). In this study, an interview guide was utilised with caution, with

the purpose of ensuring I covered main areas of interest during initial data collection. A copy is located in Appendix C. The structure of the guide was a series of dot points, rather than specific questions, and use was limited to the first two interviews. After this, to allow data collection to follow emerging concepts and not be limited to a set series of questions or points, the participant was encouraged to direct the course of the interview, while I asked occasional questions to generate discussion when required, and in keeping with emerging concepts (Glaser, 1992). Interviews were conducted in person, across several states of Australia, at a time and public place agreed between the participant and me. The longest interview took 85 minutes and the shortest 45 minutes. In this particular study, as the participants were current members of the ADF, there were additional requirements for the safe management of information. These have been explained in the ethics section in this chapter.

3.3.2.3 Data Analysis

Consistent with Glaserian GT, the method of analysis involved theoretical sampling; open, selective and theoretical coding; memos; constant comparison and theory generation (Glaser, 1978, 1992, 2011). In GT, instead of generating data then analysing it collectively, analysis occurs after each episode of data generation (the interview), producing a cycle of data generation and analysis. This results in constant comparative analysis, an analytical method fundamental to GT (Glaser, 1978; Glaser & Strauss, 1967), which works to guide the development of the theoretical concepts that would underpin the theory and direct further data collection. Thus, GT is a dynamic process responding to the data as it unfolds, keeping it highly grounded to the raw information.

In keeping with traditional GT, during this study all attempts were made to transcribe interviews and code data before collecting more data, an approach ensuring emerging theoretical concepts could be followed up at subsequent interviews through careful annotation of the initial interview guide (Glaser, 1978). Interviews were transcribed by me to protect participant identity. For this study, as there was a need to travel around the country for interviews, on occasion several interviews occurred within a short timeframe, without the opportunity for full transcription between them. Where this occurred, I wrote memos to ensure ideas that arose in one interview were linked to a subsequent one.

3.3.2.3.1 Memoing

Glaser (1978, p. 83) considered memos the 'bedrock of theory generation'. A theoretical memo describes an emerging idea and associated relationships (Gibson & Hartman, 2014). Memos capture the progression of a researcher's thinking, assisting category development by facilitating data conceptualisation. Eventually, as memos represent what Glaser (1978, p. 83) described as the 'frontier of the analyst's thinking', a theory starts to appear and eventually crystalise. Thus, memos influence theoretical direction, sampling, code and category identification, literature review and, eventually, the emergent theory. Written whenever a thought comes to mind about the data, memos represent a central tenet of GT, which is to think and write theoretically (Gibson & Hartman, 2014; Glaser, 2014).

Throughout data collection and analysis, I wrote and collated memos: while taking interview notes, when transcribing, when reviewing transcripts and at any point when contemplating the findings led to a thought. Because ideas sometimes came to mind when walking or driving, these thoughts were put to paper as soon as practicable. To ensure an idea fitted, I compared memos with the data, re-challenging my thoughts if the fit was not good.

3.3.2.3.2 Coding

To ensure a relevant and grounded theory emerges, GT coding requires a well-considered and judicious application of the method to minimise researcher preconception (Artinian et al., 2009; Holton, 2008). To identify participants' main concerns and promote emergence, I posed questions throughout coding, constantly challenging the data by asking what the participants were telling me and what identified ideas meant. It was important not to focus or commit too early, remaining as open to emerging ideas as possible (Glaser & Holton, 2004). During the early stages, coding involved fracturing and re-grouping data, producing conceptual ideas, describing their properties and identifying how they interrelated. This led to category identification, with coding the mechanism by which categorisation was achieved (Gibson & Hartman, 2014).

One of the challenges I faced as a researcher new to GT was working out what the terms 'concept' and 'category' meant, as they can often be conflated, confused and complicated.

As Gibson and Hartman (2014, p. 67) argue, when trying to clarify the distinction between concept and category, 'categories are built from concepts, but they [categories] also have to be conceptual'. To that end, concepts can be single ideas (substantive codes) or abstract and multi-faceted (categories). The coding process builds categories from substantive codes, with a category explaining how groups of substantive codes relate to each other, their variability and relationship to the overall area of interest. Categories can then be woven into a conceptual framework, such as a basic social process (BSP).

A BSP is a theoretical concept that explains a process of problem resolution (Glaser & Holton, 2004). Described by Glaser as *processing out*, BSPs must have two or more emergent phases that explain how a problem is processed, including behavioural variation in finding a solution (Artinian et al., 2009; Fernandez, 2004; Glaser & Holton, 2004). As BSPs are a process of do*ing* something, they are given a gerund label, which is a verb acting as a noun; thus, they invariably end in '*ing*' (Artinian et al., 2009; Charmaz, 2006). For example, nurses *caring* or *protecting* illustrate BSPs. A BSP focus is useful when investigating social situations through which people move and to which they must adapt (Corbin & Strauss, 2008; Streubert & Carpenter, 2011), such as an IAC environment. BSPs have two main forms: basic social psychological processes (BSPP) and basic social structural processes [BSSP] (Glaser, 1978). A BSPP helps explain motives behind underlying individual behaviour and BSSP are useful for understanding the social structures influencing a process, such as the selection process for NO going on military deployment (Fernandez, 2004; Glaser, 1978). A BSPP may be utilised to help explain the effects of a BSSP (Glaser & Holton, 2004).

3.3.2.3.3 Open Coding

As the first stage of analysis, the purpose of open (initial) coding was to *get out of the data*, transcend it and move towards conceptualisation (Glaser, 1978). This required me to develop a sense of where the data were heading, to remain open to emerging ideas not filtered by preconception to ensure theoretical relevance. There was no attempt to become selective until the next coding stage. Selectivity occurred after I had developed a good argument for the relevance of particular ideas (Holton, 2008).

Thus, data were organised with the overall goal of generating ideas (Gibson & Hartman, 2014). To identify significant words and phrases from the data, interview notes and transcripts were read, then reflected upon. Holton (2008, p. 3) argues line by line reading helps to ensure 'nothing is left out' and corrects data forcing by requiring the researcher to have read everything, not just areas of preconceived interest. As codes were identified, then labels allocated, I made notations in the margins. Whereas *in vivo* codes utilised words used by the participant, other codes explained what was arising from the data (Birks & Mills, 2015; Glaser, 1992).

During open coding, words were fractured from their context, limited to a snapshot of information. The main tenets of a code were described and a label allocated. Because, in Glaserian GT, theoretical sensitivity to underlying concepts starts with open coding, as the researcher seeks to 'generate codes that fit and work' (Holton, 2008, p. 9), the labelling and memoing process ensured ideas retained relevance to the bigger picture. Being open to what the data might reveal established a sense of how to work with the data; codes that fitted and worked for initial data informed subsequent code development and application during future coding.

3.3.2.3.4 Constant Comparison

Through enabling learning about ideas entailed in data and relationships between them, constant comparison is instrumental in producing, mapping and linking categories. It is one of the tools used in the conceptualisation process (Glaser, 2011). After the first interview, constant comparison was utilised to compare data between interviews, to create new codes and develop previously identified codes. As data analysis progressed, codes and memos slowly accumulated. Constant comparison of codes and memos revealed ideas, patterns and relationships between them.

Initially, the comparative process during open coding compared incidents to identify both similarity and difference (Holton, 2008). Difference often lies in the conditions that surround an incident. At this stage, theoretical concepts began to emerge, coalescing around a key point of uniformity and associated with various conditions. Once an emerging theoretical concept was identified, it was specified through elaboration and saturation to achieve

maximum densification (Holton, 2008). This permitted evaluation of how the code fitted the data and was relevant. Specification is not definition, where a concept is given a meaning. Rather, specification outlined specific conditions and thus articulated the standard to be met for a particular theoretical concept to be considered a valid part of a GT. According to Holton (2008), in GT a concept must earn its right to be part of an emerging theory.

Breadth and depth in the specific properties and dimensions of an emerging concept (conditions such as context, preceding events, outcomes), and therefore its specification, occurred over time with comparison to more incidents and concepts. Themes recurred, contributing to category development, and fully evolved theoretical concepts representing all facets of an idea were established. Where comparison indicated inadequate 'fit', another category would emerge. Simultaneously, through comparison, perceived links formed between concepts, a pattern slowly appeared and concepts were carefully woven into a theory (Fernandez, 2004). At the same time, it was essential I remained sensitive to all possibilities and flexible to theoretical ideas that did not occur in the earlier stages of analysis (Fernandez, 2004).

3.3.2.3.5 Core Category

The ultimate aim is to identify the main (not only) concern (social process) of participants in a given set of circumstances. This concern has primacy; it does not exclude other problems. It also explains how all issues work together and provides both purpose and coherency to the underlying story. The main problem and associated resolution processes is a theoretical concept known as the *core category*. This concept must have explanatory power, be central to a theory, relate to all the other categories, account for most of the behavioural variation directed at resolving the problem, be meaningful to participants and be modifiable given its dependent relationship to other categories (Gibson & Hartman, 2014; Glaser & Holton, 2004; Hernandez, 2009. In this study, starting from initial coding and between codes identified with each episode of data collection, I asked myself what concerned the participants the most.

To become the core category, a concept needed to be fully specified, relevant and workable in terms of the evolving theory (Holton, 2008). As coding progressed, several categories vied for prominence. Category saturation was essential to deciding which one was more constant

and influential, holding true from start to finish. For this study, two central categories were enduring, symbiotically supporting each other. However, the final choice for core category was pre-eminent because it symbolised the primary purpose and greatest concern of the Army NO. All other categories explained the uniqueness of the core category; it was around this core category a theory evolved.

3.3.2.3.6 Delimiting and Concept Mapping

In GT, delimiting correlates with the establishment of the core category (Fernandez, 2004). A key driver of selective and theoretical coding (discussed below), *delimiting* is reductionist, establishing the outer limits of a concept while encapsulating the conditions that support it (Fernandez, 2004; Glaser, 1978). As relationships clarified and the theory stabilised, categories that became irrelevant to the evolving theory were removed or absorbed by other categories, promoting an element of focused simplicity.

Glaser (1978, 1992) did not believe in concept mapping, arguing it interfered with analysis by potentially influencing the researcher to force data into a map. Artinian et al. (2009) disagree, arguing concept maps can highlight a researcher's thinking, reveal flaws and help redirect the line of inquiry. Concept maps provide a graphic representation of thought processes, revealing gaps or inconsistencies; they provide a clear structure for organising data and are a useful way to present data visually (Artinian et al., 2009). I found concept mapping, in the form of movable post-it notes, invaluable when envisaging how the various categories related and formed a pattern.

3.3.2.3.7 Selective Coding and Extant Literature

Where theoretical sampling is the process of selective data collection (choosing who you will talk to, why and what you will ask), *selective coding* is the process of using collected data to develop emerging categorical concepts. Selective coding began after identification of the core category, with the purpose of collecting data to support category development (Jones & Alony, 2011). Compared with the expressive nature of open coding, selective coding is a more predictive, strategic, delimiting process designed to focus on key categories related to

the core, a move promoting parsimony in the final theory (Artinian et al., 2009; Gibson & Hartman, 2014). Selective coding occurred as part of the initial theory development.

Once selective coding started, *extant literature* became important. Compared with his insistence on not using the literature for an initial pre-study review, Glaser (1998) suggested viewing the literature in later stages of the study. At this stage, rather than assuming its automatic legitimacy, which might result in forcing a theoretical orientation on the data, the literature provided data for comparison (Fernandez, 2004; Luckerhoff & Guillemette, 2011). Ralph, Birks, and Chapman (2014) suggest a process of contextual positioning when interacting with the literature. This involves using targeted questioning as a way to relate to the data but not over identify with it (Ralph et al., 2014). For this research, extant literature was useful for clarifying the suitability of a theoretical code and later for developing discussion of the findings and theory.

3.3.2.3.8 Theoretical Coding, Integration, Pacing and Sensitivity

The term *theoretical code* refers to and explains a framework of interrelated ideas and the relationships between categories making up the concept (Hernandez, 2009. For example, the process of dealing with frustration, which may involve multiple coping strategies (categories). How the ideas making up the framework of a theoretical code relate to each other is described in GT as 'the naming of an emergent social pattern' (Glaser, as cited in Nathaniel & Andrews, 2010). *Theoretical coding* starts when theoretical saturation is achieved (Glaser, 1992). It weaves substantive categories and theoretical concepts into a theory, in sequential but not repetitive stages, developing relationships between categories (Jones & Alony, 2011). As relationships became apparent, data coalesced into an abstract network of ideas that, as a whole, supported the core category. Emerging patterns were given theoretical codes that explained what was going on and provided scope for their *theoretical integration* into a theory (Holton, 2008).

Theoretical integration comprehensively explains a pattern of events within a theory and includes the use of storylines to make sense of and order data (Birks, Mills, Francis, & Chapman, 2009; Birks & Mills, 2015; Glaser & Strauss, 1967). Described as a delayed action phenomenon, coding eventually matures into theoretical realisation (Holton, 2008).

Theoretical pacing involves taking time to learn what the data means through *theoretical sensitivity*: constantly reflecting to avoid drawing inadequately developed conclusions, which would produce a weak argument. Theoretical pacing in Phase 1 occurred over a three-year period. Theoretical sensitivity is the ability to create theory by identifying theoretical meaning from data, to know what is important, relate categories to each other, appreciate variance between theoretical constructs, build a theory and articulate it in writing (Birks & Mills, 2015; Gibson & Hartman, 2014; Glaser, 1978; Strauss & Corbin, 1998). I used memos as a way to self-reflect and to illuminate any personal partisanship or assumptions and philosophies I brought to the study and the analytical process (Charmaz, 2006; Suddaby, 2006).

3.3.3 Phase Two

3.3.3.1 Recruitment

In Phase 2, Phase 1 participants remained in the study to provide feedback on the validity of the theory to the experiences they shared at interview. Simultaneously, recruitment of a new cohort of participants who had not contributed to the original theory occurred, with the purpose to provide theoretical validation using a theoretical sample. The primary population from which sampling occurred continued to be current members of the RAANC who served in an NO role. In this phase, to link the timeline with the most recent military operation in Afghanistan and to maximise the breadth of experience contributing to the study, operation HIGH ROAD, Afghanistan (2007 to 2021) was included in the selection criteria. New recruitment occurred in a similar manner to that in Phase one, using a slightly amended plain language flyer and consent form. A copy is located at Appendix D. Four participants were recruited in this phase: three had served in Afghanistan, and one in both Iraq and Afghanistan. Total participation across both phases was 12 nurses.

3.3.3.2 Data Collection

Once the researcher received a signed consent form, participants in this phase were given access to an online platform. The use of the Qualtrics survey platform facilitated increased access to participation in the study during the first wave of Coronavirus (COVID 19).

Qualtrics was not used to deliver a traditional survey. Participants answered a series of open-ended questions designed to elicit their thoughts on the extent to which the theory resonated with their own experience of deployment. The platform was accessed by Phase 1 and Phase 2 participants, with those entering in Phase 2 answering demographic questions in keeping with information collected during Phase 1. A copy of the Qualtrics content, which provides a short synopsis of the theory, is located at Appendix E. As an alternative, participants during this phase were able to request an interview if they preferred that method of involvement. Only one participant chose this method of involvement. The interview was conducted via Zoom, as I was locked down (COVID) in Melbourne at the time.

3.3.3.3 Data Analysis

The purpose of Phase 2 was to test the validity of the theory developed in Phase 1. To ensure the fabric of the theory was well integrated, cogent, consistent and resilient, this phase validated the theory by asking participants to identify the extent to which it resonated with, or differed from, their deployment experience. Perspectives from Iraq through to the most recent operational deployment in Afghanistan enhanced the storyline and its currency. This phase lasted two years, which allowed time for theoretical pacing through the final stage of the study.

For all participants, it was a chance to use the theory as a tool for reflecting on their deployed experience, to ascertain how well it resonated and, therefore, test its fit with the Army NO experience. Phase 1 participants had the opportunity to validate their prior input and add new thoughts, new Phase 2 participants ensured a connection with more recent deployment and provided depth through the detail they gave. Analysis in this phase involved constant comparison between the new input from each participant and the established theory. Constant comparison served as a tool for seeking similarity and difference, strengthening concept definition and inter-category links, all of which represented emergent social patterns. This, in turn, validated the underpinning theoretical conceptualisation and theoretical integration. At all times, I posed the question to myself as to what the participants were saying, using this to identify the extent to which participants' views resonated with the developing theory, ensuring the *core category* retained its primacy as their main concern.

3.4 The Impact of COVID 19

The advent of COVID 19, with its effects felt in Australia from March 2020, influenced the progress of this study. This was particularly the case with Phase 2, which ran from late 2019 to 2022, mirroring the main run of COVID 19 in Australia. On a personal level, my clinical workload significantly increased, which I juggled with study and being a single parent to a pre-school child. Living in Melbourne, given the city was in lockdown for 246 days over a two-year period, exacerbated and complicated all of these issues. I had no access to family during this time and was unable to obtain childcare for study purposes (childcare was only available for authorised workers when at work). When I had time to focus on this study, I found I was waiting for participant involvement, which was delayed because of COVID. Moreover, participants were serving Army NO who played a significant clinical role in the federal COVID response from 2020 to 2022, which affected the timing of their availability to participate. This was in addition to ongoing international deployment and their own personal requirements. Therefore, I needed to identify alternate plans to ensure progression of my thesis and obtain the recruitment required.

3.5 Methodological Quality: Rigour

The application of rigour and trustworthiness through all stages of a study is essential, insofar as they inform all actions and decisions taken, including information collection, analysis and interpretation. The strategies for establishing rigour need to be compatible with the underlying methodology. Although the criteria developed by Lincoln and Guba (1985) influence contemporary thoughts on rigour in research, Glaserian GT continues to recommend the original four canons of *fit*, *relevance*, *workability* and *modifiability* for determining truth and legitimacy in GT (Glaser, 1978, 1995; Glaser & Strauss, 1967; Holton, 2008).

In the words of Thulesius (2003, p. 27), ‘a GT is neither right nor wrong, it simply has more or less fit, relevance, workability and modifiability’. Applying these criteria to determine methodological rigour essentially means that the more a GT meets these criteria, the more faithful the theory is to the data from which it emerged. Therefore, this study utilised the original criteria for evaluating the study’s quality and rigour, including the three additional

considerations of *understandability*, *generality* and *control* (Glaser & Strauss, 1967). The following section outlines each canon; Chapter Eight examines the extent to which this study meets these criteria.

3.5.1 Glaserian Canons for Truth and Validity

3.5.1.1 Fit

In purist terms, *fit* reflects whether a theory fits the area in which it is intended for use and how well concepts naturally emerged, as opposed to being forced by conscious or unconscious preconception or extant theory (Holton, 2008). If a theory does not fit, it needs to be manipulated (data forced, distorted or omitted) and is thus not true to the findings. To this end, a good fit arises from inductive reasoning. Fit is the most fundamental point of rigour in GT, with other criteria supporting fit (Artinian et al., 2009; Lomborg & Kirkevold, 2003). To ensure the link between theory and data is strong, constant comparison largely determines fit (Glaser, 1995, 1998). The extent to which a theory fits the data contributes to determining whether a GT could transfer to other times, settings, situations and people.

3.5.1.2 Workability

If a theory can explain how a participant's world works, it has *workability*. This includes whether the concepts identified in the theory account for their main concern and how they continually achieve resolution (Glaser, 1998). Workability extends to whether a theory articulates an interpretation of behaviour that permits inference of future behaviour (Artinian et al., 2009; Holton, 2008). A good theory has the ability to suggest how people in similar circumstances may behave.

3.5.1.3 Relevance

When a theory allows the core problem and processes to emerge, it is relevant and has good *grab* for those in the field. *Relevance* thus refers to how effectively a theory illustrates a core concern that is significant to the participants and grounded in the data (Artinian et al., 2009; Holton, 2008).

3.5.1.4 Modifiability

A good GT has what Holton (2008, p. 1) describes as a 'living quality', allowing the theory to have ongoing relevance to the world it evolved from and respond to new data as it emerges. As *modifiability* is the result of inductive logic, if inferences change with new evidence, the theory should be modified (Nathaniel & Andrews, 2010). Moreover, there can be enduring universal themes around particular experiences, such as end of life care. Thus, although time may change the details, the main themes remain relevant (Nathaniel & Andrews, 2010).

Modifiability has several implications. A theory is never final or unchangeable; it should alter in response to a changing environment—such as shifting social structures and perceptions—potentially removing categories, altering connections or changing the core category (Artinian et al., 2009; Glaser, 1978; Nathaniel, 2021). A theory is never wrong; it is continuously modified because new data never disproves, just provides an analytical challenge to be adapted into the end product. The caveat is that the data must still *fit* the theory. Thus, it is essential the need for modification is determined through triangulation with the previous three criteria, rather than on its own (Glaser, 1978).

3.5.1.5 Understandability

Glaser and Strauss (1967) have described *understandability* as whether a theory is meaningful to those who work in the area. If participants can understand the theory, they are more likely to apply it. Equally, a well-constructed theory that uses terminology relevant to an organisation, as well as to the participants, increases how well people outside of the area of interest can understand the theory.

3.5.1.6 Generality

One of the challenges in GT is to produce a theory that provides a 'general guide to ever-changing daily situations', while not being so abstract a person working in the area is not sensitive to what a concept means (Glaser & Strauss, 1967, p. 242). According to Glaser and Strauss (1967), *generality* implies a level of flexibility, is tied in with modifiability and permits a person working in an area to apply elements of a theory in response to a situation.

Generality is the ability to apply principles rather than facts because the latter change over time and may not be relevant at a later stage.

3.5.1.7 Control

Control is about whether a theory allows the user some control over the structure and process of daily situations as they change through time (Glaser & Strauss, 1967). For Glaser (1978), control allows a person to be situationally responsive using principles entailed in the theory. It permits the production and control of change in any situation related to the theory. The concept (usually a BSP) that enables control must be powerful enough to do so, which implies it needs to be well specified and important.

3.6 Insider Research

Ultimately, a researcher has a level of knowledge about the people they are studying. The researcher is either familiar with or unknown to a study group, positioned by relationship as inside or outside of a study group. For the purpose of this research, the term *outsider* refers to the person who is unknown to their study participants—a position associated with a positive assumption that the outsider is unfettered by preconception or familiarity. The assumption here is that an outsider can obtain the objectivity and distance required of valid research (Brannick & Coghlan, 2007, p. 60), although this notion perhaps fails to recognise that unconscious bias can exist in all humans.

Conversely, the *insider* is familiar in some capacity with their subject—a position strongly associated with the potential for subjectivity and partisanship, often equated to an assumption of a threat to neutrality (Greene, 2014; Workman, 2007). The perception of an inside researcher is one of the hidden dangers that may adversely affect research findings, specifically by influencing a researcher's interaction with their participants and shaping decisions about a study. Underlying assumptions about what data means may reduce sensitivity to data.

To avoid these risks, researchers should arguably examine topics outside of their familiarity. Such a position is congruent with the ideals of classic GT (Glaser & Strauss, 1967), but juxtaposed to contemporary research requirements and the reality that people will tend to

examine subjects related to their own experience and interests. Further, as Dwyer and Buckle (2009) have argued, the position of outsider is ultimately unachievable because the institutional requirement for a literature review means a researcher must have some knowledge of a subject.

What this means is that a researcher approximates to either end of the insider–outsider continuum according to knowledge, experience and prior group membership. The strength of internal relationships with a study group determines how much of an insider the researcher is and, thus, the possible level of bias-related risk; with a researcher potentially occupying the space in between, to essentially sit on the fence (Dwyer & Buckle, 2009). The subsequent challenge is for the researcher to be cognisant of and mitigate bias, to acknowledge their theoretical understanding and ensure they do not over identify with a group (Dwyer & Buckle, 2009; Thornberg, 2012). Reflexive awareness is a process through which a researcher can achieve this and manage their relationship with the topic under study, regardless of where they sit on the continuum (Brannick & Coghlan, 2007; Thornberg, 2012)

As an Army NO studying colleagues, I needed to remain vigilant throughout each interaction in the research process, including not overidentifying with Army NO and armed conflict experience. This meant maintaining a mental distance, while being genuine and committed to allowing revelations to emerge. To achieve this, I acknowledged most participants had been to a different conflict to me. As I had also not met most of them previously, I entered each interview expecting to discover different experiences to mine and deliberately sought variance—meaning that I applied an inquisitive approach to exploration. If, during analysis, their experience resonated with mine, I reflected on this for some time to work out the reason for the commonality. I made notes when surprised by the findings, which occurred frequently.

In the context of GT, Glaser and Strauss (1967) noted the researcher might unintentionally influence a theoretical outcome to embody their own ideals and values. Glaser, who was influenced by positivism and a preference for inquiry from outside, considered preconceived ideas such a threat to natural emergence that he excluded a pre-research literature review (Artinian et al., 2009; Glaser & Strauss, 1967). However, rather than exclude the inside researcher, Glaserian GT established processes for limiting researcher partisanship to thereby

promote their openness to theoretical emergence. Using memos to promote reflexivity, highlight potential prejudice and mitigate assumed knowledge, I placed the participant first. This meant consciously subjugating my own viewpoint and being actively humble to the experience of others (Breckenridge et al., 2012; Glaser, 2002a). I wanted their voices, not mine, to shine.

To that end, I maintained neutrality and authenticity by being consciously aware of the risk. In particular, I implemented strategies to limit potential blindness and promote mental isolation from my own experience, focusing on remaining open to new ideas. These included the following. Constant reflexivity allowed me to move mentally to the outside, to recognise if preconception acted as a barrier or if existing beliefs contributed to theoretical findings (Greene, 2014; Maykut & Morehouse, 1994). I discussed findings with my supervisors, only two of whom had military exposure. They challenged my thoughts, requiring me to explain how a particular idea eventuated and what it meant, and to explain unfamiliar terminology. An audit trail in the form of transcripts, memos and analysis data demonstrated all thoughts and decisions made at each stage of the research process, permitting external review for evidence of prejudice. I consciously acknowledged the duality of my role as researcher and Army NO, preferentially promoting my role of researcher and subjugating my NO role, both in my mind and in interview with my participants.

An inherent requirement of GT analysis is for the researcher to have a high level of theoretical sensitivity to the data and its meaning (Glaser, 2011). Depending on one's viewpoint, it is debatable as to whether my Army background enhanced or inhibited theoretical sensitivity. In small communities, an insider can benefit from their status and level of intimacy, both useful for gaining access and tuning into the data (Taylor, 2011). In this instance, the Army has its own language and cultural reference; thus, my Army membership conferred an element of linguistic understanding, promoting free conversation without participants feeling they needed to translate military terminology. Equally, I asked participants to explain in full and not to assume I understood what they were saying.

In addition to the potential for prior knowledge to influence findings, it has been suggested that positionality and power, as they relate to a researcher's insider or outsider status, are important considerations to be negotiated (Merriam, Ntseane, Lee, Kee, & Johnson-Bailey,

2000; Taylor, 2011; Workman, 2007) to ensure access to participants and information. Issues such as race and gender may act as barriers or enablers, depending on the researcher's position in terms of the internal variation with exists within groups. Being inside a group is not an automatic access card, although it may facilitate access, including to restricted information not readily available (Merriam et al., 2000). This is particularly relevant to the military setting.

The power relationship that inevitably exists between two people, such as in an interview, derives from the interplay of cultures (Merriam et al., 2000). To avoid adverse influence on findings, this power differential needs to be recognised and understood. Greene (2014) has suggested that perceptions of confidentiality breach and power might be a problem for inside researchers. However, in this study, there was a conferred benefit for participants being able to talk to someone who understood issues of operational and national security.

It is thought the inside researcher may be influenced by their emotional connection with an organisation, specifically with regard to their perception of internal politics and how a study's findings may be received (Brannick & Coghlan, 2007). Thus, a researcher may not feel they can reveal the total 'truth' of study findings. For this study, I entered the research with the intent to provide military commanders with an honest contemporary explanation of the Australian Army NO experience on operations, to inform future planning. However, I remain aware and accept that, in a complex organisation such as the military, there are many reasons why recommendations do not always eventuate in action.

3.7 Ethical Considerations

This was a two-phase study, occurring across two different universities. Thus, ethics approval was obtained from three institutions at different stages of the research. During Phase 1, the Department of Defence and Veterans Affairs Human Research Ethics Committee (DDVAHREC; formerly the Australian Defence Human Research Ethics Committee) granted ethics approval as did, subsequently, the Australian Catholic University (ACU) Human Research Ethics Committee by recognition of external ethics approval. In Phase 2, DDVAHREC approval remained extant with reciprocal approval from James Cook

University (JCU) Human Research Ethics Committee. A copy of DDVAHREC ethics approval is located in Appendix F.

3.7.1 Command Approval

Ethical challenges for a study involving military personnel can be complex. *Command approval* to recruit from the military was required *before* DDVAHREC would consider an ethics application (Australian Government, 2019). A military commander is granted legal authority to direct people within their command and their approval is required before NO under their command can be approached to participate in a research study.

Prior to obtaining Command approval, DDVAHREC requested I approach the Directorate of Army Health (DAH) for their opinion on the study. The senior TriService nurse and Senior Health Officer in DAH provided supportive comment, facilitating submission of an application to the Commander of Army Forces Command (FORCOMD). Consequently, Command approval was granted to talk to NO employed within FORCOMD.

DDVAHREC then approved the ethics application for FORCOMD NO, who had deployed to either operation CATALYST or SLIPPER. The application took nine months to complete, with ethics approval granted from 2016 until December 2019. In addition, although a commander did not direct their personnel to participate in the study—to preserve the right to consent willingly—the perception of Command influence and direction was carefully monitored throughout the study.

In Phase 2, an amendment was submitted to DDVAHREC to include operation HIGH ROAD in the inclusion criteria and to extend the ethics approval. This required a new request to DAH and new Command approval from FORCOMD (as the commander had changed and the timeline extended). Approval was granted by DDVAHREC until December 2022. This amendment application took four months to complete.

Data collecting procedures covered all aspects of human rights protection. Ethical issues for this study were informed consent, anonymity, confidentiality and beneficence (Australian Government, 2019). The following ethical considerations reflect the policy and procedural guidelines of JCU (2019), ACU (2017) and the Australian Government (2018).

3.7.2 Consent

In each phase of the study, participants received comprehensive details of the study in a plain language information and consent form (Appendices B and D), including information collection procedures, expected time commitment, reassurance of anonymity and confidentiality and the following additional requirements by DDVAHREC.

All current serving members of Defence are deemed to be in a dependent relationship with their employer and 'on duty'—in other words, at work—while participating in the research (Australian Government, 2018). To mitigate the perception of command influence, the consent form informed participants that there would be no detriment to their career if they chose not to participate.

To ensure privacy and protect national security, the consent form (see Appendices B and D) outlined the location options for interviews and informed participants they should only discuss information of an unclassified nature. As a condition of ethical approval, the interview location was either a civilian public or Defence area—meeting in a participant's home was not permitted. In addition, all respondents were advised prior to consent that I (the interviewer) was a serving ARES NO, undertaking the study separately to my Army role. However, because—as both a RN and Defence member—I remained subject to mandatory reporting obligations, participants needed to consider carefully before disclosing unreported alleged illegal activity, which may have occurred on a deployment, to avoid self-incrimination.

DDVAHREC required all participants to receive a 24 hour 'cooling off' period after they signed a consent form (Australian Government, 2019). This period is the same as the interval entailed in contracts, to allow either party to withdraw without penalty. Once I received a signed consent, the participant was contacted no less than 24 hours later to arrange an interview.

In accordance with DDVAHREC policy (Australian Government, 2019), participants were allowed to withdraw without adverse consequence up until their data were incorporated into analysis. At the time of withdrawal, information previously given would remain part of the

study, but future participation would cease. This was because the GT analysis process embedded ideas elicited from data into theoretical concepts as soon as each interview finished or participants submitted a completed Qualtrics response. A participant only needed to contact the researcher in writing (email) and their withdrawal would be immediate. Ultimately, no participant withdrew from this study. Participants were also advised that there may be follow up activity after an interview and publication of de-identified study findings in the scientific literature would occur at the completion of the research.

3.7.3 Anonymity and Confidentiality

Both anonymity and confidentiality are processes designed to protect human privacy. As this study used interviews, and all participants provided a consent form that identified them, true anonymity was not possible, because personal identifying information was available to the researcher. Therefore, confidentiality was the main tool by which separation of personal identifying data from the findings of this study occurred; with knowledge of participant identity limited to me.

De-identification (anonymity) of all participants occurred at recruitment through the allocation of pseudonyms that were used in all electronic records, transcriptions and analysis. The pseudonym key and all hard copy information was stored in accordance with the detail given in the next section. To legitimise the data analysis process, research supervisors reviewed interview information with pseudonyms attached. However, as an additional measure to protect participant anonymity, pseudonyms were not included with quotes used in this thesis and will not be incorporated into eventual publication. The use of a pseudonym, in combination with reference to other demographic data, may potentially identify a participant, who in some instances may have shared information that could attract unwanted attention from within the Defence community. Although it may eventually be possible for someone to identify nurses who deployed to Iraq or Afghanistan, insofar as the group was relatively small, it is unlikely to occur through this study.

3.7.4 Data Management

For the duration of this research, all hard copy participant information was stored in a locked filing cabinet within my locked home office, to which only I have access. Electronic and audio information was stored in password protected computer files used by me. The use of personal data was limited to this study. On completion of the study, all information obtained from participants in hard copy, audio and electronic data, will be securely stored for seven years from the date of final study publication, and subsequently destroyed then disposed of in observance of JCU (2021) policy for the responsible management of data.

3.7.5 Benefits

There were no likely direct benefits for the individual NO who participated in this study, except where they perceived a benefit in sharing their experience. However, the findings have use in a broader professional context: they provide a clearer understanding of what an Army NO does as a unique subset of the nursing profession and give insight into the challenges encountered in an IAC. This research may provide a foundation for future investigation aimed at improving patient outcomes linked to evidence-based NO practice. The main benefits of this research are to the future of Australian Army NO, the RAANC and the Army community they serve.

3.7.6 Risks

Australian military involvement in both the conflicts in Iraq and Afghanistan ceased in 2021. Participants deployed at some point between 2005 and 2021, with Phase 1 interviews conducted from 2016 to 2019 and Phase 2 input occurring between 2020 and 2022. This means that at the time of study involvement, participants had deployed anywhere between two to 16 years prior. As participants commented purely on their experiences of deployment to and practising in an IAC, the researchers did not anticipate the actual level of risk associated with this study to be significant. Notwithstanding this, in accordance with the National Statement for Ethical Research (Australian Government, 2018), DDVAHREC did not consider this study to be low risk.

Although neither my supervisors nor I envisaged any participant would experience distress from an interview, I planned for the management of participant distress in line with University and Defence risk management policies (ACU, 2017; Australian Government, 2019; JCU 2019). In addition, both my principal supervisor (during Phase 1 of the study when interviews occurred) and I had long backgrounds in high intensity and mental health settings, with experience in identifying and managing distress in both nurses and patients.

Pre-interview, each participant received a brief on how the interview would proceed. The plan was to pause if they became distressed and needed time to collect their thoughts and cease only if they were unable to regroup and continue. Participants would then be offered support to deal with any issues that arose, through referral to appropriate support services: IMSICK, the All-hours Support Line and the Defence Family Helpline, the Veterans and Veterans Families Counselling Service, Beyond Blue or LifeLine.

During each interview, I monitored for distress and, at the end, I offered each participant a list of counselling services in case issues resulted from the interview after the participant left. Some of the conversations involved distressing topics, but the participants had all reflected on and dealt with the implications of these topics before agreeing to an interview and were thus able to provide highly valuable, well thought out and, at times, courageous answers to the challenges they had faced. No one became distressed during an interview and do not appear to have done so afterwards.

3.8 Dissemination

The purpose of this study was to explore the experience of Australian Army NO deployed to IAC and subsequently develop a theory of Australian Army nursing. This thesis presents the study outcomes and broader dissemination will occur by publication in military and nursing journals and conference presentations. Given this aim, participants remain de-identified, with no way of identifying individual responses in any reports or published articles. Where relevant and permissible under extant operational security, country locations (areas of operation) are mentioned to indicate specific context and how this may explain concept variation. DDVAHREC provided advice on this issue and, in keeping with Defence

requirements, publication will only occur after a senior military member reviews and approves all potential articles. Participants will receive a copy of the results if they so choose.

3.9 Conclusion

The chapter has outlined Glaserian GT and why this methodology was chosen for this study. In particular, because, in Glaserian GT, there is a parsimonious focus, the resulting theory can be adapted over time to changing social circumstance and this methodology can identify common purposes for behaviour, which is useful when seeking to conceptualise collective notions of the NO identity and role. The next chapter reveals the findings, which arose using Glaserian GT analysis.

Chapter 4: Findings: Preparation to Deploy

4.1 Introduction

The first three chapters of this thesis provided background to the study and explained the methodology used to explore the contemporary experience of Australian Army NO entering an IAC zone. The GT methodological approach produced a rich and complex array of data, owing much to the unsparing honesty with which the NO participants engaged with this study. From the breadth and depth of individual experience, Phase 1 data analysis distilled significant points of commonality around shared aspects of deployment. Phase 2 data reinforced the findings and provided additional detail. Points of difference between the experiences of each NO lie in the position of an NO in relation to a particular theme. An integrated theory describing common attributes of NO deployment emerged from identified categories and theoretical concepts that explained how categories were connected.

The purpose of this and the next two chapters is to describe the study findings. Using de-identified participant quotes to illustrate the findings, Chapters Four and Five provide a description of key theoretical concepts through the narrative lens of the deployment cycle, given that this is how each interview progressed. Whereas Chapter Five explores the processes of deploying to IAC and returning home, this chapter focuses on the process of preparation as a discrete precursor to deployment, with emphasis on personal, military (organisational) and clinical readiness. Two main categories underpin preparation: NO attitude and their ability to develop knowledge and skill prior to deployment.

As the findings unfold, revealing themes and establishing connecting links, a storyline becomes evident that concerns preparation linked to deployment and deployment to returning home. In the context of this study, a storyline is a byproduct, not an end in itself. This avoids Glaser's concerns about forcing data into a story, while simultaneously providing a way for the reader to understand the complex experience of Army nursing (Birks et al., 2009; Glaser, 1992). The perspective will shift in Chapter Six to revealing the emergent theory, framing and contextualising the findings at an abstract level.

4.2 The Participants

The 12 participants in this study were NO, employed by the Australian Army at the time of interview. Nine were ARA and three were in ARES. All of them had deployed to one of three armed conflict operations sometime between 2005 and 2021, experiencing variable work environments and holding a range of roles. At the time of deployment, participants varied in Army employment status, nursing experience and military background. Of the 12, two had been a non-officer rank prior to becoming an RN and had thus been trained as a military product. In Phase 1, none of the participants had previously deployed to IAC, although some had undertaken overseas deployment on humanitarian missions. During Phase 2, two participants had deployed at least twice by the time they participated in the study.

Fifty per cent of the participants deployed to primary clinical roles, covering specialty areas including Emergency Department (ED), Intensive Care Unit (ICU) and Operating Theatre (OT). These NO worked mainly with US forces and a few other allies, such as Holland. Twenty-five per cent worked as Platoon Commanders with Australian forces, sometimes also supporting allies such as the US or Singapore (see the glossary for a description of the role of the Platoon Commander, which is a combined clinical and administrative role). The remainder were in leadership or liaison roles with Australian or allied forces. Thus, these participants found themselves situated somewhere on a clinical–administrative continuum, positioning more towards one end or the other.

Diagram 1 provides comparison demographics of each individual's years of nursing (as an RN) versus military experience, although it does not indicate the extent to which nurses worked in a limited clinical capacity over that time. Among ARA nurses, two had been unable to maintain a consistent rate of nursing practice since joining the ARA, and rates of practice for the others were highly variable. Diagram 1 also outlines employment (ARA or ARES) status at the time participants deployed. Diagram 2 depicts how many participants possessed a postgraduate qualification prior to deployment, and which qualifications they held.

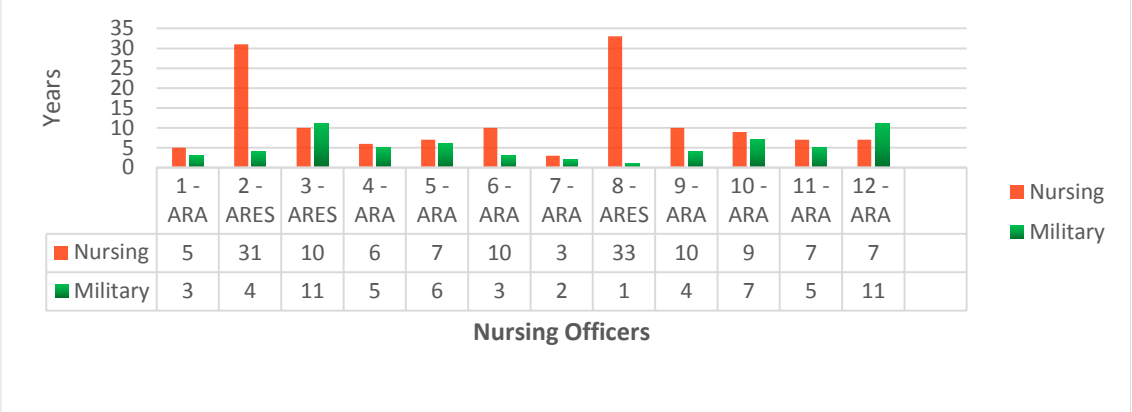

Diagram 1: Comparison of Years as a Nurse and in the Military

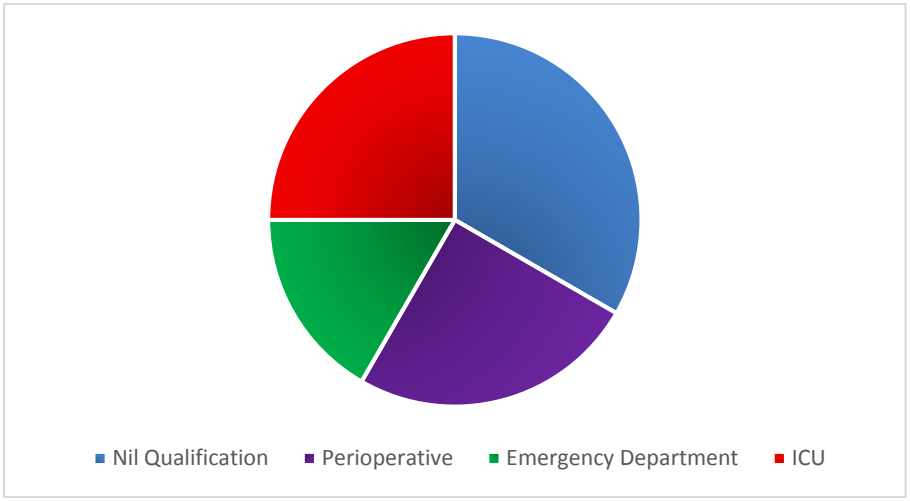

Diagram 2: Possession of a Postgraduate Qualification Prior to Deployment

4.2.1 Reasons for Going

NO decided to deploy for a number of reasons. They wanted to do their service, provide care to Australian soldiers, experience adventure, face challenges, experience humanitarian issues and find something more than they were used to dealing with at home. It was an affirmation, a learning opportunity, a chance to serve their country and, for some, to follow in the tradition of family.

> *There are Australian soldiers going over there and doing really hard work, committed to doing what they do professionally and putting their lives at risk. I see my role to help them*

out the best I can, to deliver healthcare to a high standard. I see it as a service to other Australians putting themselves at risk.

It was a practical ability to work against the odds, my chance to push the boundaries.

4.3 The Process of Preparing to Deploy

Preparation is a concept integral to the deployment process: before departure, there is always something to prepare and do. The military describes this phase as 'readying'. The overall aim of the process is to be ready to perform effectively on personal, clinical and military (organisational) levels, and to cope with and respond to the personal and professional experiences that might arise from IAC. The process of preparation commenced at different stages for each NO, according to personal and organisational factors. Personal preparation essentially lay with the individual and could commence prospectively or once the organisation informed a nurse they were deploying.

It was a consistent view among all NO that preparation was critical. More specifically, they talked about the ability to demonstrate knowledge, competence and accountability—in nursing, of the Army and about the deployed environment. Importantly, a number of the lessons participants shared resulted from hindsight, as they looked back on their deployment and considered their preparation. After deploying, many discovered they were underprepared and possessed inadequate preparation awareness—a situation they wanted to prevent for NO in the future. '*I did not have a lot of understanding till I got there*'. Participants believed preparation therefore required awareness and an acute sense of responsibility, underpinned by a positive attitude, all of which translated to actively pursuing a level of readiness.

To that end, the process of NO preparing for IAC essentially fell under two key headings: **attitude** and **development of knowledge and skill**. The discussion that follows provides a detailed description elucidating each of these categories and their subcategories (summarised in Table 1). Attitude was about how the NO approached getting ready and required the NO to be proactive and self-protective. It was the main determinant of how effectively the individual pursued preparation and related to all three domains of readiness: personal, clinical and military. Development of knowledge and skill was about being ready to respond

effectively to what a nurse may encounter on deployment, with an emphasis on clinical and military readiness.

Table 1: Preparation: Main Categories and Subcategories

Main Categories	Subcategories
Attitude	Be Proactive Prepare your own thoughts (headspace)
Develop knowledge and skill	Find out 'who' and 'what' Clinical practice—be competent The Army—know the organisation The deployed environment

4.4 Attitude

The use of the term *attitude* in the context of this study is in the psychological sense. It refers to emotions associated with, and behaviours demonstrated towards, a particular object, person or event (Cherry, 2021). All NO believed self-preparation was essential if they were to be ready, as much to overcome organisational barriers such as a lack of support for clinical work. Although some participants went into the deployment process with a sense of what they needed to do to get ready, for other NO there was limited awareness of what to prepare before deploying, with many gaining the knowledge retrospectively. Notwithstanding their position on the readiness continuum, they all unequivocally articulated the need for individual accountability and drive; believing that they needed to use the following strategies: 'be proactive' and 'prepare your own thoughts (headspace)'.

> *There was much [self] reflection on whether I was the right person for the job.*

4.4.1 Be Proactive

Being proactive was a tactical countermeasure to the organisational, time and resource barriers NO were exposed to when trying to prepare. Collectively, participants considered NO needed to be individually aware, accountable and proactive with their own preparation, particularly of a personal and clinical nature. The Army directed and controlled pre-deployment military training.

The Army determined and took primary responsibility for military readiness and expected anyone who deployed already had the relevant basic training. As described in Chapter One, initially NO gained a degree of preparatory military training on entry to the Army and, subsequently, in accordance with time and organisational exposure. Therefore, to some extent, this preparatory training was influenced by their employment (ARA or ARES) status. Specified military training relating to a particular deployment commenced in accordance with Army timelines and availability of such training. Ultimately, baseline Army knowledge varied between nurses. ARA NO gained regular exposure to all aspects of Army life and training, thus were well-prepared militarily. However, for the ARES NO, it depended on their time in the Army and engagement with training. Some were well-prepared, others only to a basic level, with no experience of interacting with the broader organisation or providing health guidance to Command.

The Army built on basic training with pre-deployment force preparation training. Force preparation varied in length from one week to several months, changing from one deployment to the next. In some cases, force preparation training was very good and in others it was minimal.

> *The military training I received transcended what I had received up to that time and therefore I felt incredibly prepared for combat experience. It built on familiar skills rather than providing me with new ones.*

> *I did force prep. I didn't learn anything more than the mission rehearsal exercise (MRE).*

When (or if) the Army provided limited direction on preparing to deploy, having knowledge of how the Army operated improved the ability of NO to get ready by knowing who to ask and increasing their capacity to anticipate what they might need. Conversely, a lack of understanding inhibited the opportunity. Short or unexpected notification of deployment aggravated this situation. An ARES nurse, received a choice of two offers for deployment, selecting one place over the other; however, given a general lack of military experience, had little idea of what they subsequently needed to do, or who to ask: '*It was Afghanistan or Afghanistan and I had no idea about anything*'.

Weapon training was a priority; NO needed a baseline standard of weapon readiness prior to deploying. All nurses accepted the role of weapons in the Army and the personal requirement to carry one; however, this aspect of preparation posed a challenge. Being aware that weapon use was an essential need but not their primary job, NO wanted to prioritise clinical practice while meeting weapon readiness standards. This issue primarily affected ARA NO. In one case, an NO was able to acquire priority clinical time (albeit, as explained later, they had to fight for it), but was unable to access what they thought was adequate pre-deployment weapon training, because their health unit in Australia was not aware of the need.

> *The unit was not aligned with the 'combat mindset' and were not skilled at supporting me to deploy. Thus, my weapon training was poor.*

However, more frequently, clinical time was not always achievable because the people who usually made decisions about deployment training and preparedness were inherently combat-oriented and not health professionals. Thus, they prioritised weapon training, a position in contrast and opposition to the nurses' belief that they needed to be clinically prepared. In addition, some NO perceived that combat personnel relegated clinical practice to a lower priority because they had a negative attitude to the comparatively (to infantry) poorer weapon handling skills of nurses. For some NO, this attitude engendered a sense of guilt over the standard of their weapon practice. In one case, an NO decided as soon as they knew they would be deploying to be proactive with weapon readiness to mitigate negative comments and improve their own weapon confidence. This NO felt fortunate to have a prior solid clinical base of practice.

> *They expect everyone to train on weapons like the infantry rather than doing our own [nursing] training.*

The availability and commencement of clinical preparation was highly variable. All NO had some degree of prior clinical experience; however, their ability to develop their knowledge and practice in preparation for deployment depended on a range of factors including, but not limited to, employment status. For ARES NO, clinical preparation was their responsibility and they all worked clinically in a civilian capacity on an ongoing basis. Clinical preparation was a shared responsibility for ARA NO who required Command approval and support to

work clinically. However, there were a number of organisational barriers to ARA NO gaining clinical exposure, thus the perceived need to be proactive.

In general, it was apparent the Army had a clear idea of what NO needed to be militarily ready because this aligned with the expectation of all deploying personnel and the organisation's core business. However, notwithstanding the exception described earlier, it was clear to participants that the Army did not understand the need for nurses to practise regularly in preparation for clinical work, including deployment, or that NO had variable specialty areas of practice.

> *It is still clear that the organisation [Army] has an antiquated or poor grasp of what a Nursing Officer brings to the table, so the employer doesn't really know what we do [what a nurse is and can do].*

The Army did not require NO to demonstrate recency of practice for the organisation to consider them clinically ready and deployed postings frequently mismatched actual skill with required skill, suggesting the Army thought all nurses could fill any position. This was described as: '*they think a nurse is a nurse and knows their job*'. Further, participants considered there was little evidence to suggest non-nurses understood the professional clinical readiness needs of NO in terms of establishing a solid practice foundation upon which they could maintain and develop advanced clinical skills, competence and currency over time.

Sixty per cent of the participant NO entered the permanent Army (ARA) after completing their degree and undertaking two years clinical practice as a civilian RN to consolidate their learning. After entering the ARA, most ceased to work clinically on a regular basis and initially undertook extensive training to militarise. Thereafter, although it depended on the location of an NO posting, the main emphasis of the nursing job was administration. Regular clinical practice was not the usual role expectation.

> *Our job was to run platoons, administer medics, do non-technical inspections and supervise. We worked in the garrison [primary health facility], did vaccination parades and did clinical placements [in external hospitals] when time permitted.*

Focusing on others was an expectation by Command, with the NO job in Australia framed around establishing combat force medical readiness, through health preparation and administration. The role was essentially primary health care, with a limited and intermittent requirement to provide resuscitation care in a field setting. Once deployed, NO were aware the job role would shift to trauma management and become more reliant on high-level clinical skill. Therefore, when possible, ARA nurses would undertake supernumerary clinical placement in a civilian hospital as a way to gain and develop other skills, such as critical care. This required Command approval to take the time from other 'tasks' such as administration.

> *My day job was as a primary health care nurse in a busy garrison facility, however, my critical care skills were totally reliant on limited short courses, rather than extended practical experience.*

However, most ARA NO received limited clinical placement time. This supported the belief that Command did not understand that nurses, to be prepared, had professional knowledge and skill development needs—skills that could not be gained or maintained solely from routine work on an Australian Army base. Moreover, NO in this study perceived that Command were not aware of the changing scope an NO may experience on deployment. These participants wanted improved understanding and recognition of their clinical readiness needs.

> *Getting ready to deploy … we were having workforce meetings due to the health restructure. I still had my day job, I had to transition out of that. We were so under the pump with all these other admin duties we had to do … we ended up having to prep … I remember it being some exorbitant number, like 2500 people. To get them medically ready … and days of vaccination parades. … I just remember it being HUGE.*

ARA nurses were encouraged to consider postgraduate (PG) study in areas such as Critical Care or Perioperative Nursing as a way to further their knowledge and develop a specialist skill set. In keeping with the previous suggestion that the system did not understand how clinical skill evolved and consolidated with practice, when NO undertook PG study, the Army only required them to complete a minimum number of days of practice (two days a week, not the usual three to four days required of non-military students). Subsequently, the Army system did not expect the ARA NO needed practice to maintain their new skill, a

situation aggravated by the absence of policy direction to commanders to enable clinical placement and ongoing specialist skill maintenance. Combined with a high tempo of other 'tasks', the system ultimately passively discouraged commanders from enabling clinical practice development. The consequence of the organisation's general approach to clinical readiness was a culture of minimum expectation in terms of clinical skills.

> *The minimum expectation was two days a week in specialty practice whilst completing the qualification. I did not have to practise after that. I knew that meant I was not experienced.*

> *Clinically I was able to get some access to a local operating theatre to refresh skills not adequately practised in the previous year. I met the requirements set out by the ADF to be ready to deploy but was apprehensive as I had limited exposure to trauma and was not confident I would be able to support the surgeons when required.*

Barriers to clinical preparation were, therefore, a significant issue for the ARA NO who required Army support to work clinically. However, organisational barriers to clinical preparation were not an issue for the ARES NO, as their primary role was working clinically in the civilian world and the Army did not control their clinical practice.

Although the intent of being proactive was to enable readiness, a lack of awareness, time, resources or organisational support proved inhibitory at times. Despite such barriers, all NO made a distinct effort to prepare by way of reading or practice, albeit with varying levels of success. One NO did not wait for a prompt and met the clinical preparation challenge by organising two weeks of pre-deployment clinical practice. To further their knowledge and compensate for an inability to gain more clinical experience given time constraints and other workload, this NO said that '*I just read, I know that I read as many journal articles as I could*'. A very experienced ARES clinician also chose to read as much as they could before going because they wanted to build independence and avoid under preparation. They were aware of where they were going, the role and, in particular, how they needed to develop clinically. This NO did not want to be someone who was, as they described, '*underdone*' in clinical terms. They were alert to low levels of clinical practice among some NO.

> *I just wanted to go completely and utterly prepared for any challenges. I would do the best I could. I wanted to be fully there, right on the ball*

One NO was an exception to the minimum expectation approach when they undertook postgraduate study. Near the end of their course, they were advised they would be deployed if '*qualified and experienced*' because they were to fill a specialist role that required appropriate qualification. This NO explained that many Army colleagues thought 'experienced' meant a course was completed, not that the NO necessarily had any subsequent practice in the relevant area. In expectation of a demand for high-level skill, with nothing to lose and everything to gain, this ARA NO argued for extra clinical time, in the form of an extension of their time off from Army (it took 12 months to complete the course).

> *I knew we needed as much clinical as possible … knew I was not experienced as I had just finished my [postgraduate] qualification and others thought they were experienced by just having the qualification. I extended by 3 months and worked full time. It was ultimately the best form of force prep.*

This attitude was not because of clinical experience prior to deployment, but rather the NO's own sense of professionalism, self-reflection and awareness, and what they perceived was needed to do a '*good job*'. With some resistance to their request, the NO was both proactive and determined to acquire the experience before going and made every effort to maximise their clinical hours. They challenged the position of minimal expectation and noted that not all of their colleagues at the time (or even now) agreed with this position. In addition, the NO negotiated to do some leadership work and team communication to improve critical thinking and problem solving.

After several rotations to Afghanistan, parts of the Army organisation started to inform clinical preparation through proactive training designed to build the team. This training was not available to all NO who deployed to IAC. Known as a Mission Rehearsal Exercise (MRE), this training included working in simulation laboratories under pressure, to simulate the expected tense environment of IAC. The MRE was a benefit to some and not to others, largely dependent on their prior experiences. NO with prior experience in pressurised environments found they were able to perform effectively during simulation activities, implying prior exposure facilitated adaptation. Thus, they felt a sense of accomplishment and affirmation of readiness. However, other NO were left with a sense of feeling unprepared from having struggled to benefit from the training given a lack of relevant clinical currency

and lack of experience in dealing with a high pressure and variable environment. On its own, simulation did not appear to improve readiness, rather acting to confirm whether an NO felt ready or not.

> *I personally did well due to familiarity with the environment.*

These findings under the heading of 'be proactive' suggest the preparation deficiencies some NO experienced may have resulted from a lack of organisational understanding about nurses and what is required for a nurse to be clinically ready. Despite nesting within a combat system, the priorities of the Army and the clinical needs of NO were not reconciled. Up to a point, proactivity could be utilised as an enabler and countermeasure to organisational barriers, albeit with variable success. However, a lack of conscious understanding by some NO about what they needed to be able to do clinically meant not all NO were able to maximise a proactive stance or provide guidance to their command on why clinical readiness was important. Ultimately, in spite of varying levels of awareness about what preparation they needed to undertake, all NO demonstrated a degree of proactivity and were as ready as they could be, demonstrating they were responsible, accountable and leaders. The following excerpt summarises the concept of being proactive and why it is necessary if NO are to be adequately prepared for deployment:

> *Acknowledge the Army is not going to give you everything. You [should] know your own deficiencies and where your deltas [gaps] are, so you need to be proactive*

In the end, nurses' voices were not as evident as they would have liked them to be prior to deployment. However, the experience of deployment retrospectively raised their awareness and, through this research, has strengthened their voice for advocating for what they believe NO need to be deployment ready.

4.4.2 Prepare Your Own Thoughts (Headspace)

NO described preparing their own thoughts in advance as a way to build their mental defences and be ready to cope with the personal, clinical and military demands of deployment. This was largely about psychological preparedness in the domain of personal readiness. In various ways, each NO interviewed stated that it was essential to establish a clear 'headspace' for

managing what was to come, without truly knowing what that may be. NO did not assume coping was an automatic reaction and preparation was essential to ensure maximum function.

> *Headspace prep is the same for a whole-of-unit deployment, just as it is for a ROCL [short term position to cover leave] relief and [single] embed positions. An effective compendium of coping mechanisms, scaffolded on life experience, qualifications and personality traits set the individual up for success in the deployed environment.*

NO considered it was crucial to know before deploying what their own coping mechanisms were and how they were going to support them—to work out in advance through self-reflection how they would cope with what they might see, the uncertainty of a nearby threat, how they would cope with the effects of austerity on clinical practice and where they may have gaps. This included reconciling how they felt about leaving family, particularly children, behind.

> *Know your coping mechanisms; there are things that are unpleasant about any trip.*

They needed to know and test their general coping ability as much as possible, before being put under significant duress. As one NO suggested, '*you have to think about who you are going to be looking after and how you cope with certain situations*'. This was one aspect of deployment that many NO realised with the benefit of hindsight.

Having identified their coping strategies, NO talked about establishing mental parameters to delineate a mental comfort zone, which would enable them to operate in the deployed environment and deal with threats, potential practice challenges and personal stress. This started with identifying potential risks and challenges and subsequently moved to how they would deal with risk. Thus, nurses made conscious assumptions during preparation such as what they might see in terms of patients and trauma, what personal security maintenance might mean and how living in relative austerity might affect personal comfort and clinical performance. Prior experience appears to have influenced the extent to which they were able to make assumptions about potential military or clinical situations.

> *You make certain justifications about or level of safety and risk, and all of those kind of things.*

Having identified potential risks and challenges, NO then focused on thinking about their attitude to and knowledge of a particular situation. In this sense attitude was about thoughts and feelings towards dealing with these potential risks and challenges, including how to live with themselves and potentially cope with limited support. Knowledge acquisition was not always possible prior to deployment, especially where security information was required.

> *[On advice for future nurses] Have they thought about what they are going to do; they are about to step out of a safe and supportive environment to a very unfamiliar, austere and hostile one.*

Part of preparing their headspace included self-expectation management and working out how to maintain a degree of control. To that end, these nurses considered it important to be clear on one's own zone of clinical and military influence. Being clear on what the NO *could* control promoted comfort with choices and actions, and reduced the stress associated with not being able to control some situations.

> *Afghans were not accepted [by the mission], they were sent back out the gate. It was outside of my control, so I accepted it.*

This approach to preparing for what an NO might witness and have demanded of them, supported self-expectation management and reduced the risk of being overwhelmed, although it also assumed the NO was clinically aware enough to maintain a semblance of control within their sphere of influence. Ultimately, NO enhanced their mental preparedness by acknowledging their sphere of influence.

> *Prepare your own thoughts about where you are going and what you are doing and whether you are comfortable with that … I can't worry about things out of my control and I don't know about … Be able to get along with yourself*

In retrospect, participants said it was essential to establish clear (but not rigid) expectations before deployment about what the military mission would entail and where nursing practice fitted in. The reason was that boundaries set by the Army on the circumstances for healthcare provision ultimately influenced decisions about who could be cared for and how. They

considered that knowing when they might need to refuse care was important to self-expectation management.

> *Understand the strategic and operational objectives of the mission and how the health plan supports those objectives.*

Despite the clear importance of security as part of the military mission, the prioritisation of weapon training over clinical practice aggravated a tension felt by some NO between the effects of weapons and the nurse's primary role to save life. Although they used the potential need for self-defence to reconcile any conflict they felt between using a weapon and doing no harm as a healthcare provider, it was irritating to have weapon training given a higher priority than their core business of caring. For others it was a case of reconciling with the weapon as part of doing business.

> *Ensure competence with weapon handling and combat skills. Developing a strategy to reconcile the burning juxtaposition [life saver, yet potential life taker] will help contextualise the nature of clinical care delivery in armed conflict.*

In addition, many participants thought being ready for the eventuality of death by thinking about it during preparation supported coping if it occurred: '*I thought about it before we went, I had seen death before, we cannot save all*'. Each NO considered various personal justifications for managing this potentially negative consequence of armed conflict.

> *I was more 'military mission' focused [due to a previous deployment], so less concerned with 'perfect nursing practice'—a lesson learnt previously, after observing others struggle initially. Death never crossed my mind, it was a given; I think that having deployed before—made it less daunting. But you also put it out of your mind, as deploying is exciting.*

Although some did not appreciate the exact challenge until they got there, all NO realised when preparing that they needed to be ready to face unexpected, difficult and morally challenging situations. They strongly recommended that to manage ethical challenges effectively, it was necessary to be very clear on their own ethical framework in advance of being required to test their ethical position against alternate viewpoints. At the same time, they realised it was necessary to think about their conflict management skills and how they could utilise them to support difficult situations.

When your view of adversity is so different to those around you, it puts nurses in a context where there might be conflict. Nurses need to think about ethical dilemma before deploying, they need practice at case-based scenarios.

In this section, NO identified the need for pre-deployment mental preparation with the purpose of preparing themselves personally for what was to come and strengthen coping skills. This helped confer a level of comfort with potentially difficult circumstances on deployment. As an adjunct to personal coping, NO believed it was essential to be as knowledgeable as possible about what they would be doing on deployment.

4.5 Develop Knowledge and Skill

A necessary precursor to effective functioning and safety was gaining knowledge about the environmental exposures an NO may experience. An ability to respond to the implications of that knowledge and, in particular, be adaptive to changing circumstances, was vital. Thus, the main premise behind the need for knowledge and skill was readiness to respond on a personal and professional level. In turn, a sense of being as ready as possible helped with the overall personal experience of deployment and coping. The more an NO knew about what they would face, the better they could prepare and being prepared enabled individual expectation management. Conversely the implication was that not knowing was a barrier to effective readiness and response. To that end, participants argued that it was necessary to 'find out who and what' and to develop knowledge and skill about 'clinical practice—be competent', 'the Army—know the organisation' and 'the deployed environment'.

4.5.1 Find Out 'Who' and 'What'

To be able to prepare, NO needed to know where they would be going, who they would be working with and what they would be doing. Although all nurses were advised what country they were going to and their likely role, they did not always acquire more information than this. Therefore, participants spoke about what they thought they should have been able to find out, mainly in a clinical sense, before they deployed. They were clear that gathering information was not only about what they would be doing as an individual, but that it was essential to find out who the team would be because this would be a critical aspect of both

their role and support. Practising with the team they were deploying with was very useful if they knew who they were.

> *I had been deployed with [group name] before and had a good rapport with command. I was detached to them and the anxiety of having to work against the system to gain information and build rapport was eliminated. Working alongside them [beforehand] was a luxury not afforded to most.*

> *We were lucky enough to go away with the [Anon group] for a week. We got to know them and them to know us well.*

Most NO wanted to talk to someone 'over there' to help them understand how they needed to organise. This was only possible if they knew who to contact. There were several drivers behind contacting someone already there. Due to variable information flowing back to Australia, there was a general lack of information about the deployed environment at home. Moreover, either before or after deploying, NO noted that in IAC information could quickly outdate as technology and practice, both health and military, attempted to keep pace with rapidly changing circumstances. Contacting someone already 'on the ground' would ensure access to the most current information. Even then, information could rapidly become outdated, but they considered deploying with some information was better than deploying with none. The lesson was to expect things may have changed and be both ready and able to adapt.

> *By any means possible, get in contact with the person who is over there, and find out exactly what's happening on the ground. That is not just so you are prepared, but so the team is prepared. I think we lack that communication.*

> *I called a colleague on the first rotation to better understand the [nature of] work. This was invaluable.*

> *I was provided the opportunity to conduct a recon of the hospital to identify what was available and get a good understanding of the layout and environment. This helped with my initial knowledge gap and anxiety about the deployment. In addition to preparing as a nurse, I needed to prepare for the role of Commander, receiving no training or previous exposure to the role.*

When it was not possible to contact someone currently in the deployed zone, some NO contacted other nurses who had deployed previously. The purpose was to increase their general awareness of what to prepare for, such as what to take with them for comfort, the probable scope of clinical practice and what the other forces were like to work with from a cultural perspective. This would help shape their expectations and potential for coping. At a practical level, it was also about getting information they believed no one else in the organisation thought they needed to know before they went. One participant found that other people were unaware until they deployed that they needed to gather such information during the preparatory phase.

> *I spoke to others about what to take for comfort, scope of clinical practice, the US, safety, weather and what trauma they [those in the zone] were seeing. Other people did not have that information or awareness [that they needed it], they did not search for it.*

When available, MRE training also acted to provide information not otherwise available. Some NO found this training useful for general development of teamwork, communication and assertiveness. Others, once they deployed, would find MRE lessons to be outdated or irrelevant because of an inconsistent ebb and flow of information from the conflict. Thus, training did not always incorporate lessons from prior deployment. Outdated training was problematic because it established false expectations, potentially leaving NO inexperienced for the role they filled on deployment, heightening their stress.

> *The MRE was mostly military in nature and only consisted of clinical scenarios created and assessed by ourselves.*

One NO had just qualified as an ICU nurse and gained as much experience as they could in the time available before departure. When they deployed, the standard was one week of military-oriented training shortly before departure. This NO had hoped for team-building, which did not occur, and, in retrospect, they found the training irrelevant to their deployment and clinical care. Instead, it focused on politically sensitive issues of the time. The participant suggested the lack of appropriate training was because of system inexperience. This, they thought, was because Australia had not seen any significant IAC activity since Rwanda in the mid-1990s and understanding of a nurse's pre-deployment training needs was non-

existent. Despite their personal concerted effort to be ready, the lack of force preparation training left them feeling very underprepared, leading to significant stress.

> *They were just ticking boxes … Australia had a poor track record of preparing people at that time.*

To be able to prepare clinically in a way relevant to where they would be working and thus feel ready to meet the demands of practice, NO needed to know exactly what their role would be. Otherwise, they deployed with a skill set mismatched to their ultimate role, such as an ED nurse in ICU or a theatre nurse in ED. Sometimes they knew before deploying what role they would undertake and at other times they did not. However, even when they did know, outdated MRE training worsened the skill set to role mismatch situation. In one case, an NO found what they practised before deploying did not match the deployed experience. This was despite knowing their destination and maximising preparation through MRE training, plus two weeks recent clinical practice to offset a general lack of clinical currency and consolidation.

> *I think it [training] should have been set up more about how it was on the ground there … they should have gained more insight into what specialisations they had, how the processes worked … [what they said] … it wasn't true.*

Conversely, knowing beforehand that they were going to be working in ICU, an area this NO had not previously worked in, they organised to work in ICU for several months, building upon his extensive background in resuscitation. Designed to obtain knowledge and skill, this action was a form of proactivity discussed in the previous section.

> *I knew I needed solid ventilation, haemodynamic, pharmacy, trauma and post-surgical skills. I did not want to go in with half the amount of skills and knowledge for an ICU position*

In addition to the essential need for NO to be clinically prepared, there was a strong focus on preparing the clinical team, which could be a doctor and medics if working in a platoon, or a group of nurses, doctors and medics if working in a hospital unit. Building the team before deploying was the ideal because prior bonding conferred a benefit by reducing the tensions

that can occur in teams where people are unfamiliar with each other and the environment. A few NO had the opportunity to get to know the team in advance, learn about personalities and skills, identify language issues—or the absence of—and generally bond before deploying.

> *The Doc and I, we practised with our team … all that high end stuff we weren't exposed to, chest tubes and things like that … that I knew of, but I hadn't ever been exposed to.*

> *The whole-of-unit deployment facilitated an early and informal team-building process. This seemed to reduce the tribal behaviours [faced by ROCL and single embeds] which by their nature can be conducted on a truncated preparation timeline, especially team building. Coalition deployments add a layer of complexity.*

However, many NO did not have this chance, with team-building occurring once they deployed. Some NO were essentially working as a sole clinician and would have to work on fitting into a non-clinical team once on deployment.

> *I had no opportunity to get to know my team before deployment and was the only NO there.*

In summary, the fundamental need to find out 'who and what' was driven by a primary desire to be clinically prepared. The need to pursue this information by whatever means possible came from the realisation that information was not forthcoming from the broader system. Thus, both as an identified need to know and often in the absence of impending information, NO found their own ways of gathering the knowledge they felt they needed.

4.5.2 Clinical Practice—Be Competent

Earlier in this chapter, clinical readiness was discussed in the context of why NO needed to 'be proactive' at an individual level. The extent to which they pursued clinical readiness was dependent, however, on their awareness of what was required, their sensitivity to their own baseline clinical ability and their opportunity to practise clinically. In particular, ARA nurses faced organisational barriers in the form of misunderstanding about the need for clinical practice and, subsequently, they often had a low base of clinical experience.

In this section, the discussion focuses on the nature and level of skill NO believed was required to work in IAC, regardless of whether NO had a direct or an indirect clinical role. Specifically, it was considered essential to '*prepare clinically and mentally as much as possible, [to] research the country and potential clinical experiences*'. Building on the prior discussion about pre-deployment levels of clinical experience and organisational culture of low expectation concerning clinical practice, there is also consideration for how well NO met the actual clinical readiness required to work in IAC.

NO often discovered they needed to be ready to perform at a high level and to cope with practising in an unfamiliar, austere environment as soon as they arrived in their destination. If patients were to be cared for as quickly and effectively as possible, nurses realised they had to be able to manage a combination of limited handover, low staffing levels, high casualty numbers and extensive injuries. Most realised there would be no time for a handover from others or time to get to know the environment before needing to start work—NO needed '*to be able to perform from day one, land and go*'. Therefore, being appropriately qualified and clinically experienced for a particular role—arriving armed with a repertoire of skills and knowledge—meant NO were less likely to experience the stress of feeling unprepared and unable to cope. Individual performance was critical, as was team performance.

> *Clinical skills need to be 'squared away' because it is a challenging environment with new people; you need something you are familiar with [your clinical skill base] and can adapt from.*

As previously mentioned, ARES nurses had no barriers to preparing clinically. Details of their overall quantity of clinical experience is available in Diagram 1. All possessed well-established foundations of consolidated clinical practice; they were all PG qualified nurses with an advanced practice skill set, deployed with relevant experience for the role they undertook, and they realised before deployment that they might see significant trauma. This realisation arose from their general exposure as clinicians to trauma, combined with critical analysis assumptions about what an IAC environment may produce in terms of injury. Each of these NO also had a sense of what effects austerity may have on their clinical practice, albeit not necessarily with any actual austere experience. They were able to appreciate what not having equipment might mean and hoped their prior clinical experience would enable

them to perform under pressure, including being able to cope with unexpected and difficult conditions. A sound clinical skill set provided a repertoire of skills that could be adapted to a variety of situations. Each of the clinically well-prepared nurses felt comfortable with their level of knowledge and skill when they deployed, albeit with a vague sense of concern over how this would align with the reality of conflict.

> *It was unknown you know, how much trauma are we going to see? Are we going to see a massive amount of trauma every day, day in day out, or is it going to be on the quieter end? I just thought, if it is on the really busy end I don't want to be having to rely on others.*

Most ARA nurses started with less clinical experience than those in the ARES because of organisational structure and priority, aggravated by variable levels of self-awareness as to what they needed to prepare clinically. The ARA group were faced with significant problems. For example, a number of these NO were unaware they were inexperienced, so felt ready to deploy. When they did attempt to gain pre-deployment clinical experience, they were largely unsuccessful because of the competing interest of other tasks. Their awareness changed in retrospect, specifically after finding they were not clinically ready to provide the level of care demanded by patient acuity in IAC and manage the influence of austerity on clinical care. Importantly, because people would rely on them, they believed they needed to be accountable. They did not believe the ultimate state of their clinical readiness was acceptable, for either the nurse or the patient.

> *Ensure clinical skills are at the required standard to ensure that the mission is not compromised. Feel confident to advocate.*

Two ARA nurses had a background of about three years of graduate nursing experience, some MRE training and limited recent practice since they completed their first two years as a graduate nurse. With their expectations of what clinical readiness meant shaped predominantly by the Army system, they thought they were prepared both for the clinical work and as Platoon Commanders—the person others would be turning to and relying on clinically and administratively. On arrival in Afghanistan, they would discover that, to varying degrees, they were not ready for the clinical component of work. Both subsequently

felt that there was no substitute for real-time experience and more experience in total was essential before granting permission to deploy.

> *It was like … I am so junior. I was looking up as I was going along … you can do a thousand scenarios but you are never going to get what you get on the table. Nurses must know what level of skill [they] need to be able to demonstrate and not expect to be taught when they get there.*

One NO admitted with stark honesty that a particular problem was '*not knowing you don't know till after you get there*'.

ARA nurses in possession of more than four years of consolidated practice, combined with a postgraduate degree and ongoing clinical practice, demonstrated greater awareness of what they needed to do to be clinically ready. This suggests clinical experience directly influenced awareness, especially when paired with a postgraduate qualification, thus acting as a counter influence to organisational attitudes to clinical readiness.

> *I had an unrealistic expectation that I would need to be perfect and know everything and be expected to be a whiz in high live care. This was difficult to obtain being full time [ARA]. I negotiated time and studied relentlessly in case I had to do anything that was in the realm of ICU.*

The NO who had challenged the culture of low expectation when undertaking PG study (six years as a nurse), '*knew*' they needed to be prepared. Subsequently, they worked full time in the lead up to deployment, aware that less experience would equate to what they described as '*gaps in [their] experience of patient acuity*', affecting their ability to perform.

An NO who had felt prepared with three years of nursing experience and currency at the time of deployment initially felt the system had given her thorough pre-deployment preparation. However, in hindsight, this NO believed they were inexperienced, particularly as an advocate and leader. They identified these as important skills for an NO to have, especially as a Platoon Commander who was required to lead a team.

> *The preparation from both a clinical and military perspective was extremely thorough; the entire process took over 6 months, with MRE, exercises etcetera. I felt clinically prepared,*

but in reflection probably not as much as I should have been. I coped, but struggled with advocating. I tried to gain control, so I could advocate, but inexperience held me back.

In summary, NO consistently believed good nursing knowledge and skill prior to going was essential, although for some this knowledge came in hindsight. Thus, a number would deploy unaware they were unprepared for the practice reality of armed conflict. All knew where they were going but not all of them had the skills relevant to their deployments. The reasons for this were variable and included a combination of organisational and individual factors. One NO summarised why nurses focused on the need for clinical competence:

I wanted to be an independent practitioner … and it wasn't the team factor, the driving factor always in the back of my mind, was that I would do the best I could, be the best I could be for any Australian soldier that was injured and came through.

4.5.3 The Army—Know the Organisation

As mentioned in Chapter One, the Army commenced preparing personnel, including NO, from the moment they entered the organisation. The purpose was readying the individual to deploy as part of a military force able to respond to circumstances they encountered, at least in a military sense. This included acknowledgement of military authority, weapon readiness, appreciation for security structure and function and a distinct emphasis on teamwork. Although civilian environments also focused on teamwork, in the Army teamwork was at the heart of successful battles and a source of protection. One participant explained this as, '*we dwell on the team from the time you start in the military*'. Moreover, the employment status of an NO tended to determine the degree of military language and culture they adopted, largely because of the extent to which they interacted with the Army on a daily basis.

The role of the NO was a conflation of two roles, requiring enough clinical and military acumen to perform well in a clinical sense within a military organisation. However, none of the participants remembered specific socialisation on adapting clinical performance to and within the unique demands of the Army—there was no specific training on the implications of rank as it related to clinical decision-making. The emphasis was on the Army officer. Thus, the Army persona the NO developed focused on learning what the military expected of them as an officer, rather than how the nurse and officer merged to become an NO.

We are both nurses and an officer, they converge. Nurses have a global awareness of people and their sensitivities, we are a caring profession.

The clinical component of their role was individual and self-guided. It evolved over time as nurses adapted to each new military and clinical experience, while trying to align with a non-healthcare system view of what a nurse is and does. As previously suggested, the military system understood the essential need for practice in terms of combat readiness (e.g., weapons), but did not demonstrate it understood the value of clinical practice to NO capability. For some NO, this led to a lack of role clarity and tension over how they fitted within the organisation and were ultimately utilised. To some extent, NO found their own path as they sought to identify how nursing nested within the Army system.

We do not really know what we are supposed to be doing. If I don't know my place (or potential) in the organisation, how can I perform effectively to achieve a health mission, in an organisation whose relational grasp of its health workforce is clouded by varying biases?

Simultaneously, the NO was balancing personal priorities, which potentially competed with their military nursing identity and deployment. Personal networks were part of the NO support system and influenced coping mechanisms and strategies.

Family are critical. [There is an] innate struggle to leave behind very young children and be an NO (being able to do the role you trained for) and balance guilt.

NO needed to appreciate and be able to work with several conditions unique to the military. The nature of the Army training system and deployment could produce patterns of injury and illness not necessarily seen elsewhere. Army personnel relied on an NO or other healthcare provider for care, both proactively and reactively—they were part of that provider's 'dependency'. NO needed to understand how their decisions could affect the individual soldier, which in turn required an awareness of the Army health system structure and, in general, of the relationship between people and their jobs.

In healthcare terms, NO also played an important role in providing emotional and welfare support. Bonds developed between nurses and soldiers, which translated to a unique social

structure and support system, albeit with cultural similarities to a close-knit community and family. The role of an NO in this setting was different to roles in civilian environments they may have worked in. NO needed a social awareness of the Army community—how it differed to the civilian world and how care decisions needed to account for a unique social environment.

> *I'm not just employed to be a nurse. You have to understand the whole organisation, so you can interpret [and] do your job as a nurse. You need to know what for example, the infantry role is, how they play, what not to do. You do care plans on both the clinical and social aspects. Our social aspects are our organisation, all the faces which make up the Army.*

As a commander had legal authority over the people in their command, with associated requirements for select sharing of information about their soldiers, those who shared that information, such as NO, needed to understand how to manage both this need for information and the issue of confidentiality. Nurses needed to know what they could share with a commander and why. NO interpreted medical advice for a commander in accordance with their experience (capability) at interpreting medical advice given by doctors to patients. This advice needed to account for the non-health background of the recipient and their own agenda, which could be counter to that of health care providers.

> *You need to be able to talk to command in their own language.*

Generally, NO needed to understand the impact of their own rank and how to advocate for a patient to personnel of both higher and lower rank, especially those in the combat arms (e.g., infantry) and when tensions were high. Resolution of conflict when tensions were high relied on an understanding of all parties. This required solid clinical knowledge and the ability to communicate in a manner understood by those receiving the message—thus, being able to speak the language of the Army and understand their priorities, while balancing those priorities against the patients' needs and then being able to defend a clinical position through advocacy. Whether NO developed this capacity or not was dependent on exposure to the system, opportunity and attitude.

Those who don't have to worry about clinical skills (or their own perceived lack of) can focus more on adapting to the chain of command and mission.

You are a military nurse that is the difference. Some NO won't take on anything military. 'I'm employed to be a nurse' [they say]. I think it's probably a transitional thing, when they come from the civilian world and expect to be a nurse, working in resus, going overseas and doing all the flash whiz bang things. Then they actually have to do … they have competing priorities.

Pre-deployment force preparation training involved weapons re-familiarisation, security briefings, cultural orientations, customs and other relevant administrative briefs. Fundamental to all pre-deployment training (and Army training in general) was a focus on drilling personnel on critical safety issues. Failing to understand the purpose of that training posed significant risks for the individual and organisation.

If someone is junior from a military perspective they may not see the value of the rules, therefore [they] will have challenges.

Thus, NO with a good working knowledge of how the Army trained people found themselves comfortable with force preparation and clearly understood the intent of the training for their deployment and safety. Conversely, a knowledge deficiency about the Army training system resulted in some NO not absorbing as much knowledge as they needed to, potentially leading to greater challenges on deployment.

In summary, militarisation of the nurse began on arrival in the Army. Using a time-honoured term included in the parlance of many NO, it took time to adapt to the 'green', with 'being green'—a term equating to 'being in uniform' and understanding what wearing the uniform meant. The reference to 'green' reflects a past tradition of khaki uniforms. To work effectively with the organisation and perform the NO role, NO had to learn how rank and hierarchy worked, how to speak Army language, appreciate unique customs and generally understand Army culture. However, NO had varying degrees of exposure to the Army, which influenced their understanding of the system and how it affected nursing practice. ARA nurses in this study were all well-prepared militarily; they had good Army experience and understood clearly how to be an officer. Paradoxically, however, several possessed

inadequate clinical experience, thus undermining the primary clinical effect of NO. ARES NO were very well prepared clinically but possessed variable military readiness. Thus, although some were ready, others were underprepared to work with the organisation, and subsequently experienced challenges.

4.5.4 The Deployed Environment

Being prepared for the deployed environment was essentially about developing an appreciation for the conditions that may be experienced, and how these would influence being an NO delivering patient care. NO believed the two main considerations for preparing for this aspect of their experience were understanding austerity and the cultures they may work with.

Austerity was the term used to describe a persistent constraining characteristic of the deployed environment that posed both personal and professional challenges. In the context of this study, austerity refers to conditions such as limits to available supply and time, less people to do the same job, low levels of personal comfort and severe environmental factors. These restrictions had several implications. On a personal level, NO needed to be ready to live with minimal comfort through austere living conditions, limited personal support structures and difficult climactic situations—something they thought about when 'preparing their headspace'. Clinically, NO needed to prepare themselves to work effectively unsupervised and to deliver quality patient care despite being potentially constrained by limited resources and time.

NO suggested the following strategies for preparing sufficiently to deal with an austere practice reality. They believed exposure to the Australian Army field environment—such as rural or remote settings—would provide experience of austere circumstances, enabling nurses to challenge themselves to deliver quality care, despite limits to available resources, and to practise developing alternate plans. These settings would expose NO to less surgical capability, less blood supply, less supervision and long evacuation times. Nurses needed to have a foundation of '*solid basic clinical skills with which you are very familiar*' that did not rely on equipment.

Moreover, in the austere space, NO could not guarantee support to learn once they were 'there'. This meant that they needed to prepare to practise more autonomously and be good at adapting existing clinical skill sets to meet the demands of a situation.

> *When you are faced with losing all your stuff that is all you've got [basic clinical skills].*

In terms of who NO may work with, knowing about other cultures was an important element of finding out who and what, as discussed earlier. In the deployed environment, this knowledge was important because of its potential to affect patient care. All NO realised they might be looking after patients who were not Australian or allied soldiers and prepared themselves for this eventuality through a combination of clinical experience, cultural information provided during force preparation and consideration of what they may be doing clinically. All nurses were familiar with the multicultural environment of Australia, albeit with varying levels of exposure.

Knowing that they would be working with people from other cultures, it was important an NO was able to manage difficult cultural conditions. They needed to be culturally literate, as non-Australian cultural demands could be counter to the Australian position. Sometimes pre-deployment training provided beneficial cultural knowledge, in addition to the occasional opportunity for people from different backgrounds to get to know each other, including personalities and skill sets. Working with other cultures exposed NO to differences in healthcare structures and roles, expectations and languages. A foreign force could do the same job differently. For example, the US had different structures for their teams and processes in the OTs, ICU and ED.

> *[We] don't have anaesthetics … ok, I would be scouting; that would have been a good thing to know, because I would have done a lot more of that before going.*

As will be described in Chapter Five, pressure points during patient care arose primarily from ethical challenges posed by other cultures working with Australians. Nurses could encounter differences in ethical viewpoints, medical terminology, practice and personal comfort. This could affect clinical practice and personal survival, specifically regarding how they dealt mentally with their experiences. Advanced warning of a need to work with other cultures allowed the NO to maximise their clinical preparation. This helped avoid a mismatch

between experience and actual role, improve individual expectation management and performance, heighten understanding of risk and enhance the use of translators—therefore, maximising nursing capability. In turn, better preparation potentially supported coping, by reducing stress associated with trying to perform while learning on the run.

> *There were conflicts between differing views of advocacy, cultural issues ... communication issues; we were learning lessons on the run.*

NO needed to be ready to learn new repertoires of drug terminology, imperial measurements and equipment. Being ready to adapt to new technology was important, with prior familiarity of working with different equipment in variable environments useful. Several NO thought that a structured, supported environment such as an OT, which used standard processes, increased the likelihood of facing familiar processes and equipment, and therefore increased coping. However, it was not uncommon for NO to find themselves doing a different role, thus a different practice reality to the one they expected.

> *I knew what I needed to do and the equipment was largely familiar. Although it would have been nice to know they [people and roles] did things differently [no scout].*

In summary, NO wanted to understand the physical and cultural environment to which they were deploying to prepare for its personal and clinical implications. From a personal perspective, NO needed to be ready for differences in living, food and support structures. Possession of knowledge about how austerity could influence nursing practice enabled the nurse to adapt more readily. Knowing which nationalities they would be working with allowed NO to prepare their expectations and develop an appreciation for alternate attitudes and practices before immersion in other cultures and exposure to potential personal or professional clashes.

4.6 Conclusion

This chapter focused on the social process of preparing for deployment, identifying two important subcategories to preparing to deploy, those of **attitude** and **developing knowledge and skill**. Conditions for an NO to be prepared (ready) included proactivity, preparing their own headspace, clinical competence, knowledge of the Army and understanding of the

deployed environment. This involved access to information, adequate time and resources, clinical and military experience and a supportive organisation (Army). In the following chapter, the findings will reveal what happened as each NO set off on deployment and how their preparation, or lack thereof, was to have profound implications for the next stage of their experience.

Chapter 5: Findings: Deployment to Armed Conflict

5.1 Introduction

The previous chapter described the findings of this study in the context of the preparatory phase of the deployment cycle, focusing on the preparation nurses believed was important to achieve what the military would describe as being 'ready' to respond and perform on personal, clinical and military (organisational) levels. In this chapter, the narrative explicates the experiences discretely entailed in deployment and, subsequently, in returning home, linking back to Chapter Four by demonstrating both the value of preparation and how circumstances in an IAC zone could vary from what an NO had prepared for. Because of the non-linear nature of this study's findings, this chapter will, by necessity, revisit key issues identified in Chapter Four to ensure clarity of context and the anchoring of concepts.

The overall aim of the deployment process for NO was to deliver care to the ill and injured, directly or indirectly. Thus, four main categories underpin deployment, revealing how NO interacted with and responded to their environment as they pursued their objective. These categories comprise: identifying as an Army NO, responding to the armed conflict environment, caring under fire and coping with challenge. A fifth category describes the process of returning home. This chapter thus closes the deployment loop, bringing the storyline back to Australia and revealing how the depth and breadth of experience would leave lasting impressions on participants. The next chapter will encapsulate the findings from Chapters Four and Five, summarising the theory that emerged.

5.2 The Process of Deploying to Armed Conflict

In this study, deployment refers to the process of transitioning into, through and out of an IAC zone, with both physical and psychological transition points. Physical deployment was precise, commencing when a nurse departed Australia, ceasing on re-entry. However, the physical journey to the deployment destination frequently occurred in stages through other countries. Psychological transition into the IAC usually began when the NO first knew about the deployment, accelerating with increasing physical proximity to the risk as they flew to their intended location and culminating on entry to the IAC zone, when the reality of conflict

was immediate and they had finally 'arrived'. Psychological transition out of IAC occurred in two phases. Phase one occurred when the NO left the immediate threat behind as they departed physically. Phase two involved the psychological transition home, which took much longer, was highly individualised and involved mentally processing memories of, and thoughts about, their deployment.

Once in an IAC, each NO operated within an environment that was complex, confronting and ever-changing. As they focused on caring for the injured, each component of the surrounding environment exerted an influence on both personal and professional levels. Influential factors included, but were not limited to, geography and climate, the nature and purpose of the Army, persistent demands of national professional regulation and international law, the challenges of IAC and the actions of people within this environment. The consequence was a sharpened focus on their identity and caring role as an Army NO, which evolved with their experience, transforming their professional and personal views of themselves. Eventually, the NO returned home, continued to care as nurses without the imposition of an external threat (from a conflict zone), coped with their experience, maintained their relationship with the Army and prepared to deploy again.

The socio-ecological context of an Australian Army NO is like a series of concentric circles (see Diagram 3), with the NO representing two intersections: one between the nurse and Army and a second between the NO and the IAC zone.

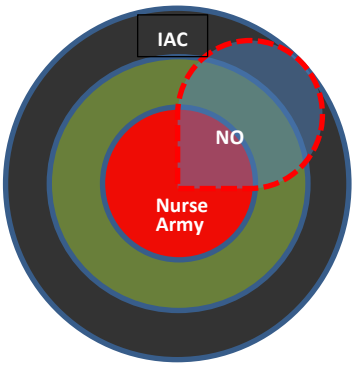

Diagram 3: NO Socio-ecological Context

From this, four interlinked concepts provide a frame for understanding the experience of being an Army NO in IAC, within which care delivery lies at the heart. Each NO had

obligations to the organisation and was responsible for identifying and resolving barriers to care delivery and managing adverse influences. Whether they delivered nursing care directly or through supervision and training, NO needed to possess a range of effective coping strategies to navigate and negotiate a myriad of challenges and work in the space where they all coalesced. Therefore, nurses needed to *respond to the armed conflict environment*, *identify as an Army NO*, *care under fire* and *cope with challenge*. These categories and their subcategories are summarised in Table 2.

Table 2: Deployment: Main Categories, Subcategories and Subthemes

Main Categories	Subcategories
Responding to the armed conflict environment	Dealing with austerity Reconciling with the threat Working with other cultures
Identifying as an Army Nursing Officer	Working with the Army family
	Finding a new sense of self
Caring under fire	Performing clinically
	Managing ethical dilemma
Coping with challenge	Being resilient
	Learning to live with the new self

5.3 Responding to the Armed Conflict Environment

For the purpose of this study, the IAC environment refers to the surrounding terrain, prevailing climate, local population, conflict and other cultures working in the area. NO deployed with variable levels of information about the environment and, regardless of what information they possessed in advance, the need to gather knowledge about the deployed environment became a reality once they arrived in their destination. Once in IAC, the three main issues NO experienced were ‘dealing with austerity’, ‘reconciling with the threat’ and ‘working with other cultures’.

Before NO needed to deal with austerity, they experienced the process of getting to their deployed IAC zone. The journey to IAC was a staged process, usually beginning on a civilian

aircraft that frequently did a colloquially described *milk run*—that is, landing in several places before arriving at the NO's first destination in the very early hours of the morning. In addition to transferring to a military flight for the final leg of the journey, most NO undertook additional training and processing at the transfer point between the civilian leg of their journey and the military leg. This encompassed threat level, security and quarantine briefs.

Commencement of initial exposure to the threat began on a mental level in force preparation training, and then accelerated in both physical and psychological terms as NO prepared to enter the IAC. On arrival, NO '*got force prep briefs, about the threat level, security, quarantine and customs, an idea of where the enemy was and what they were doing, the injuries and casualty flows*'. Depending on the country they were destined for, there might also have been information on injuries and the location of other health facilities. Participants would use this initial information when establishing and reinforcing their mental comfort zones.

Arriving in their destination at night resulted in a sense of disorientation and lack of location awareness. This disconnection from a concrete sense of where they were could aggravate anxiety associated with knowing that somewhere there was a threat. As one plane descended for landing into Afghanistan, the visibility was extremely poor. The NO on board could not see the runway and they experienced a significant sense of nervousness. After what they described as a '*bag drag*' of their personal equipment, they waited alone by an airstrip in the desert with armour on, weapon ready, waiting to be picked up '*with no idea where I was until I heard, "welcome to Kandahar"*'. Although waiting alone 'somewhere' was not a particularly uncommon experience—especially for people like NO who often deployed individually as opposed to as part of a team—it was an isolating experience. Notwithstanding, most NO usually spoke about such experiences of the environmental situation with a dry sense of humour.

For two NO, however, their arrival was more challenging. When they flew into Iraq, because an attack was occurring on the base, the last leg of the flight was tactical given the risk of ground fire. Tactical flying meant that as the plane approached its destination, it descended rapidly from altitude before rapidly climbing again, repeating this approach several times before going into a holding pattern until it was able to attempt a landing (once flight control

cleared them to land). This type of flying produced significant motion sickness. The initially aborted landing was the NO's first experience of mortar fire and one they would later discover was frequent for that location. In their case, 'welcome to Iraq' was a precursor to a significant experience of threat.

> *I remember, green light, red light, going to land, not going to land … then I heard overhead 'they just mortared the runway' … I thought … danger … interesting. Very steep drop, then landing. The noise, getting onto the minibus in the dark, no light. I'm sure I had a thought about getting back on the plane with my return ticket [laugh].*

The arrival process usually involved more briefs, access to accommodation, advice on where to find meals and what they had to do with mobile phones if they had one. In general, security issues meant phones were either not allowed or use was limited. At some point, there would be a tour of the hospital, accommodation and ablutions. NO carried their weapons at all times until they entered a health facility.

> *At Camp … we cleared weapons, got bags, a command brief, room keys and what to do to eat.*

5.3.1 Dealing with Austerity

Austerity was the term NO used to describe a consistent constraining characteristic of the deployed environment that posed both personal and professional challenges. Although personal comfort was almost non-existent, NO appeared relatively unconcerned by this. However, the effects of a difficult and dangerous environment on nursing practice, and therefore their patient, generated significant discussion. Some nurses had prepared for austerity, although once deployed the majority found that their prior knowledge, despite being useful, turned out to be inadequate to meet the demands the environment posed. The consequence was a need to adapt rapidly.

> *Austerity and armed conflict should not have a deleterious effect on our reason for being. Strive for a classical utilitarian approach to patient care.*

On a personal level, NO had to learn to live with relatively austere living conditions. This included being in close quarters to others, often strangers, and generally with limited room

for, and access to, the little things people may use for comfort. Access to family was limited to the success of technology and available time to use it. For some participants this was difficult, particularly if they had children or new partners at home. Nurses dealt with constraints on personal freedom and comfort with an attitude of pragmatic and dry humorous acceptance. None of the participants expressed particularly negative thoughts about their personal circumstances.

The nature of accommodation was similar across Iraq and Afghanistan. Shared facilities were common, often located between five hundred metres to a kilometre from the main health facility. They frequently consisted of demountable style buildings, with two to four people accommodated in each building. Space was limited with little room for personal items. Depending on the cultural tendency of forces NO were deployed to work with, showers could be communal, requiring men and women to share, separated by doors or curtains.

> *[We] slept in them, so just a single shipping container size accommodation, which would fit four of you comfortably. You know tight, but not completely uncomfortable; air-conditioned. Shared ablutions though, the [country name] share, male and female ablutions all in one. There were no divisions, all the toilets and showers in one big block. So the girls had to walk past the blokes at the urinal and things like that. I wasn't bothered by it [them walking past].*

Showers were often some distance from accommodation. Toilets could be portable and within 50 metres of accommodation, or more comfortable 'porcelain'—which was a US reference to toilets that flushed into a septic system, rather than the long drop portable toilet—located up to three hundred metres away. In the persistent heat, the smell from portable ablutions could be very unpleasant.

The dining room was known as the 'mess' if using the Australian Army term, or the DFAC (Dining Facilities Administration Center) if working with the US. Arriving at night, NO usually relied on someone to show them where to find the mess the next morning. Large bases tended to have multiple mess facilities, usually located several kilometres from the hospital, with a small mess commonly located inside the hospital. Food was always available

in reasonable quantity but varied in quantity, type, freshness and quality, rarely resembling food eaten in Australia.

> *There were a few choices for food. If you went to the British mess there was a LOT of curry. There were two US messes, mainly with Asian food.*

> *The Dutch pre-cooked meat in Holland, flew it over and reheated. For most part, food was edible. Sunday was interesting, you loved or hated it. I liked it.*

Although none of the participants directly complained about the food, some noted that having to eat food that varied significantly from a person's usual diet, took away a level of comfort associated with a necessity. At times, this could be challenging, especially for the health conscious and during periods of stress. Several NO commented they were lucky they did not mind the food they were served.

In Iraq and Afghanistan, sandstorms were frequent and able to reduce visibility down to ten metres. Sand penetrated tent workspaces, reducing visibility, coating equipment and challenging infection control. It could be wet, cold and very muddy in winter. Conversely, it was hot in summer, with temperatures up to 50 degrees centigrade in the shade, with some NO noting that '*fatigue and heat were overwhelming at times*'. Air conditioning was available for those living or working in hard walled containers or buildings. For those working in tents, such as in Iraq, there was air conditioning inside the hospital tents, but it often failed in severe heat and offered little value to the NO working in body armour during an attack.

> *The heat was a challenge to both humans and equipment.*

Although the personal effects of austerity could generate both laughter and a grimace, professionally, austerity was a significant challenge. Surges in casualty numbers beyond human or physical resources were a consequence of military activity, especially where the battle tempo was high. Limited downtime was common and there was a frequent requirement to be on call, especially when back up by others was limited. This required the individual to do more on their own or with a small team.

We had this MASCAS [Mass Casualty], I was overwhelmed, [name] told me just to keep going, I was doing a good job in the circumstances. We didn't have enough of anything.

The days were relatively quiet; we could be idle for 12 hours, go to the mess or to bed and be woken by radio, then running to resus some distance away to attend incoming casualties. You would get to bed in the early hours of the morning and then in a heightened state be unable to sleep, leading to cumulative fatigue. [We had to] parade at 0700 the next morning.

Supply lines could be vulnerable, affected by military action or temporarily cut because of weather conditions such as sandstorms, which stopped air traffic. Road supply was limited in Iraq because of security issues. Equipment could malfunction because of the weather, sand and heat and there were challenges transporting adequate supplies, particularly heavy items, to where a health facility was located. Despite a high level of extreme trauma, there were fewer resources (e.g., blood and surgeons) than one would expect in Australian civilian practice. Therefore, paradoxically, items such as blood were in high demand but were less available. At the extreme of austerity was the need to deliver care without any equipment, using nothing more than one's own senses and knowledge.

In the end, NO needed to be aware of limits to or variations in supply, able to determine their effects on nursing practice and adapt their practice to match the resources they had, while attempting to maintain a standard of care. To achieve this meant NO required several attributes, both mental and clinical. Mentally they needed to be flexible and able to accept variation, a coping strategy that operated alongside clinical adaptation.

Adapting to the environment is key and those who cannot will be left behind very quickly. Deployment is no time to be catching up on these skills.

This attitude of flexibility relied on the nurse having enough clinical skill to draw ideas from and feel comfortable with varying their technique to match altered circumstances. To cope on a practical level required a solid working knowledge of principles of practice, allowing nurses to maintain principles while altering technique. In particular, participants were adamant NO had to be competent and able to demonstrate very good clinical assessment and

intervention skills that required very little or no equipment, reflecting a more traditional pre-technology approach to clinical care.

> *Creativity in terms of using what equipment was available to achieve required outcomes was constant throughout the deployment. Knowledge and training received prior, enabled workable outcomes with identified equipment and staff.*

As a point of future concern, participants felt solid non-technology dependent skills were not as well-developed among contemporary nursing graduates, posing challenges for how those nurses would cope in austere settings. This was described by one NO as the '*art-science*' gap.

> *I wonder if the nature of contemporary undergraduate (UG) nursing preparation, compared with UG preparation [in the past] (when technology was not readily available and technological cognitive aids were scarce), has an effect on the human factors aspects of nursing, Does contemporary foundational nurse preparation, facilitate learning which [could] translate to the austere environment?*

In an Iraq ICU, which operated inside a tent, NO found that because of a high industrial noise level, they had to accept they could not assess patients in the way they normally would and then find a way to work around the problem. For instance, while looking after multiple seriously injured ventilated patients, there was a constant background thrum of white noise 24 hours a day: suction units, augmented by helicopters landing next to the tent, persistent ventilators and other noises that got in the way of patient care. Because they could not hear alarms, NO needed to be able to identify non-auditory signs of a patient in difficulty. On a personal level, one NO still abhors the sound of suction units because of how they affected their ability to practice:

> *I hate the sound of suction units; they never stopped. You can't assess, it's a constant tiring stimulus, [causes] sleep deprivation for patients producing ICU delirium aggravated by unrelieved pain and restraints [for enemy].*

Given their observation of others who did not cope and the implications of this for colleagues and patients, NO argued prior knowledge of austerity was essential for a nurse to prepare mentally for what they might face. Therefore, military experience, especially in the austere

field environment, was of significant benefit because it promoted lateral thinking and prepared nurses for working with fewer resources. However, military experience without a solid clinical background was not enough to cope with clinical challenges, and thus clinical experience was the greatest enabler of practice adaptability.

> *Fortunately due to the opportunity to conduct a recon and lead up training … as a team we were able to identify key items that would benefit our clinical treatment of patients and deployed with sufficient stock to support the deployment. This greatly aided in patient outcomes and reduced the stress of trying to come up with alternatives.*

5.3.2 Reconciling with the Threat

The presence of a human-made threat, in the form of weapons and the people who used them, was an inherent constant in the IAC environment, posing a number of challenges. NO deployed having acknowledged the threat, considered the risk and thought about how they would deal with it. Once they deployed, there was the reality of learning to live with evidence of the threat's presence. The structure of bases, sandbagging of buildings, people with weapons and a range of other physical reminders ensured the NO was always aware. One participant noted that '*living conditions and surrounding threat was a constant reminder of where you were*'. In addition, they would quickly see the negative consequences of the threat, in the form of profound injury. In a few cases, nurses flew into a base under fire, resulting into exposure to the threat as they tried to land.

> *I saw the fireworks [reference to illumination of fragments when a blast occurred and tracer rounds] out the window of the plane just as we got there. I knew they weren't, we were in a war zone … it was surreal.*

The mental comfort zones NO started developing prior to deployment evolved as they learned to deal with the immediacy of the threat. This involved several strategies, including knowing where the threat was in relation to them. Therefore, they gained knowledge of who was fighting and where, what protected them and what the weapon threats were. In addition to the brief during transit into IAC, the security brief on arrival provided some understanding of how the layers of security were structured and designed to protect. An appreciation for the security situation and structure coalesced into an awareness of the overall picture, which

provided a sense of safety. Left alone by an airstrip, slightly afraid and awaiting collection on her first night in Afghanistan, one participant used her time to develop a mental strategy for dealing with the threat—contemplating where enemy activity might occur in relation to her position and how she was protected.

> *I was in a foreign place, knew no one and only the movers [people who moved her into the country] knew I was there. From the security brief I worked out the right and left of arcs [limits set by the Army for military style action, originally associated with 'arcs' of weapon fire] for the Australians.*

After working out the security situation, NO established what to do in response to a security incident, starting with drills in the event of a close and immediate threat, such as mortar attack. General military experience and training improved how a nurse responded, with standardised approaches ensuring each nurse experienced similar drills. At the same time, they needed to learn to control their personal physical reactions and mentally justify their willingness to work while exposed to a threat. They achieved this by mentally clarifying what their role in the conflict was and how to respond if an attack eventuated.

> *We followed the actions you were supposed to. It was the artillery and there is a big siren, you go through all the actions.*

> *I remember them telling us about … if you hear a rocket hit the ground. That didn't worry me [the potential risk of an attack]. I just thought, we were medical and they were going to look after us. We were told there were a few rocket attacks, but they were not very accurate. I figured if it got to the hospital … we were all gone by then.*

One NO demonstrated how prior experience could promote adaptation to the sensation and potential consequence of a mortar attack. Working in a mining town, they became used to the physical sensation of feeling a blast and established mental strategies to deal with the next event, ultimately helping with controlling their reactions on deployment. On day one, they experienced their first 'impact':

> *It was not unusual for the odd IED to come in over the top of the fence, mortar type stuff or rocket rounds … it was okay, I just thought at the time, there is nothing I can do about this … The person next to me suddenly grabbed my leg. We heard that familiar whistle, you*

know from the movies … an incoming round … then a thud and that was that. I heard it coming and I thought 'oh well, nowhere to go'. Just there.

Generally, NO demonstrated a pragmatic acceptance and significant resilience to the risk that attacks posed, as well as a positive approach toward continuing with their job despite the surrounding threat. They were aware there was nothing they could do, beyond take every precaution, if an attack occurred.

I was walking across the runway, it was pitch black and the other group were leaving, heading towards us for the plane we had just arrived on. Someone grabbed my hand, looked me straight in the eye and said 'take care and keep your head down'.

The previous two excerpts, and the way the two NO described their experiences, demonstrate that one of their coping strategies was a pragmatic alignment of their experiences with prior wars—in particular, with terminology and imagery from the media. Aware there was nothing they could do beyond take every precaution, the main theme from all NO who participated in this study was one of forward-looking resilience to dealing with the threat and, in one case, a creative approach to protecting patients.

Attacks occurred occasionally, but there was nothing I could do about it. Don't live in fear, keep going.

I was at work one night. The siren went and people all left, [name] was in the bathroom and I later discovered he wasn't allowed back, we had a paed [child] on a vent. I was frustrated that there was a real threat, those in non-clinical roles all left, but somehow we as nurses had to stay. I put on armour, patients on the floor … no procedures on the wall about how, no idea … I put them over my shoulder and got them down. We had a laugh about it later, it was just a bad shift.

Despite a pragmatic approach, the new way of living with a constant threat was confronting and NO needed to work out how to manage their lack of direct control over the threat. They relied on surrounding safety structures at work and in their rooms. Sandbags protected the walls in some locations, but it was testing to leave the room and walk several hundred metres to a toilet. The roof of a building was not necessarily immune to mortars. When an alarm sounded to indicate an attack, the NO would need to either stay in their room or find the

nearest bunker, remaining there until the 'all clear' was given. A bunker could be a series of end-to-end concrete tubes like those used in industrial sewerage systems. If an attack produced injury, the NO would often be expected to find their way to work, sometimes in the dark.

> *There were no locks on the doors, I was told not to answer any knocks. An attack happened the night after I arrived, there was a mass casualty (MASCAS) incident. I grabbed my pistol and sat by the bed, unable to sleep … then the pager went off … it was dark and I had only seen the hospital during a brief tour during the day … getting there [to the hospital] was an eye opener.*

NO knew they had a job to do and did it, accepting the threat was there and part of the job, but it took time to adapt. In one case an NO '*felt safe on my first deployment; [but] on my second deployment the risk was much higher*'.

> *I felt underprepared for about a week … I lacked control over the personal threat, I felt vulnerable in bed, going to the shower, the toilet or anywhere on base which may be hit. I initially struggled to find a way through the noise, heat, dark, body armour and weapons. One night I was going to the shower, there was an alarm, I was stuck in a bunker on my own, the percussion … counter battery … it was surreal. After a week, I adjusted, adapted, the threshold gets set.*

One NO learned to deal with the threat through distraction from the external reality and group support. During an attack, they went straight to work, to be in the same place as everyone else, so they were all in it together, while waiting for clearance. This NO focused on what was inside the tent in the form of injured soldiers.

In Iraq and Afghanistan, adversaries were called 'insurgents', as this term accurately described the nature of their action and origin. The traditional term 'enemy' is used in this study as this was the term frequently used by participants and in literature referred to in this thesis. The enemy could originate from the local population and identification could be difficult. Base access required assessment and clearance, to ensure people seeking care were identified, risk assessed and not carrying weapons. However, this evaluation did not always occur—a risk NO needed to be aware of when working with or caring for local security

forces, civilians, contractors and enemy combatants. This mix of patients posed additional security challenges that needed addressing before providing care.

In Afghanistan, Australians were exposed multiple times to an internal threat from local forces they worked with. Known as '*green on blue*', this situation described a threat—usually in the form of an unexpected attack—by supposedly friendly forces, and it tended to occur 'inside the wire'. The term 'inside the wire' is a common reference to the perimeter fence of a military base, which is a place traditionally associated with force safety. The colour terms relate to the colours the Army used to designate forces when creating pictorial maps in conflict zones. Blue referred to Australians and allied forces such as the US. Green forces included local soldiers working with the Australians, who had access inside the security perimeter.

> *We had five 'green on blue' that year. It was just something we had to deal with. I had a job to do.*

NO working in these environments needed to be aware of and ready to manage this risk, without relying on the assumption that inside the perimeter was safe or that work colleagues may not pose a threat. On arrival in Afghanistan, briefings enabled nurses to prepare themselves. Acutely aware that other people could view the world differently, NO—as a mechanism for self-protection—acknowledged and accepted the possibility local friendly forces were capable of such an act and established a non-judgemental wariness and an element of distrust toward non-Australians.

> *One day they could have been Taliban and the next day they weren't … it was the nature of their culture. I did get angry one day, after several Australian soldiers died in a green on blue. The interpreter said 'everyone is my friend' and I said 'they are not our friend if they are shooting at us'.*

Mentally, each NO knew they were never truly safe; however, few ever felt truly unsafe. They all found their point of mental acceptance on the safety continuum. There were several aftereffects from the experience of facing a threat, most of which were positive. After initially being very alert, familiarity with mortar attacks and layers of security resulted in a new sense of calmness. This calmness was underpinned by a pragmatic acceptance of the ever-constant

physical threat—facilitated by a sense of security knowing they were being protected—and involved a routine response to attacks with a mental '*here we go again*' and enacting the expected security routine.

The experience of transitioning through conflict led to a transformation in how NO interacted with the world, focusing their attention on pragmatic and resigned action in the face of a threat. The sound of the siren warning of an attack became just another reminder that the routine response was needed; yet, more importantly, that there might be an influx of patients. Thus, the siren became a warning of more than personal attack; it was a potential omen of incoming injury. When one participant returned home, they noted the silence and absence of the siren. Even now, certain sounds in their workplace trigger a need to react quickly. It was not the threat that stayed with them, but the consequences for someone else and a need to respond clinically. The overall lasting effect is in their speed of response—always being slightly more aware and vigilant to what might be required in any situation, remaining calm and without fear.

> *It's something that you're always hearing, listening out for and I even get it now … it's just a reminder of Afghanistan because that pager was going off, to say we needed to come to resus.*

Once an NO arrived at the base, which would be their home for the duration of deployment, travel 'outside of the wire' was often limited. In Iraq, because ground transport was considered too unsafe given improvised explosive devices (IED), travel outside the perimeter for NO was limited to air transport in and out of the country. In Afghanistan, some nurses would occasionally travel outside for the provision of humanitarian health care, increasing their individual risk. However, they had a job to do and approached the situation with an acceptance in accordance with an understanding of the physical and cultural risks, and faith in those protecting them. When one NO decided to go outside by choice, to provide health teaching to a local hospital, they made a personal evaluation of the risks and placed significant trust in the assigned infantry protection party.

It was nerve racking, I had my Steyr [rifle] loaded, I was the only female, I had two 'guardian angels' [protection party], who went everywhere with me, even standing outside the toilet.

5.3.3 Working with Other Cultures

Whereas NO who deployed to Iraq embedded within a US military hospital, in Afghanistan they went to a variety of settings, including Australian health units (sometimes co-located or embedded with allied forces) or a US hospital. They also worked with local translators. Thus, although all participants deployed as members of the Australian Army, not all ended up working exclusively with Australians. Sometimes NO knew they would be working with people from other cultures, sometimes they did not.

NO considered competence in working with a variety of cultures, both within the allied forces and the local population, vital to achieving a good clinical effect. Some NO deployed with prior experience of cross-cultural patient care, by virtue of broad general nursing experience, which enhanced patient care of humanitarian victims. However, the majority started with a lack of knowledge about the people (colleagues) they would be working with, even though, as discussed in Chapter Four, a few were fortunate to obtain pre-deployment team training with allied forces. When finally embedded with other forces, NO discovered they needed to be able to communicate across cultural divides by understanding differences in practice, terminology and overall cultural attitudes, particularly of an ethical nature. In practice, they found cultural conflict within teams was a barrier and a significant level of tolerance for alternate cultural views was required to ensure care delivery.

The next morning [after arrival] I presented to the ICU, to become familiar with US drugs and equipment, in a hurry. The US were changing over [staff]. Only a few US Army were staying. I made a point of identifying what was different and learnt that.

I brought a skill set and a voice to the table and a goal of contributing to the broader health mission. However, for this trip, I was acutely aware that I was a guest in someone else's house, yet part of the family, nonetheless.

Failing to learn and manage cultural aspects of another force could expose NO to significant challenges, inhibiting clinical decision-making and implementation of interventions. When

Jack worked with US forces, he found there were different rules for Australian compared with US nurses. As the Australians were a small contingent in a much larger US force, the onus was on the Australian nurses to adapt to the US way of providing healthcare—albeit, a process involving a number of significant care and ethical challenges. These will be discussed in more detail later in this chapter. One participant tried to resolve the issues they faced, but felt inexperienced and intimidated:

> *I volunteered for night duty, but was 'demoted' to the Iraqi ICU as I had to prove myself to the US before I was allowed to care for US injured. I was tired as I was not acclimatised to either the time zone or environment. I was on my own. When your view is different to those around you, it puts nurses in a context where there might be conflict.*

Another NO working in the same ICU had several decades of clinical experience and was comfortable working in varied environments with a range of personalities. Although there were ongoing cultural and ethical issues when providing care, they took the following mental approach to the challenges Australians faced with the people they worked with.

> *The US wanted to look after their own, whilst Australians would look after anyone. The US wanted to ignore insurgents [enemy] because they were killing their own. We don't discriminate. The US Army were burnt out due to lengthy deployment and they disliked change because it increased their workload. They also had family pressure issues, cyclone Katrina etcetera. I tried to look at it from their perspective and took up what slack I could. They were eventually okay once they understood we were there to help them.*

5.4 Identifying as an Army Nursing Officer

As mentioned in Chapter Four, in the pre-deployment phase the Army readied the individual to participate effectively as part of a military force, with training tending to emphasise the Army officer side of the NO. As this chapter reveals, deployment focused NO attention on their clinical role and identity, highlighting an element of duality between Army officer and nurse and shaping their understanding of what it meant to be a *Nursing* Officer. Ironically, the clinical component of their role was still individual and self-guided, evolving over time as they reacted to IAC.

Working in a hierarchical system, the nurse's capacity to identify and act as an Army NO was central to their ability to ensure care delivery, which was their primary role and concern. They had to know when the general qualities of an officer took precedence over the nurse, while holding firm to the attributes of the nurse, especially from an ethical perspective. NO had to be able to work effectively with the system and within the environment to survive their deployment and deliver care. This meant they needed to be able to 'work with the Army family' and, in response to their experiences, reconcile 'finding a new sense of self'.

Nurses detailed a range of characteristics they considered fundamental inputs to the attributes and capabilities required of Army NO and their ability to survive an IAC. Specifically, being compassionate, courageous and caring comprised a key triad of abilities used to describe NO. Further, participants considered essential characteristics for NO were emotional intelligence (EI), positivity, decisiveness, ethical intelligence, humanitarianism, advocacy, leadership, self-expectation management, being able to communicate and being '*easygoing, flexible, adaptable and passionate*'.

> *Ideal nursing behaviours include being humble, patient focused, critical thinking, emotional intelligence, self-awareness, compassion, advocacy and leadership.*

5.4.1 Working with the Army Family

NO entered an IAC zone having already worked with the Army following recruitment, albeit with variable exposure and appreciation for the effects of the organisation on their practice. Thus, all had some sense of what the Army expected of them, having experienced the military process of readying. Military readiness was most pronounced in ARA nurses.

Some ARES nurses lacked Army experience when they deployed. Using a common Army colloquialism (referred to in Chapter Four), 'being green' was not initially the same as understanding 'the green'. A lack of general military knowledge meant NO spent valuable time trying to learn once deployed, despite competing priorities such as clinical demands. The results were feelings such as frustration, anxiety and being overwhelmed. Militarily inexperienced NO found themselves on a steep learning curve, with increased reliance on coping mechanisms, such as debriefing or group support (discussed in the last section of this chapter).

I did not have a lot of 'green' experience; the use of rank was reinforced to me by a senior nurse. It was a new challenge.

At the time of deployment, one NO felt uncomfortable with their Army persona, was confronted by US forces with ranks different to the Australian system and feels now as though they were so focused on learning what they would have liked to know beforehand that they failed to make the best of the experience.

Sometimes I wish I had been going now, when I knew a little more about the military … I just feel like I would have appreciated it more.

There was a clear difference between how most NO thought the Army viewed them and how they viewed their own potential clinical capability. NO were driven by a desire to give soldiers the best care. As partly described in Chapter Four, they considered the Army's view of nurses was shaped by what it believed about nurses from a non-nursing perspective—that is, what it wanted from them without necessarily understanding what they could offer and how NO could be militarised to fit within the broader military paradigm and way of thinking. Thus, NO thought they were undervalued and had more clinical capability to offer the Army and their patients than the Army had appreciated at the time these nurses deployed.

We are definitely underestimated in terms of what we provide. I think sometimes it is a self-underestimation, not just the organisation that underestimate us, it is us. We can actually be used; it is not just the doctor.

This situation became more apparent on deployment, especially to those who worked with the US, as American nurses were able to fulfil clinical roles to a higher rank than the Australians. At the same time, Australian NO acknowledged that until the Army appreciated the need for NO to gain a greater degree of clinical experience, it would be difficult to argue for greater capability.

The phenomenon of working with the Army family is best understood under the subheadings of 'protection and the mission' and 'leadership and advocacy'. Both of these codes describe key aspects of readiness to work within the military.

5.4.1.1 Protection and the Mission

Protection and associated security structures were an inherent need in the IAC environment. This included the security drills NO discussed when talking about 'the threat' and deploying with a baseline level of weapon readiness. To manage the tension some felt over their need to use a weapon and accept its place in their role as an NO, they used the following mental strategies to reconcile issues and find a zone of acceptance for carrying weapons. They viewed their role as humanitarians cleaning up the after-effects of conflict, ensuring soldiers received the care they deserved and were entitled to. They emphasised their clinical role as the main work Army wanted from them.

> *We have to carry a weapon, we have to think about that. I know it is important, but it is not my priority. What they want from me is a good clinical skill. We rely on those who use weapons as core business [to defend us] and in return, we care for them if needed.*

Socialisation to weapons and the Army side of the persona was part of becoming a NO, rather than just a nurse serving in a conflict zone. Handling weapons as part of personnel safety was an organisational occupational requirement. Nurses had a clear sense of purpose within an organisation focused on the weapon—they focused on repairing the effect weapons produced. The nursing focus was on 'the inside of the tent', rather than what was happening outside, although they all knew what was happening externally given the casualties they were treating. Army NO walked a fine line between complying with international law and carrying a weapon; thus, self-defence was their primary justification for weapon handling.

> *I was comfortable with need for self-defence, rather than offence.*

> *From a combat and safety perspective, I was fully armed, competent with firearms usage and had full force protection when I moved into the village to conduct a series of medical activities.*

Although they arrived on deployment ready to use a weapon, NO were not used to its constant presence. NO initially transitioned to carrying a weapon as part of their physical self and learned to live with it for the duration of their deployment. In some cases, this led to a mental transformation in how they interacted with the world and established a sense of security—

the weapon had become part of their persona and life. When she returned home, one NO described a sense of '*feeling naked at home*' because the weapon had become part of them, protected them and they kept it safe. For others a sense of discomfort at handling a weapon persisted, largely given a lack of familiarity. Thus, they felt unprepared to use a weapon in the face of a real attack.

> *I went and sat in my room and read a book, with armour and weapon as required … staying inside to avoid the risk of using the weapon … What I find with a weapon; it's something we pick up every now and then. It wasn't about killing someone if they were threatening me, it was would I be able to use it quickly enough to be able to do that … it's not because I am a nurse, it's because it is not something you do every day.*

It was previously suggested that a nurse who understood and could work within the Army's mission—and, thus, why they had deployed—could better manage their own expectations of what they might experience and why. A mission was invariably about prosecuting some type of military action, which, in turn, was likely to produce casualties. Despite the dichotomy between the roles of the nurse and the military, the NO who participated in this study indicated they understood and accepted their purpose in resolving the consequences of military action. However, despite this acknowledgement, NO still needed to resolve several issues. Care decisions had to meet mission requirements, while not overtly clashing with nursing expectations, such as who could receive care. Specific challenges entailed in this decision-making process are discussed in the section on the process of caring.

> *Sometimes it was more important to put the mission first than your own view of compassion or care.*

Mission guidelines were not always in line with what actually happened, which led to frustration and unexpected clinical decision-making challenges. As one NO found, '*due to a changing battle plan, the mission was not kept up to date with paediatric presentations*'. In this case, the mission did not officially accept children for care and did not provide resources to care for children. This placed moral pressure on healthcare workers who received children for care from combat personnel who found them injured.

NO deployed with an element of appreciation for the Army community, having become aware of its unique social construct and needs during training and from time in the system. The extent of their appreciation tended to reflect their employment status, although an ARES NO with many years of experience could have a very well-developed sense of the Army community. Deployment had a significant effect on the nurse's view of the Army, intensifying their appreciation for the organisation. Specifically, it produced an emotional connection with the Army community, bringing the 'family' into sharp focus.

> *My team was a little family … I felt like a mother to my soldiers.*

> *I was a surrogate mother, sister, someone Command could talk to, an all-round dog's body, morale officer, for anything that required someone with basic social skills and influence. Often I found I knew the soldiers better than their command team.*

Key factors in promoting this sense of closeness included the processes the Army community used to keep each other safe, and the consequences of this activity. Essentially, everyone was more reliant on the Army team than when at home in Australia, and a nurse's safety was, to some extent, supported by the job soldiers undertook 'outside the wire'. Thus, it was particularly difficult to see those soldiers injured. In turn, the NO gave soldiers a sense of safety, knowing someone was there to help if they were injured.

> *One of the hardest parts was that you were a symbol of safety and apparently if you were on patrol then you would make everything better. It was a hard rouse to uphold.*

Despite most operating 'inside the tent' as they would in a hospital or clinic in Australia, at some point NO realised they were seeing and thinking about what happened in the wider world. As one NO said, '*we focused on our core job—saving lives, but were always aware [of the external threat]*'. Their awareness of the security situation, what was happening in the conflict, and a new view of the Army family took their thoughts outside the tent, opening a view of the overall microcosm of war.

> *It affected how I think … I am more outward [looking], I see the bigger picture.*

Awareness was accentuated by working closely with a small team and injured soldiers in the midst of a dangerous environment.

We looked out for and protected one another.

A benefit of seeing the bigger picture was a more heartfelt appreciation for the Army, underpinned by a sense of loss from the trauma and death seen, and the knowledge of the effects this would have on young lives. The person became more apparent.

> *It was difficult because I saw all the team [his team] come into the hospital. I think some of that stuff was sad. They operate at a really high level and we send them home minus an arm or leg, or with a head injury.*

5.4.1.2 Leadership and Advocacy

In Army terms, being a leader was a primary function of the Army officer side of the nurse, with associated authority to direct lower rank. Clinical leadership was a specific requirement of the RN and the qualities of being an Army officer supported this by lending authority. Ultimately, whether in the role of Commander, Platoon Commander or single NO embedded or working in a hospital, a function of both their RN and officer status was that NO were required to lead soldiers and other health providers. This involved gaining their respect, demonstrating professionalism and providing guidance, supervision and emotional support.

> *Once you lose the confidence of command or the soldiers—you might as well be sent home.*

NO needed to be able to undertake administrative tasks and to evaluate the effects of Command decisions from a health perspective—to ensure Command were aware of what would happen because of decisions they made. There were times NO were the only person available or willing to advise a commander on what might happen in healthcare given a particular military decision. This situation required the NO to be able to apply critical analysis to a given situation and demonstrate the courage to act.

> *You need to know who you are there for, such as know how the supply chain worked in order to maintain a supply of resources. We needed to understand the big picture implications in order to do the job.*

Participants believed clinical leadership by NO was vital to ensuring good care by both the individual and the team. It was associated with ensuring clinical governance and, therefore,

quality of care delivery. A lack of leadership had an adverse effect on patient care and some NO felt the need to defend their clinical authority to ensure the team delivered quality care. To lead clinically and make *nursing*-related decisions that affected the Army, NO drew a connection between the leadership qualities of—and their authority as—an officer and a nurse's clinical knowledge to establish an idea of what military clinical leadership looked like.

> *Clinical leadership—despite the organisation's view of nurses—is a thing. According to a former peer, '… there's no such thing as clinical leadership in Defence'. Infuriating to hear, at the time there were shards of truth. Defence does not train its health professionals to be clinical leaders. It seeks those with raw leadership potential, to grow and develop as quasi-general service officers, who also happen to be health professionals. It seems to fit comfortably [with] the infantry (hierarchical) model narrative. This is at odds with contemporary trends in modern health systems. We are, by the nature of our role description [military nurses], congruent leaders. We are clinical leaders and this links to the organisation's paucity of grasp on our voice and what we bring to the table as nurses.*

NO with significant clinical experience were able to demonstrate clinical leadership from their civilian experience as leaders and solid clinical base upon which to make decisions.

> *Trust your clinical skills and knowledge and stand up for your patients. Note that you may not always get it right but you have colleagues there to support you.*

However, despite the leadership legitimacy conferred by rank, a lack of clinical experience undermined clinical leadership and the ability to defend one's clinical position.

> *The Army helps leadership development, we are put in a position where we are forced to lead, plus we are given rank, therefore formal responsibility. Leadership develops with time. You learn to back yourself. I now know more [than when I deployed] and have the confidence to push the point. Back then, I was inexperienced [clinically]. I was held back from being a good advocate.*

Equally, NO needed to be able to utilise their officer status and Army qualities of courage, combined with compassion, to act in the best interests of the patient, pursue the best care and lead by example.

Nurses need to demonstrate a willingness and authority to act on caring. Use their officer status to provide care. In my limited time in country, the way I executed my role as a Nursing Officer… was fundamental to rebuilding a fractured team.

The ability to lead influenced the NO's ability to advocate. Participants argued that as an officer the nurse should advocate for personnel within their authority and, as a nurse, for patients and the team. This included the defence of good practice by using their authority to speak up about deficiencies in care.

In all things, to do good, to do no harm, champion patient autonomy, within the bounds of Geneva Law and the tactical picture.

Much work was done navigating our ethical dilemmas in addition to just surviving in preparation for the next patient.

Influences on advocacy included a nurse's cultural competence, environmental barriers, ability to resolve conflict and clinical experience. It was necessary to rationalise, to be strategically and tactically aware of the effects advocacy may have in the broader context of the Army and armed conflict. It was important to '*Work out which battles to fight or not*'.

5.4.2 Finding a New Sense of Self

Transition into IAC exposed NO to a new set of experiences, leading to a transformation in identity and evolution of role and practice. It was more apparent for some than others, with employment status having no direct bearing on this change. Those who were inexperienced, either militarily or clinically, felt the greatest transformation into what being a 'military nurse' meant. In each case the subset was 'Army Nurse'.

I'm no longer someone … I'm an Army nurse.

Deployment challenged nurses in several ways. They had to reconcile differing priorities between those who prosecute a war and those who clean up the subsequent injury, and to work out how to apply nursing within the Army context. NO saw the consequences of injury, the effect on the 'family', feeling a sense of loss they may not have felt in a hospital in Australia. Their patients were part of the Army family and their deaths were different because

of this perceived connection. The experiences entailed in responding to the environment and working with the Army family clarified the NO Army identity and role in nursing terms.

> *Over there I realised I had 'come home' [to myself], that was where I was meant to be. You need to mature into an Army nurse, there is a lot to learn.*

> *Sometimes it sucks to be a military clinician, though, the armed conflict experience facilitates growth and development that informs and can be reinvested, day-to-day in clinical practice in the civilian sector upon return to Australia. It's [IAC] also useful as a means of developing a solid evidence base around the identity and lived experiences of military nurses and nursing, as a profession.*

Being an Army NO was not necessarily easy; personal and organisational barriers to the process existed. Being low on the military learning curve meant less opportunity to influence, both clinically and militarily. A potential issue for any NO new to the system, the participants most affected by a lack of military understanding in this study were ARES. Although they were able to compensate with their extensive clinical backgrounds to a degree, a lack of socialisation to the rules could expose NO to the potential for security breaches and personal difficulties—both for the individual and team they interacted with.

Organisational barriers to the role of Army NO appear to have resulted largely from a lack of understanding about nurses. Moreover, once in uniform, particularly when operating as Platoon Commanders, the nursing side of the NO was less apparent to immediate view. Some nurses felt that the uniform, which was the same that everyone else wore, acted as a block to others remembering the NO was primarily a non-combatant humanitarian. Moreover, some nurses perceived that others focused on the officer side of the NO role as a way to nullify the nurse effect, consciously or unconsciously. This potentially allowed other Army personnel to use NO in a way that suited the military agenda, an issue discussed in the sections that follow.

> *I was there for the Australian soldiers, not the 'bad guys', but the uniform can alter perception [of who we are]. The qualities of an officer are also the qualities of advocacy. I gave a damn and used leverage [as an officer], I would do it again.*

This NO experienced situations where they felt the uniform was used as a way to try to invalidate their obligations as a nurse. Experienced in the Army and life, this NO was clear on their boundaries and moral obligations, yet found they were expected to participate in activities they believed were morally wrong. With an instinctive humanitarian heart and solid understanding of their obligations and values as an officer, this NO identified and provided an alternative view on situations they were unwilling to walk past. The reaction to their efforts was challenging to live through.

5.5 Caring 'Under Fire'

The reason most NO deployed was the opportunity to ensure the delivery of quality care for soldiers and other victims of conflict, whether they delivered care themselves or supervised others to do so. Care delivery challenges arose from the Army and surrounding IAC environment. Although a common application of the term 'caring under fire' is in the sense of an Army medic applying first aid during a battle, in the context of this study the term is an analogy for the effects of the surrounding conflict, reflecting the reality that a number of nurses found themselves delivering care during mortar attacks. The Army NO was responsible for identifying and removing barriers to effective care, using their organisational knowledge, status as an officer and clinical acumen. The latter was particularly vital to knowing how to adapt principles of practice to ensure quality care delivery. The two predominant sub-themes in caring under fire are 'performing clinically' and 'managing ethical dilemmas'.

5.5.1 Performing Clinically

NO needed a number of attributes to meet the practice challenges they encountered. These included clinical competence, leadership, advocacy, emotional strength and an ability to deal with death. Whereas competence enabled care delivery, especially in unfamiliar settings, leadership and well-developed communication and advocacy skills were essential for dealing with hierarchy, emotions and conflicting agenda. NO were central to team dynamics, building and maintenance; the team was critical to being able to complete care delivery. On a regular basis, most nurses dealt with death, not only because it was a nursing job, but also because other healthcare providers found themselves unable to.

The advantage of solid clinical skill and developed clinical acumen, prior to joining the Defence organisation, prepared me to deploy to a relatively familiar clinical environment (albeit with the added layers of security and austerity). Previous austere deployment experience was also useful.

Within the category of performing clinically, four codes predominate and explain the processes NO worked through. These were 'clinical competence and currency', 'building and supporting the team',' providing emotional support' and 'dealing with death'.

5.5.1.1 Clinical Competence and Currency

NO consistently referred to competence and currency as critical to care delivery and patient outcomes. Clinical competence referred to the nurse's possession of a well-developed knowledge and skill set, with a solid base of practice from which a nurse could demonstrate the ability to respond to a range of challenges that included unexpected circumstances, austerity and significant major trauma. A consolidated recent clinical base also permitted scope of practice expansion, higher-level clinical judgement and increased autonomy, flexibility and adaptability.

We all know stories about clinicians, either full time or reservists who go away on deployment and are underdone [clinically]. In my mind, I think that maybe their clinical knowledge or skills is not up to the standard required.

Familiarity with a particular clinical environment (such as ED) promoted clinical competence in the deployed setting because the nurse had a greater understanding of what the clinical demands were likely to be. This was especially true for specialist nurses such as ICU or OT. For a relatively inexperienced NO, familiarity partially compensated for challenges such as major trauma, unfamiliar equipment or a lack of the usual resources, thus improving their chance of coping clinically.

It was like walking into a hospital at home.

Conversely, NO who worked in Platoon Command roles walked into a resuscitation setting they had only experienced during field training and that bore no direct resemblance to their limited clinical experiences in Australia. As they did not know what to expect in terms of

clinical reality, they found that they could not anticipate and get in front of their workload. They were responding to each crisis, struggling to deliver the basics and unable to employ higher order skills, such as clinical leadership and advocacy, to the extent they believed was required. On realising they were inexperienced during deployment, these nurses entered survival mode, learning on 'the run' to try to accommodate for a lack of clinical readiness.

> *I realised when I was there, I was like, OMG!*

Moreover, they had no way to measure their effectiveness. Thus, it was possible for a nurse not to fully realise the extent of their inexperience. One NO deployed thinking they were prepared, eventually working out that their experience was neither adequate nor appropriate, given that what they knew had little relevance to patients' needs, what they saw and were expected to be able to do. However, working largely on their own, full appreciation for how unprepared they were occurred several years later.

> *It wasn't till I did my postgraduate degree I realised how grossly inexperienced I was. I came home with an over-rated sense of clinical competence.*

The unpredictability of IAC further complicated an already austere environment; an NO could never know what would happen, when or to what extent. They could know what resources they had, but not what could be lost, when or why. Underpinned by an adaptive mindset, NO realised they needed to plan alternate courses of action (COA—a common Army reference and approach to battle planning) in advance, including working out what the worst-case scenario could be. Having a second and subsequent plan ready increased coping and care provision—a process improved by knowing and being able to manipulate principles of practice. Principles provided a foundation from which the nurse could adapt, allowing for practice variation and change. NO '*never knew what they would lose, thus they must have a backup plan, which means know your clinical basics and know how to manipulate them to effect*'. The less NO knew about clinical practice, the harder COA development was. Increased awareness, alertness and need for preparedness, flexibility, decisiveness and speed were key traits nurses needed to have and develop.

> *You have to be confident and flexible. You don't know what you are not going to have. You don't know what is going to be taken from you or if something is going to be blown up.*

Those old-fashioned skills are very good. I still look for the emergency response procedures and equipment in each new situation I enter.

Flexibility was a mental ability to adjust to circumstances, promoting comfort with practical adaptation—such as looking after multiple ICU patients rather than one or responding to casualty surges and accounting for the inability to manage patients sequentially. In the setting of a casualty surge, patients would die waiting if approaches to assessment and management were not simplified and sped up. Essentially, NO had to cut these processes back to the basics without sacrificing critical aspects of care.

Effective clinical judgement required critical analysis and good problem solving. A lack of these skills in protocol driven health providers—who acted without an ability to adapt according to principles—was frustrating for NO trying to achieve a lot with very little. NO could achieve more with less by questioning and critically analysing, rather than just implementing a protocol. This was important when working in an environment with resource and time constraints.

I found it difficult working with people who were protocol driven. They were not thinking about 'what next', or 'so what'.

As alluded to in Chapter Four—and explained earlier in this chapter as a strategy for dealing with the effects of austerity—the ability to 'go basic' was essential. In this section, the focus is on the process of caring, highlighting the importance of competence and currency. The foundation for 'going basic' was a repertoire of technical and non-technical skills that the nurse knew instinctively and could 'traction off' to flex and adapt their decisions in accordance with principles of care and need—particularly when equipment was absent or not working. A mental bank of stored clinical information that NO could extract, fit to a situation and act on was beneficial. In technology-dependent settings such as ICU, where environmental impacts such as noise could nullify the effect of alarms, NO needed to be experienced in using equipment to the extent of not relying on the machine to tell them something was wrong.

The Impact ventilator was treacherous … the general level of noise [suction units and helicopters] made it hard to know when a vent cut out [alarms were not heard]. You had

to be watching your patient for breathing. This was hard when you had to look after multiple patients and everyone else's when they were at tea or had to go to the toilet.

Time was a precious commodity; ratios did not exist and workloads were larger than in Australia. High simultaneous casualty numbers and time-critical injuries, where the time from point of injury to definitive care determined survival, meant NO had to assess, decide and act fast.

Time was not a luxury we had.

A secondary effect, which evolved from the need for speed, was a focus on what they needed to do next. An attitude of '*let's move on … what are we going to do now?*' reflects how NO were always thinking forward to what they could influence and what they could not.

When I got home I suddenly realised when I went back to work I was getting everything done much faster.

Deployment challenged the scope of practice each NO possessed. The consequence was a need to extend scope amidst conflict and by necessity—to respond 'under fire', as the Army would describe it. Experienced nurses found they had enough knowledge and skills to be able to expand their scope according to need, feeling challenged by the circumstances but comfortable in their ability to respond and maintain delivery of effective patient care. Clinically inexperienced nurses found their scope was not adequate to meet clinical demands. Thus, for them, advancement of scope was ultimately about catching up to the baseline they needed. Generally, the extension of scope for NO was about doing more than they had prepared for and in the realm of advanced nursing practice, sometimes akin to that of the nurse practitioner.

I was very confident with my skill and knowledge, but I knew I could not rest on that because I was not sure what we would see.

Because NO were often on their own or in a small team, it was necessary for them to be able to work effectively unsupervised. Not all deployed with this ability, with some NO previously practising in a supportive environment and possessing a relatively low base of clinical skill.

This posed significant challenges to coping clinically, with no one to turn to for guidance. They ended up working unsupervised for the first time in their career.

> *I was expected to operate well beyond my scope of practice with no medical officer supervision. I had not done that before. It was a challenge because I had no one to talk to. We needed to have rural and remote, or ED and primary health care experience. I found that the greater diversity of casualties I had the more I was able to develop professionally as a nurse and an officer.*

Working largely on their own conferred a degree of autonomy and an element of isolation. Some nurses were not used to or ready for this; others flourished and valued the opportunity. An unexpected consequence was how to deal with a loss of autonomy on returning home.

> *They [nurses] need to understand the autonomy of work. I am not sure I could work in the civilian system now because we have no autonomy.*

Decisiveness was essential for getting the job done quickly. Experienced NO managed the challenge effectively, despite finding that time and resource constraints required them to be more decisive than they had previously experienced. Inexperienced NO found decisiveness hard to develop because of their lack of foundational knowledge and experience. Where nurses were able to expand their scope, they developed increased confidence and questioned themselves less.

> *You were allowed to make decisions. It made me more decisive, less second guessing, it definitely made me more confident.*

There were times NO needed to use equipment or processes with which they were not familiar and were arguably not within their scope (because they lacked either prior training or experience). This was potentially dangerous with significant risks to the patient, such as using a ventilator for the first time. Most of the time nurses found it was a case of different equipment but a similar practice, meaning they were able to adapt with no change to their scope and no risk to the patient.

It would have been beneficial to know a lot more about ventilators. Sometimes you had to hold a patient for quite a long time, some time without an anaesthetist. You would have to maintain [them] and that wasn't something I was used to.

Most of the stuff was familiar, equipment wasn't much different to what I was used to.

The predominant patient experience was extensive trauma caused by blast injury and gunshots. The nature of the trauma seen was confronting, both on a personal and professional level. Worse than anything a nurse had seen in Australia, the destruction of human flesh by an IED was challenging and, initially, '*the trauma was overwhelming*'. Patients lost limbs or experienced significant head injury. Pre-existing trauma knowledge was inadequate even for experienced nurses. Each nurse found themselves on a learning curve, which was steeper for the less experienced. On a personal level, blast injury challenged the senses.

I learnt the IED look and smell on day one: 'burnt, sooty, limbs missing, always burns'.

The care of children was not a standard expectation in the Army but, because people took humanitarian victims of conflict to them for care, it was an experience for a number of NO. Prior experience working with children was limited and variable among NO. When caring for children, participants had to adapt the best they could, using whatever resources were available—essentially expanding their scope of practice. Those with children felt a connection to the child's parents, including those sending their children to war as soldiers.

The saddest, the worst thing was the kids and we did not have a lot of kids, we were very lucky. That was the sort of thing we thought about at home, that we are so lucky [not to have IED here]. They have a different attitude, culture about children; they have lots [because they will lose some]. I know when I work with young soldiers now … I asked one 'how does your mum feel?', he said 'I haven't told her yet'. I think, as a parent it must be really hard.

Additional challenges arose with ethically questionable decisions regarding the provision of care, managing the emotions experienced at seeing injured children and exposure to cultural differences. Particular issues were caring for ill children and discharging them before they no longer needed ICU care, either home or to a civilian health system that had no capacity to care for them. Hospitals had a priority to maintain access for injured soldiers, meaning that

was a time limit on a child's stay. Children were high-level care and technology-dependent, cynically referred to in Iraq as having '*the "Balad Ring": tracheostomy, gastrointestinal feeding tube and indwelling urinary catheter*'.

Nurses in Iraq discovered that when the family left with the child—after being told their time in the hospital had to finish—many families removed the tracheostomy not long after leaving the hospital. This allowed the child to die in the arms of their family, given that the family had no way to care for the child.

> *It was hard to draw the line. We had a duty of care to look after those who were injured by the US [or other force], but there needed to be a time lapse [pre-determined] on care. It was wrong to give hope to families when we could not keep the child.*

Generally, as part of their care for all patients, NO adjusted the process of planning care to accommodate changes in practice, such as shorter timelines to the OT and early retrieval to definitive care in another country. Although ICU nurses held their patients for longer than NO in other parts of the system, when working with other cultures they had to deal with different attitudes to care planning. This was initially confronting and a challenge to the expectations of Australian NO, directly opposing their clinical conscientiousness.

> *The US thought we washed our patients too much. The RT's managed the vents, it was a challenge to watch the US nurses reduced frequency of observation [of their patients], and particularly the tendency to sit some distance from a patient, arguing the alarms would warn them of an issue. You could not hear the alarms because of the background noise.*
>
> *They used a number not a name, there is psychology in not using a name. We were belittled for showing niceties to our patients.*

NO were used to planning care for the time a patient spent with them, less used to thinking about the next stage of care. The compressed nature of the IAC world and NO's new view of the bigger picture and the family meant a nurse might start to see more of a patient's care journey than they were used to in Australia. Some started to think about what would ultimately happen to a soldier they sent home with severe injuries, often to what they thought must be an uncertain future. They found themselves instinctively looking along the expected trajectory of recovery, to where they expected that person to end up.

[In Australia] … you don't get to see … you only see that little bit. Over there we were in communication with the US each week, we saw the next stage of a patient's journey.

In addition, the usual boundaries between areas of practice such as ICU and ED were less obvious or disappeared in some cases. Thus, a nurse's awareness could go places they never expected their professional glance to go.

We did trauma stuff differently, but in some ways better. I went forward to ED with the TQ [tourniquet] machine. In Australia we would only know once the patient arrived [in theatre].

5.5.1.2 Building and Supporting the Team

NO described teamwork as being at the heart of the Army approach to training and warfighting, it was essential to the process of winning battles. As was discussed in Chapter Four, NO relied on the team outside the wire to protect them and those outside relied on healthcare providers in the event of injury. Inside the wire, the health team was critical to getting the job done, because it helped to compensate for the effects of casualty surges and resource constraints. A nurse could work on their own, but never achieve as much as in a team.

Teamwork is critical to getting through the day. You can't get the job done on your own.

My position as Contingent Commander required me to ensure administrative and support requirements for the team were in place. There was limited preparation prior to deployment … the biggest issue was rank disparity among team members. The requirement to conduct myself clinically and as commander, increased the stress and I had a greater need for support from the team. My experience and knowledge in the perioperative environment supported positive leadership activities within the OT. My limited ED clinical experience meant my leadership [in ED], focused on my military skills and medical advice, when directing the use of staff and resources. Within my clinical speciality, I felt comfortable and able to work effectively through all issues. However limited exposure to the care of critical injuries in resus limited my ability to assist [casualty surges], thus focusing my involvement in ensuring teams had resources they required to provide the best possible care.

Participants perceived that in Australia they were fundamental to team-building and maintenance, through providing clinical, administrative and emotional support, as well as leadership and communication—believing this was the same on deployment. This included roles in building both nursing and multidisciplinary teams.

> *We are always there, the glue that holds the team together.*

Whether NO knew the team they deployed to or deployed to an unknown group, as more frequently occurred, they found themselves part of a co-located group of people they needed to work and function with. The latter occurred in a variety of ways, all out of necessity and dictated by the environment. An imperative such as a mass casualty (MASCAS) situation where everyone had to pull together to manage the large number of casualties—a situation that breached the limits of human and equipment resources—acted as an enabler to producing a functioning team. This situation exemplified challenges in IAC and produced a forced bonding—the team supporting each other while under significant stress. There appears to have been a lasting effect of positive team dynamics when this occurred.

> *We had only been there a week when we got our first MASCAS, which was probably a really good thing. They were just changing over staff. You know what it's like integrating into a new team. So we managed to … it was like, well oh, you're now part of the team.*

> *As a team we were fortunate to be provided a period on arrival into country to gain an understanding of the layout and security requirements. This greatly reduced the stress at commencement [of tour]. Team support was vital and quickly established between ADF personnel; building of relationships with other nations was slow as there was limited interaction during shifts and relationships were mainly built outside [after hours]. The need to assimilate into a multinational team that had been working together, having established procedures, created some initial tension.*

One NO's experience demonstrated how they identified other ways of supporting a team and recognised how they could promote team communication and debriefing. They were able to give others an appreciation for what had happened around them while they focused on their tasks, giving the hospital-level team a sense of cohesiveness and subsequently improving teamwork in MASCAS situations.

On the MASCAS day I gave myself the job of being note taker and photographer, following the medical director around. So I could provide this back to the headshed of the hospital for review of the whole event. It gave everyone some background to the whole story. It gave them a storyline to what had happened. It was a great way of reflecting on ow the whole team, how the hospital pulled together.

Teams also came together to mitigate and manage the general burden of care. The extent to which a team coalesced to manage patients was more variable than the baptism of a MASCAS, depending on personalities and leadership, thus affecting the degree of collaboration. Collaboration was encouraged by the nature of the group NO worked with and the hospital and retrieval systems, then shaped to meet the demands of seriously ill patients who had time-critical injuries.

Be prepared to work as a team and support colleagues, you are as strong as the weakest link. Show respect!

A collaborative environment made team members feel supported, encouraged communication and enabled achievement under pressure. People felt comfortable asking questions and had less fear concerning the consequences of speaking up. When working with the US, the boundaries between nurses and doctors were less explicit and the nature of IAC blurred them further as a result of the necessity of helping each other.

Everyone just helped each other, even doctors [US surgeons] would help the nurses. In Australia, there is greater role delineation. I miss the collaboration and feel underestimated and undervalued [here].

Some teams required effort to work out the strengths, weaknesses and general knowledge of each member of the team to pull them together and get the job done. In Iraq, the conflict created when NO had to prove themselves clinically before permission was granted to care for US personnel, as well as cultural clashes over care Australians gave to Iraqi and other non-US personnel, initially inhibited teamwork. The onus was on the Australians to pull the team together, to understand what the barriers were and why some people were initially disrespectful and rude. When challenges came from non-nursing colleagues, the nursing focus was to keep their own team together where possible, acknowledging when they had no

influence beyond that team. Clinical inexperience made it harder for some nurses to resolve team and inter-team conflict.

> *The personalities amongst the US surgeons were difficult, disruptive and not cohesive. I tried to gain control, but inexperience held me back. I focused on keeping my team together. Now I know more and have more confidence to push the point.*

With no opportunity to get to know a team, and particularly when arriving after someone else had to leave, some NO found the challenge of building a team to be significant.

> *The team concept is an enviable one; I did not have the full enjoyment of that experience within my immediate Army resus team. However, I did experience this with Dutch clinicians. I was inserted into a pre-existing team, where a nurse had been removed. So there was already a significant mistrust between the team and NO prior to my arrival.*

Beyond the need for a team, NO wanted to build relationships so they had a level of personal support in a difficult environment—facilitating their achievement of their workload. The team was already part of the broader Army family, as a subset it could become a little family on its own. Nurses applied a natural tendency for caring to how they interacted with team dynamics.

> *Look after yourself and your team.*

The group helped to reduce a sense of aloneness and stress associated with being the sole NO in a platoon or working alone on a shift while also supporting others by providing a source of information sharing and debriefing. At the same time, to have maximum effect, some NO felt it was necessary to first establish their own credibility within the team.

> *My team was my little family, at the end of each day we sat down and had a chat, an informal debrief.*

5.5.1.3 Providing Emotional Support

Emotional strength, both personally and professionally, was required by NO to cope with their experiences. A high tempo, limited downtime, long work hours and frequently being on call meant people became tired; being emotionally strong underpinned coping. An additional

challenge NO experienced was that people they worked with, often non-nurses, themselves struggled emotionally. This led to NO providing emotional support—whether they intended to or not—beyond their patients: to colleagues, a patient's team and Command. This appears to have been an extension of their professional caring, empathy and advocacy roles, ostensibly going beyond the patient to the team.

> *We spend time with people and their families, we have experience at giving emotional support. In turn, this helps us … I was a 'mother' to young soldiers who needed emotional support.*

Providing emotional support to others while looking after themselves required a high level of emotional intelligence (EI), which refers to the capacity of an individual to be aware of and manage their emotions while creating and maintaining effective relationships (Salovey & Mayer, 1990). The NO who participated in this study were able to achieve this, with one NO commenting that '*emotional intelligence is an ideal nursing behaviour*'.

NO were required to manage their own feelings at the same time as they held their teams together, helping other team members deal with the good and bad of armed conflict, in a similar way to helping patients deal with their illness or injury. In the complex and emotional environment of IAC, they found things were different when it came to interacting with medical staff. Supporting medical staff in their decision-making was common. Less experienced doctors, who were used to having their decisions confirmed by medical colleagues in Australia, valued the support of an experienced nurse.

> *Yes, I found that was probably the biggest challenge, you are the only nurse [in a platoon], so, that meant supporting the doctor, mainly with being happy with their decisions, providing that reassurance … and then supporting the medics, not just medically but emotionally, because they had not seen trauma or death.*

Emotionally supporting the team altered the NO workload. For instance, NO took on a significantly greater role than others did in the care of children because they were able to do so with calm professionalism, despite feeling underprepared clinically. NO put on a 'brave face' to ensure delivery of care, to role model how to approach difficult situations professionally and to relieve others of the burden. This was particularly true when dealing

with dying patients, which they found Medical Technicians (see glossary) were often unable to do. Indeed, care of the dying was a role NO considered part of their clinical repertoire and, depending on their prior depth of experience, knew well from their civilian practice. However, there was the added burden of dealing with overt emotion from those who could not undertake the role.

> *I arrived [shortly after] five Australian fatalities with more [subsequently]. I found I had to recalibrate the team after fatalities, to prepare for other incoming casualties. The MO [medical officer] was largely absent during these critical periods, possibly due to the extensive workload he had post fatalities. I was accused [by a Medical Technician] of being uncaring because they were emotional and I did not cry while I worked. They said, 'what's wrong with you?', because they did not understand what it meant, or took for me to be professional and give the patient dignity. I was proud to be able to care for that soldier.*

NO also believed it was important to get to know their patient, especially as soldiers were part of the 'family'. The sense of closeness brought about by the nature of conflict, while relying on soldiers for protection, enhanced this imperative. However, severe trauma and unconscious patients were barriers to this, reducing the opportunity to establish a rapport.

> *We didn't get to talk to them in recovery like we usually do.*

Some NO provided emotional support to humanitarian victims of the conflict, particularly women. This group were highly vulnerable because of their gender and surrounding cultural perceptions of how to treat them.

> *I provided emotional support to Afghan locals—single females unable to find their family.*

5.5.1.4 Dealing with Death

A sad reality of the IAC environment was that people would die. The extent to which NO were exposed to death depended on the nature of surrounding conflict, the force they were working with and whether civilians were accepted for care in the facility they worked in. Nurses needed to deal with their own thoughts about dying soldiers who they knew had been protecting them, as well as dying civilians who were humanitarian victims often caught in the crossfire. Knowing why they chose to deploy was an important part of accepting the

negative consequences of conflict. All participants deployed prepared for the eventuality of death, appreciating it was an unfortunate byproduct of conflict and realising they would end up disillusioned if they expected everyone to live.

> *I found an obvious disconnect between the nursing experience and that of the Medic [Medical Technician]. I could dissociate from those with injuries inconsistent with life. Medics often ruminated about what additional training they could have had or applied, to give rise to a different clinical outcome. I surmise this is due to a lack of clinical exposure to death and trauma, in addition to emotionally connecting to their battle groups through training and as the primary care providers.*

To be mentally comfortable, NO used three primary strategies to deal with and accept the risk of death: privilege, chance and dignity. NO considered it a privilege to care for injured and dying soldiers and civilians. They gave everyone '*their best chance [to survive]*'. Further, while accepting there were limits to what they could achieve, insofar as a soldier was part of a team and part of the military family, an attempt to save lives occurred even in the face of expected failure: '*We take someone to theatre even though you know that [they will probably die], sometimes you have to do that for people*'.

This approach ultimately helped others who survived an attack—and returned to fight in the conflict—deal with what happened to a team member. It did not matter if the casualty was Australian, Dutch, from the US or somewhere else, they were all part of 'the family' and all mainly young. At the same time, NO knew there was a point at which they needed to let a person go: '*We cannot save all*'. When this occurred, NO wanted to allow people to '*die with dignity*' and stepped into this gap to do what they could to remember someone's humanity.

> *There is no choice about how to die. We can give them dignity.*

NO found the US attitude to death by non-US personnel difficult to appreciate, with such personnel frequently left to die alone unless an NO chose to stay with them, which the Australians did. Conversely, sometimes the US would consider transferring US patients who were facing impending death from a profound head injury home on life support so family could say goodbye. This depended on the deployment, available resources and the person's physical state—whether they would survive the transfer or not.

I had no problem with it, someone else did. They [US] kept him alive [to Landstuhl] so his family could say goodbye. They donated his organs, which helped them [family].

5.5.2 Managing Ethical Dilemmas

NO deployed with variable experience at managing ethical dilemmas and all expected they might occur. However, despite believing they were clear on their ethical position, a number of NO— when faced with ethical challenges on deployment—did not achieve the outcome they felt was required by the situation or consistent with their underpinning humanitarian philosophy. The most common barriers were a perceived lack of authority to respond or a lack of experience in taking on ethical issues. Finding ethically robust answers was desired, but not always achievable.

I have seen ethical challenges. As long as the decisions are ethically robust … that they are well thought out and there is a good reason … I miss the mental barriers which ethical dilemma posed, and the challenge of overcoming them.

Professional obligations arose from several sources. Because the Army required nurses to be—and remain—registered for the duration of their deployment, NO were answerable to the AHPRA. Therefore, even when on deployment outside of Australia, NO were obligated to comply with the Code of Ethics for Nurses in Australia (NMBA, 2008) as well as the International Council of Nurses (ICN) Code of Ethics for Nurses (ICN, 2021). NO also remained answerable to the covenants of the Geneva Convention, covered in their Army training. Knowledge of these frameworks informed their ethical intelligence, meaning the capacity to be aware of, control, express one's ethical viewpoint and manage ethical issues (Weinstein, 2011).

Coming up against clear differences in how other nations perceived treatment of coalition, local population of enemy fighters was challenging.

Although moral courage was not absent and fear was not usually present, NO experienced challenges with acting on their beliefs. Barriers to acting on their ethical beliefs were a lack of confidence combined with inexperience—clinically, militarily or both. NO found they could be isolated in their viewpoint, intimidated by other military personnel, overruled by

rank or challenged by opposing military expectations, leaving them unsure or powerless. One NO believes they initially failed to demonstrate moral courage in the face of aggression because they lacked understanding of US culture—specifically, how questioning the US decisions would be received and how NO could work around ethical and cultural differences. Despite knowing their ethical framework, NO had little training in how to apply it when challenged by opposing cultural views. Moreover, NO did not have obvious authority to act in that setting. This could be important in the hierarchical military system or when working with other cultures.

> *I needed a role model and ethical training beforehand would be useful. Including ethical dilemma problem solving, how to defend a patient's rights, laws and frameworks. I think the military reduces willingness to discuss issues. I was not sure how to act, how to interpret the US viewpoint. They have a different world reference. To take on [an] ethical dilemma took courage and confidence, both of which require experience in life and work.*

NO encountered potential breaches of humanitarian law. In one health clinic, the primary intent was not to deliver healthcare. Although people would receive genuine care, the NO—who were able to identify when health and military agendas conflated—questioned the ethics of the situation and had the courage to stand up for what was potentially wrong. NO were aware they offered an ethical counterpoint in an environment where other imperatives and emotions could obscure morality.

> *The rules of war are clear. It is one thing to relinquish status, another to threaten the emblem [Red Cross]. I made a point of wearing my red cross whenever I went to the clinic. As one of the few nurses who spent time outside the wire, I found myself in very compromising situations clinically, ethically and from a safety perspective. The greatest challenge was balancing the desire for a full combat experience with agitating and challenging the status quo of running the clinics, which also served as alternate mechanisms for intelligence gathering. With rank, I was able to negotiate with the Patrol Base commander to ensure non-clinical personnel did not impersonate clinical personnel; however, I was compelled to have those same personnel in clinical consultations against my wishes. In this regard, I failed to advocate adequately for my patients in a way I was used to. Upon return [to base] I wrote a report and advocated for a doctor to attend the next clinic, to avoid further situations where I was forced to work outside my scope [and*

in ethically questionable situations]. This was received with little resistance and complied with [by the MO]. I did feel I was constantly being judged [as a consequence of my stance].

Some NO observed or heard about health providers from other forces operating significantly outside of their scope of practice. However, NO could only advocate for the patients in another person's care if they had the authority to do so. It was frustrating for nurses to know this happened and be unable to do anything about it.

It was jaw dropping moment for me; that it was happening. I felt terrible. There was nothing I could do.

In the IAC environment, NO were exposed to children who were active enemy or used by enemy to harm Australians or other allied forces. To be safe, nurses had to change their mindset to see children as a potential risk, rather than the relatively innocent creatures Australians would normally expect. This was a confronting mental challenge. However, it was a matter of survival to accept this realisation and NO were left thinking about it until they returned home.

It was confronting because of the age at which they became involved in armed conflict [as agents using weapons], and the level of corruption of their minds.

Two groups were especially vulnerable, inherently at risk and a source of ethical dilemmas. The two codes covering these groups were 'humanitarian victims' and 'dealing with the enemy'. The latter were the most problematic because of their actions in the IAC environment and the risk these posed to Australian Defence forces—and because of obligations under international law to protect them when vulnerable following injury.

5.5.2.1 Humanitarian Victims

All health care occurred within the constraints of time and resources. Often referred to as the Medical Rules of Engagement (MED ROE), mission boundaries determined what assets would be required to support Australian forces and, if pre-determined, whether Australia or another force would provide treatment to injured local forces and civilians. Commonly, MED ROE for humanitarian victims were determined in relation to the capacity of the local health infrastructure, insofar as all humanitarian victims ultimately returned to their own health

service. Thus, limits to care ultimately meant its delivery was inequitable for others in comparison to an Australian or allied soldier.

> *Where you were from determined care … it was inequitable and mission controlled.*

This position was in juxtaposition to the belief of NO that being unbiased was a tenet of nursing and that all humans were entitled to receive or be denied care on an equal basis: '*Our job is to do the best we can no matter where the patient comes from*'. It was challenging for NO who operated on the basis that they had an ethical obligation to provide care according to need and not a patient's beliefs or behaviours. However, if surgical care occurred, and humanitarian victims made it to the OT, '*care was the same in theatre*'.

Humanitarian victims with difficult-to-treat injuries occurred frequently in some IAC settings. Therefore, NO were involved in making difficult ethical and clinical choices about whether to provide care—if they were allowed to or not—ultimately resulting in decisions about whether it was more humane to allow someone to die or not. In trying to deal with these choices, NO emphasised their role as humanitarians, advocating for equitable care.

> *There are no winners in any war.*

Some NO found that when humanitarian options did not allow them to provide the same care, the team were able to attempt to establish care alternatives that fitted within mission boundaries.

> *The greatest challenge was navigating differences between various cultures in the health facility, having the courage and confidence to stand up for the care of patients regardless of background. For the care of local nationals, having a strategic understanding (due to my military exposure and officer training), that equivalent care and outcomes were not always possible for patients, as the host nation health system would not be able to support them through recovery or community participation [was helpful]. This meant alternative treatment options were employed to ensure survival into the future.*

Sometimes, when a patient received care, a lack of suitable resources compromised the standard of that care.

I was asked to provide treatments and adjuncts to patients who did not speak English, impacting my ability to gain a full medical history and determine their clinical ailment and best treatment. It is reasonable to suggest those with more serious chronic conditions did not get the treatment they were expecting.

At other times, NO needed to find a way to deal with prioritisation of the military objective over both nursing perceptions about unbiased and equitable care and mission guidelines as to who was entitled to care.

Ethical dilemmas were experienced when dealing with patients who, due to their relationship with people [whose relationships were deemed important], received preferential medical care over other civilians, when there was no clinical need or when the MED ROE did not support their entitlement to coalition treatment. Unfortunately, I don't believe any rank would have been sufficient to ensure equity of treatment. Whilst operationally for intelligence reasons this made sense, from a nursing perspective it was incongruent with ethical conduct.

5.5.2.2 Dealing with the Enemy

NO placed humanity at the heart of their decisions, regardless of the other person's behaviour. Thus, if the enemy required care, NO attempted to offer it. Nurses were able to subjugate their emotions about an enemy combatant's activity beneath their professional obligation to provide care. However, they encountered opposition to their 'care' from non-health providers and from health personnel in other forces, and experienced challenging behaviours around enemy treatment in hospital. Importantly, not providing care when they thought they should, left NO feeling as though they had failed in their duty of care.

Enemy etcetera, if they need care, they get it.

Enemy combatants wore restraints at all times, including when sedated, paralysed and ventilated in ICU. At times NO found it difficult to manage the anger, which pervaded the workplace from non-Australian colleagues, about treating enemy. According to the US health providers, enemy should receive basic ICU care but no hygiene. Operating on an unbiased model of care, a participant 'cared' for the enemy because the enemy was a patient and they applied the standard of care they used before deployment. This NO would not have walked

past such an issue in Australia, but when operating in a foreign offshore environment, amidst IAC, it was much harder to determine how to act, especially as they were essentially alone as an Australian and felt threatened. They did not have any pre-planned way to handle the situation. By not standing up at the time, this NO subsequently experienced moral distress, feeling angry and guilty for failing to protect their patient.

> *They were handcuffed, sedated and blindfolded; sent from gaol malnourished, stressed, with armed guards … it was surreal. A US Army tech told me off, saying, 'we don't wash our enemy'.*

In hindsight, the NO felt their military experience increased an ability to advocate. For an NO to succeed in managing IAC ethical dilemmas, they needed to appreciate the big picture of the conflict, understand one's '*right and left of arc*' (boundaries), know what the Army's expectations were, have the experience to know when to act and do so decisively. This required the NO to use their dual status as an officer and a nurse to resolve the dilemma.

> *[Have a] strategic understanding … know your area of influence and how far you can push it.*

During overwhelming incidents such as 'green on blue', where caring for the perpetrator conflicted with the casualties produced, NO found there could be resistance to treating the enemy by both those who took the enemy to a healthcare facility and other health colleagues. However, they focused on doing the job rather than arguing with those who voiced their antipathy. Although the NO felt a sense of confidence in knowing they had fulfilled their obligations to treat the injured placed in their care, it was difficult to tolerate the displeasure of others.

> *POW, people who had done nasty things to our guys, when we had to treat them. At the end of the day I was there to do a job and that [caring for enemy] was the job [at that time] I was there to do.*

5.6 Coping with Challenge

An ability to cope underpins the deployment cycle and is fundamental to dealing with challenge. Chapter Four explicated how NO prepared to cope with and survive the personal,

clinical and military demands of deployment. This chapter carries the story forward, looking at what happened on deployment. Although nurses deployed with variable levels of readiness, all demonstrated several common coping characteristics, underpinned by a number of traits, abilities and strategies. The two main sub-categories to the coping process are 'being resilient' and 'learning to live with the new self'.

> *Having supportive connections with members was vital to getting through the deployment; regardless of rank/speciality or experience, all members needed each other at some point.*

This section on coping explicates several mental strategies—connected by common threads—including situational awareness, a focus on the positive and keeping busy. Situational awareness allowed the NO to be mentally comfortable despite ongoing risk and, therefore, focus on their job. For example, being aware of layers of security informed the coping strategy of reconciling with the threat. In addition, focusing on the positive and using humour enabled the avoidance of dwelling on the human destruction surrounding them and their personal risk. An ability to see the darkly comic side of the tragedies they experienced ameliorated barriers to coping: '*we used humour and debriefing with the team in order to cope*'. It was also not hard for most NO to remain busy. By doing so, time went quickly and NO were focused on something other than their environment and its consequences.

> *We had a lot of fun and humour. It is a coping mechanism. We have a way of letting go of steam, you know under stress, but this [experience] was more about the personality. It was a bit of Aussie larrikinism. We all kind of related to it. It made working together really good.*

NO deployed with a series of coping mechanisms derived from their pre-deployment personal and professional environments. This included the Army and its standardised way of doing things. On deployment, NO experienced the familiarity of the Army, variability in clinical settings and starkly different personal circumstances to Australia. Once deployed, NO needed to work out how their new environment influenced and tested their coping mechanisms and how these mechanisms might need to be adjusted or strengthened. This process of adjustment and adaptation was itself a coping mechanism.

You have both clinical and psychological coping mechanisms build in around your workplace, which you need to draw upon at a moment's notice. You don't think about them, they just happen. They are automatic, you have done them before. Then right at the end you think, where did that come from?

5.6.1 Being Resilient

Resilience is the ability of an individual to bounce back after difficulty and adapt in the face of adversity (American Psychology Association, 2022; Bonanno, 2004). Resilience to the physical and psychological impacts of the environment, and how these affected them personally and professionally, was an apparent trait across the group of NO. Participants demonstrated resilience in how they adapted to difficult circumstances and kept moving forward with a positive attitude, despite tests to resilience from the surrounding environment, organisations and people.

I'm more resilient. We were grieving with people, dealing with good happening to bad.

A very pragmatic undertone and a resigned sense of acceptance for the consequences of conflict was a common characteristic among the narratives nurses shared. '*If it's going to hit, don't live in fear … keep going … if it's over it's over*'. This pragmatism reflected a strong resilience to their experiences, noting that NO regularly experienced significant trauma and demands on their emotional and ethical strength by colleagues, patients and the military team.

Before going people ask if you are scared, but we are medical, they are going to look after us. There were a few rocket attacks, but they were not very accurate.

Philosophically, NO had thought about their part in the armed conflict. Self-awareness enhanced a nurse's resilience, including recognition of their coping mechanisms and knowing how they would deal with such situations as looking after injured soldiers, enemy and children. A lack of such awareness increased stress.

I was there to do my bit in resolving the consequences of war.

Two key strategies explicate how NO achieved resilience in response to their experiences in IAC: 'talking it out' and 'saying goodbye'.

5.6.1.1 Talking it Out

Being alone and unsupported could undermine resilience. Participants recommended debriefing with each other about challenges at work, the 'war' and what was happening at home. This was described by several participants as a '*need to talk it out*'. This was particularly important '*if you are struggling*'. On a daily basis, when support networks were available, NO shared with colleagues and patients, offered support and sometimes received support in return.

> *A collegiate approach is key to building resilience. Find 'your people' and nurture that relationship. It will yield a considerable return on social capital investment and [likely] reduce the development of maladaptive coping mechanisms, post-RTA. Routine, and work-life balance, need to be 'a thing', in the deployed setting. Embrace a hobby, or adapt an existing one, to create distance and layer texture to the deployed experience.*

NO could avoid an internal build-up of emotions brought about by their work and personal interactions (such as frustration, anger and grief) by seeking out someone and talking about it. Where possible, Australians established a weekly get together, a leadership decision influenced by notions of mateship and care. This provided a network of culturally similar people and maintained visibility of how individuals were going, ideally to achieve early identification if someone was struggling.

> *We, our group [Australians] would meet weekly. We had our chocco [abbreviation of 'chocolate soldier'—colloquial joking reference to ARES personnel, originating in WWII, to describe the belief ARES would 'melt in the heat'] Tuesday night and you had to go unless you were working. Things like that were really important because you didn't have … that was your way of having a debrief.*

> *Embrace your down time with a good book or exercise, and debrief regularly with a trusted colleague. Regular debriefs occurred following casualty surges or undesired outcomes for patients. I still use coping strategies from activities experienced during my deployment. Reminders that the team achieved the best results for all treated patients continues to be a mantra of coping.*

Some NO were able to establish support networks in the workplace, although this depended on personalities as to whether people got to know each other, noticed if another was struggling or not and sought them out to offer support.

> *In the middle, about two-thirds in, I was really missing my family and there was a knock at the door. He [colleague] said 'are you ok, I know you are not right'. It was one of those things, I was just missing my family and sometimes you feel a bit isolated.*

However, frequently some nurses found themselves working alone, away from other Australian nurses or on opposite shifts. The opportunity to talk to each other could be limited and cultural difference meant it was not always easy to establish friends and support among other forces.

> *I was on night duty on my own. I could not debrief. There was no one to talk to about the issues I faced.*

For those who could not establish workplace networks, having someone to call and talk to was important, as long as they met security requirements for information protection. In several cases, participants did not have this option. As one reported: '*I didn't really have anyone at home I could talk to about things*'.

Celebrations were an important way to reduce stress and support each other. Australians would celebrate important events such as ANZAC Day, considered particularly meaningful when deployed to IAC. If deployed with the US, celebration of big events such as Fourth of July or Halloween was common. The US were well organised socially, supported each other and had fun in between the bursts of injury. The US were also very good at setting up community-based activities such as craft events, although it depended on the group as to whether Australians were invited.

> *The social committee, it was great. We had lots of craft things, we had a big party for Halloween. We had an Australian week! They celebrated stuff for us and so everyone sort of knew everyone.*

5.6.1.2 Saying Goodbye

Resilience was an important survival characteristic on deployment and played a significant role when the NO prepared to return home. Innate attitude was important, with resilience strengthened to some extent by establishing supportive workplace relationships that provided someone to talk to. It also became apparent that, at the same time as they demonstrated resilience, all NO went through a process of letting go, particularly as they commenced a transition to returning home. This included saying goodbye before, during and after deployment.

NO found themselves saying goodbye to people, places and circumstances, a process that required them to be resilient, pragmatic and emotionally strong. Initially, they readied themselves to leave home. Both a physical and psychological process, nurses spoke to family, friends and colleagues before they left for deployment. Depending on their family circumstances, they had parents, partners or children to leave behind. '*I told my family, my son moved home to look after that house and the cat. That was it*'. Simultaneously, these nurses had to consider what they could tell their family and how they would stay in touch, because the family would also need to cope while the NO deployed.

> *I warned the family out, it was one of two places. I could not tell them which initially.*

For NO going to an armed conflict potentially unpopular with the public, such as Iraq, their families had an added sense of concern. Parents who remembered the post-Vietnam War era worried their child would receive adverse treatment on return.

> *It was a potentially unpopular war. My parents were determined to care.*

On deployment NO lived through the process of caring for and saying goodbye to patients, many with horrific injuries, seeing them for intense but brief periods before the soldier returned home. Colleagues came and went. A number of patients died, usually under the care of an NO. This could involve sitting with the patient until they died, supporting their teammates and supporting other healthcare colleagues through the process of letting go.

When they left deployment, NO left behind colleagues they had faced adversary with, new friends, their Army family and a life that epitomised what they, as Army NO, believe they existed for. They had to let go of a tense and emotional environment that had been part of their life for up to six months. Running through the challenge of saying goodbye was a strong thread of resilience. The process of saying goodbye was easier for NO who could return home with the team. For one NO, there was a feeling of regret at having to leave earlier than everyone else.

> *I wish I had not gone home early, I wanted to return home with the team.*

5.6.2 Learning to Live with the New Self

All NO in this study deployed from between one to 16 years prior to interview, allowing time to reflect on their deployment. The rich detail, articulate and, at times, courageous self-analysis they shared revealed the extent of their self-reflection. At the end of each interview, NO were asked how they felt generally about their deployment, to give an indication of how they had responded to their IAC experience.

> *That's my job, send me back to finish it, it's my duty, I miss it in part. I did my bit to fix the world, I wanted to set an example for my daughter.*

All NO displayed some type of positive view of their overall deployment. This included feelings of being lucky and appreciating the freedoms Australians have. NO valued the opportunity to deploy, found it interesting, personally and professionally challenging and exciting. They enjoyed the opportunity to work with other nations, to grow clinically and personally, to make their mark and do their share in resolving issues.

> *I wish I could go again, now I understand and have more military knowledge.*

Despite the positive aspects of returning home, there were also things NO missed on their return, such as the collaboration and autonomy experienced on deployment. This produced tensions with their civilian practice in Australia, some of which could not be fully resolved. It took time for nurses to become used to the relative silence in Australia—compared with 24-hour noise on deployment—the absence of drills in response to mortar attacks or the vigilance associated with waiting for the pager to go off. With the realisation of how much

worse things could be, most nurses found their perspective changed. This established a tension point between NO and civilian perspectives in Australia.

I had a vague sense of being disconnected, I realised how lucky we are.

In particular, '*little issues are [now] less important*', with the most frequent comment from participants being '*I don't stress/sweat over the small stuff*'. This also suggested a point of tension with people who had not deployed and who were stressed about issues participants saw as minor in the context of the global picture.

Participants saw the world in a new way—it was bigger. They had learned to live in a world of conflict, to be aware and vigilant while not afraid, to instil new practices—such as security drills or ways of dealing with austerity—into their personal and professional lives. Through their contribution to patient care, they had shared much of their emotional self with others: helping a soldier's team deal with injury or loss and both pulling together and maintaining a team of health professionals. In particular, many of these NO had experienced ethical challenges that required a high level of ethical intelligence and courage to act on their beliefs. They had lived with very little in terms of personal comfort and become used to new noises that invaded their life, night and day.

[The conflict] affected how I think about things.

Then they returned home to their pre-deployment life, sometimes in the company of others, often on their own. They all went back to work, caring, but no longer under fire. They were all still an Army NO, but this role had no place in the civilian world. This was a particular professional problem for the ARES NO. In addition, not everyone in the Army understood how the NO had changed or how their experience was important, producing tensions for ARA NO trying to fit back in. All returned to a life where they needed to reintegrate to their family, friends and work, with the onus on them to do so.

Returning home was difficult as my experiences in country were intense, however there was no concept of decompression (at that time). I was not met at the airport by anyone but my family. From there I immediately returned to my home unit and commenced leave. There was really no time to reconcile my thoughts.

Same person, different mindset, bigger view, more aware. Home had become foreign, I was a bit lost. It took me three months to re-adjust, to re-establish my sleep pattern, to catch up with friends and to reintegrate to my old life.

Their new self-perception and worldview did not align with the world they returned to, requiring a process of adjustment.

Learning to live with your new self is an ongoing journey and one that I continue to work through.

Learning to live with the new self, saw participants 'dealing with frustration' and 'refitting to fight'.

5.6.2.1 Dealing with Frustration

Part of the adjustment process involved dealing with frustration. Every NO felt they had gained something; all felt a sense of loss of at least one aspect of their deployment, challenging their return home and reintegration into life. In the civilian context, NO were frustrated by losing the autonomy they gained in the challenging conditions of the IAC. A number now feel underestimated in their civilian lives from a perceived loss of professional value since coming home. In the military context, it frustrated NO that the people making decisions about NO were not nurses—that they were not enabling NO for future deployments. It was also felt that people at home, including non-deployed NO, were complacent and unaware of what exposures an NO could face on deployment.

By not understanding nursing they inhibited the nursing effect. I was not tracking well. The structure of training at home irritated, they were cutting corners. So a lack of preparedness for what I knew could be experienced. I was anxious, people around nurses did not understand, therefore prevented enabling. I was burnt out.

In both civilian and military workplaces, a source of frustration arose from colleagues who did not possess the speed, decisiveness, collaboration, teamwork and awareness NO had developed on deployment.

In retrospect, some NO found a lack of preparation for deployment meant they did not perform as well as they would have liked, leading to a sense of inadequate achievement and frustration when they returned home and reflected on their experiences. These issues included failing to stand up to ethical challenges, delivering good clinical care and providing high-level advocacy and leadership. The extent of loss they witnessed was also a source of anger and frustration for some.

> *I was angrier when I came home, gains are fragile and easily reversible. I returned with an acute stress reaction that subsided over a number of months. I have paradoxical feelings about the deployment.*

5.6.2.2 Refitting to Fight

The process of learning to live with a new sense of self took time as NO found ways to learn to live with themselves and others, both personally and professionally. They found ways to grow. All reassessed their life in some way, each one making a decision that involved improving the future for nurses. Each NO used the gap between their first and any subsequent deployment to re-evaluate, adjust and move forward, to ready themselves for the next deployment, ultimately beginning the deployment cycle again. This is what the military would call the 'reset' period. The infantry would call it 'refitting to fight'. Timeframes were individual and not all were able to explain exactly what happened in the gap.

> *I don't know [what happened in the gap], I just think I needed a bit of time. It was also about letting my friends go and helping others to get there.*

> *On coming home, I reassessed my purpose in life, moved to the ARES, did some study and had a family.*

In hindsight, they had advice for NO thinking about deploying in the future. Although much of this has been covered in these chapters, they offered additional advice. There was an emphasis on being ready. Participants also suggested that it is important to show respect, even for those with different views. A focus on the positives is a way to offset the many negative aspects of armed conflict and to avoid dwelling on what an NO cannot control. NO needed to be aware in advance of the potential for confrontation, especially of an ethical

nature. Therefore, ethical awareness is essential—including possession of a management plan for ethical issues, which the NO is able to act on. It is essential the NO is strong to deal with differences between people. To avoid deploying people who lack '*experience as a human being*', lack values and ethos—which, ultimately, detracts from the delivery of patient care—it was suggested recruitment should focus on people with personalities suited to surviving deployment and providing good care.

> *For the first timer … Set the standard. Others will follow, or they will fall away.*

5.7 Conclusion

This chapter focused on the categories that explained the process of deployment NO undertook in their pursuit of being able to deliver nursing care—to care under fire. Important sub-categories to caring under fire included being competent and managing ethical dilemmas. Supporting social processes included being able to respond to the environment, function as an Army NO and cope with challenge. Prior personal and professional preparation—in particular, clinical and military experience—influenced ability to perform on deployment. These foundational experiences were important for higher-level skills such as advocacy and leadership, which were essential traits for an Army NO to maximise their effect. Although nurses experienced a number of challenges, they found ways to overcome them. Underpinning their ability to cope was a strong and critical thread of resilience. In the next chapter, integrating these theoretical concepts reveals a theory that represents the process of delivering care in an armed conflict environment.

Chapter 6: Findings: A Theory of Caring Under Fire

6.1 Introduction

The aim of this study was to investigate and theorise the experience of being an Australian Army Nursing Officer deployed to an IAC zone. The previous two chapters provided a description of the findings in the context of preparation for, and deployment to, IAC. These findings demonstrated how Australian Army NO engaged with several interrelated processes to focus on their core purpose and primary concern, ensuring the delivery of quality care during IAC (under fire).

The purpose of this chapter is to illuminate the GT of caring under fire, framing and contextualising the findings, explicating relationships between concepts. The first section describes the theory. This section uses font highlights to identify the different category types, with the core category in **bold UPPERCASE**, supporting concepts in UPPERCASE, key subcategories in ***bold italics,*** and associated codes in *italics*. In the next section, a working exemplar of the theory is provided in the form of a case study incorporating two characters who represent predominant variable aspects of the deployment experience. The case study will illustrate the processes, strategies, conditions and consequences of caring under fire. The next chapter will discuss these findings in the context of the literature, demonstrating how the substantive theory adds to knowledge of Australian Army NO.

6.2 A Theory of Caring 'Under Fire'

This study used Glaserian GT to create a theory that depicts a core category underpinned by a BSP and supported by key concepts. This produced an abstract conceptualisation of the processes underlying Australian Army Nursing in IAC. Diagram 4 provides a pictorial representation of the GT of caring under fire and how categories were integrated into a substantive theory. The theory is explained in the subsequent storyline, which explicates the relationships between each main and core category, their sub-categories and conditions.

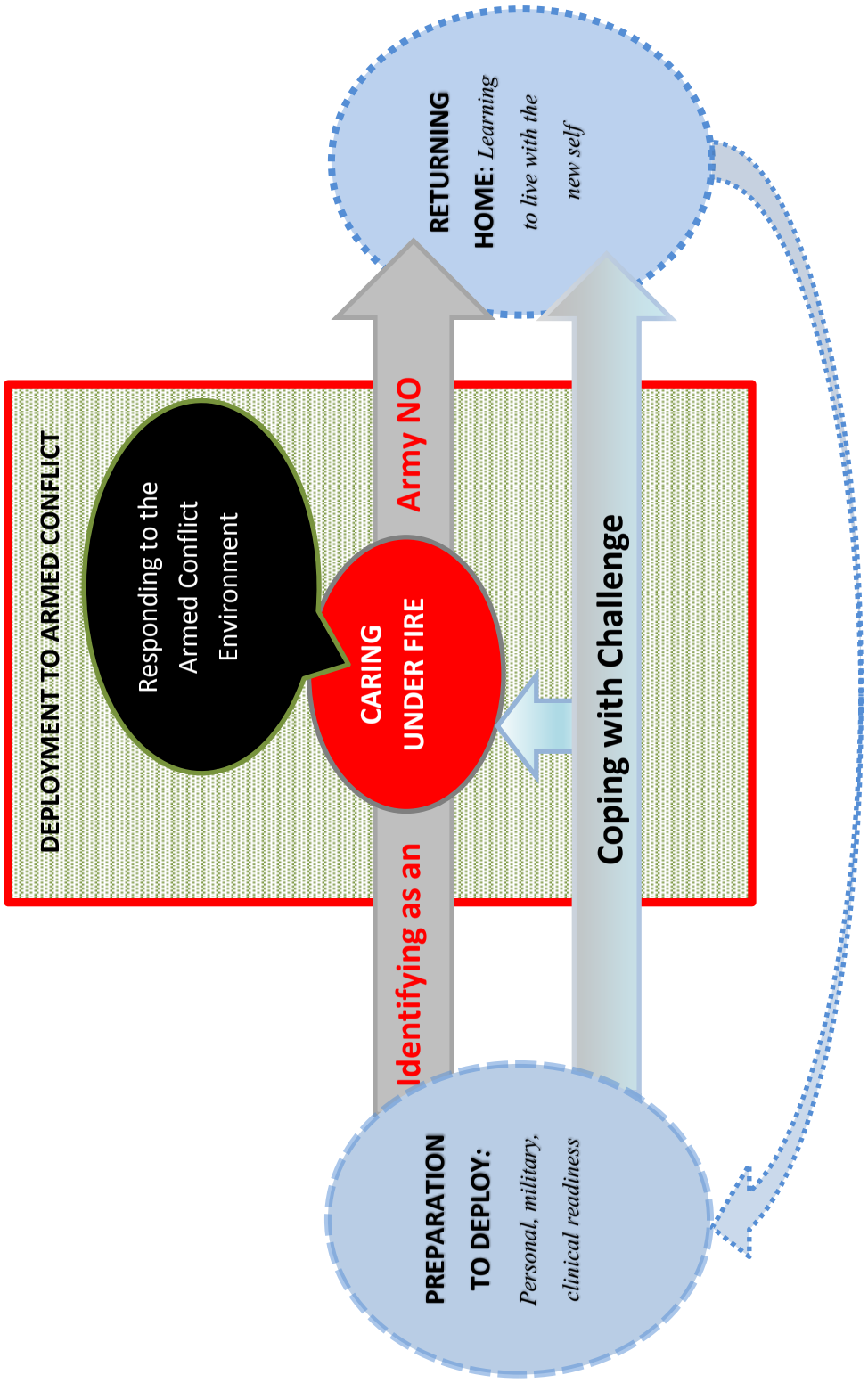

Diagram 4: The Grounded Theory of Caring Under Fire

6.3 Storyline

6.3.1 Preparation

PREPARATION TO DEPLOY commenced the deployment process, with the purpose of ensuring NO were personally, clinically and militarily ready for deployment and able to undertake their primary role of **CARING UNDER FIRE** (in an IAC zone). It was a process occurring over variable timeframes, in accordance with individual and organisational factors.

General military readying was about learning to ***work with the Army family*** and the organisation's unique demands, a process that commenced on recruitment to the Army. The nurse began socialisation to their Army role, as both an officer and a nurse, with a primary responsibility for ensuring care delivery, directly or via supervision.

Working with the Army family meant NO needed to demonstrate clinical and administrative acumen, reconcile the duality of nurse and Army Officer roles, learn how to give advice to higher command and appreciate the social context of the Army to plan care, be a leader and develop security readiness. Clinical ability alone was not enough to function as an NO. Security readiness would subsequently link to RESPONDING TO THE ARMED CONFLICT ENVIRONMENT when ***reconciling with the threat***. In reality, Army training focused on the officer, with little direct socialisation to the nursing side of the NO role. For each deployment, the Army built on prior military training during force preparation.

In general, nurses found it necessary to demonstrate a positive ***attitude*** toward getting ready, with an emphasis on *being proactive* and *preparing your own headspace*. *Being proactive* was a tactical countermeasure to barriers NO faced in getting ready, especially of a personal and clinical nature. It was important for personal readying, which could start prospectively in the hope of a deployment, and accelerated once they received notification of a deployment opportunity.

Clinical preparation started when the nurse graduated, with subsequent development of a foundation knowledge and skill set dependent on access to clinical time. Clinical readiness was influenced by employment status. NO who controlled their own clinical time possessed high levels of clinical readiness in terms of baseline experience and overall skill set, *being*

proactive as necessary to enhance their clinical baseline in readiness for what they thought might occur.

NO who required Army support to work clinically were adversely affected by a lack of organisational understanding about the need for clinical practice to be ready. In addition, if NO were to maximise a proactive stance in the lead up to deployment, they needed to be sensitive to the amount of their baseline clinical experience. Given a culture of low expectation in terms of how much clinical experience NO needed, some NO were not aware that their clinical practice baseline was inadequately developed, leading to some NO deploying without the experience to meet the clinical demands of the deployed environment**.**

The purpose of *preparing their own headspace* was to ensure that NO had established an initial mental comfort zone regarding the risks they expected to experience and the coping strategies they would use—linking to COPING WITH CHALLENGE on deployment. This included issues such as understanding mission guidelines, living with a threat, potential ethical challenges and the risk of death. Overall clinical experience influenced NO ability to evaluate likely clinical risks and prepare for clinical challenges. Thus, a lack of clinical experience adversely influenced COPING WITH CHALLENGE in terms of clinical issues encountered when **CARING UNDER FIRE**.

In addition, it was essential to ***develop knowledge and skill*** in advance of deploying. There were four priorities. The first priority was to be ready in terms of clinical practice—to *be competent* in delivering the required standard of care in an austere setting, where an ability to vary practice according to principles of care was essential. This required a well-developed clinical skill set, which was a significant challenge for NO who needed, but did not have, organisational support to work clinically.

The second priority was to *find out* '*who and what*' would be in the deployed zone, allowing the NO to prepare themselves in advance for what might be expected of them. In addition to discovering what role they would fill, NO sourced information from people already in the deployed zone and from MRE training. *Being proactive* about this was a countermeasure to a lack of information from the system; undermined, at times, by outdated information provided in MRE training or a lack of familiarity with the organisation.

The third requirement was to understand the Army—to *know the organisation.* The NO needed to be ready to deploy as part of a military force, to work with the organisation effectively, respond to circumstances they encountered (in a military sense) and understand the effects of a hierarchical system on clinical decision-making. This included acknowledging military authority, weapon readiness, security appreciation and teamwork.

Reconciling with the threat was part of COPING WITH CHALLENGE. This started before deployment, as NO gained weapon confidence and considered, when *preparing their own headspace*, how they would cope with a threat. NO who were well-prepared militarily, with a solid appreciation for the Army culture and language, coped well with organisational demands. Conversely, NO who possessed a low level of military readiness and appreciation for how the system would influence their life and practice, potentially affected security on a mission.

The final requirement was to recognise what challenges *the deployed environment* would pose. Conditions such as austerity and working with other cultures would influence clinical decision-making, requiring a high level of clinical acumen to ensure care delivery. Thus, ***attitude***, ***knowledge and skill*** would ensure a nurse was as ready as possible for IDENTIFYING AS AN ARMY NO who was responsible for **CARING UNDER FIRE**. Deployment experiences would highlight what IDENTIFYING AS AN ARMY NO meant.

6.3.2 Deployment

The deployment process involved physical and psychological transition points, with physical deployment a precise process commencing on departure from Australia and ceasing on re-entry. Psychological transition was a process that began before deployment and accelerated with increasing physical proximity to the risk associated with a threat. This aspect of deployment did not have a singular or consistent end point.

Once the nurse deployed, four key non-linear processes began, escalating on arrival in IAC. This included RESPONDING TO THE ARMED CONFLICT ENVIRONMENT, IDENTIFYING AS AN ARMY NO, **CARING UNDER FIRE** and COPING WITH CHALLENGE.

The dangerous and unpredictable nature of IAC required the NO to start RESPONDING TO THE ARMED CONFLICT ENVIRONMENT. Because, primarily, they needed to remain safe, ***reconciling with the threat*** required NO to know location of the threat and security structures, as well as what to do in the event of an attack. They deployed having acknowledged a threat, considered the risk and thought about how they would deal with it. This was followed by learning to live with the existence of a threat, physically and mentally. Sometimes this occurred suddenly, such as when they arrived at a base under fire. Getting used to the constant carriage of a weapon also took time. Their mental comfort zones evolved as they adjusted, a process that could take a week or two, with the NO eventually finding their baseline in terms of acceptance along a safety continuum and being able to focus on what they needed to do in nursing terms. Thus, RESPONDING TO THE ARMED CONFLICT ENVIRONMENT also began a process of COPING WITH CHALLENGE, underpinned by a strong thread of pragmatism.

At the same time, surrounding environmental conditions were challenging, which began a process of ***dealing with austerity***. This had personal implications for the duration of their deployment, such as shared living arrangements and significant limits on personal space and comfort. Climatic conditions were frequently hot and dusty.

CARING (UNDER FIRE) was a nurse's primary target. It was essential NO was mentally prepared and clinically experienced enough to cope with and respond effectively to clinical demands, including the need to work unsupervised and autonomously. They needed to be *clinically competent and current*, able to manage the new experiences of severe trauma and dealing with children. Solid basic skills that did not rely on technology, and an understanding how principles of practice could be manipulated, were essential for ***dealing with austerity*** and the constraints imposed on resource availability—such as resource limits, extreme heat and the likelihood of casualty surges. Conditions varied according to the surrounding conflict. Circumstances such as high industrial noise levels meant standard assessment processes may not work, meaning that NO needed to adapt and find other ways to assess their patients. Time-critical life-threatening circumstances required the nurse to develop speed.

COPING WITH CHALLENGE processes underpinned the strategies NO used when ***managing ethical dilemmas*** and overcoming barriers to ***performing clinically***. Coping with

the need to vary practice required clinical experience, flexibility, adaptability, high-level clinical judgement, problem solving skills and decisiveness in identifying alternate plans for the delivery of care.

Work usually started on the day they arrived. Not infrequently, this involved ***working with other cultures***, which some NO had prepared for and others had not. To be **CARING UNDER FIRE**, nurses needed to identify how ***working with other cultures*** affected their clinical decision-making, then negotiate an agreement on how to practise. This required clinical experience, cultural awareness and appreciation for alternate viewpoints. Importantly, NO needed the clinical acumen to identify and respond to ethical issues, to be ***managing ethical dilemmas***.

Leadership and advocacy were functions of both the nurse and officer; officer status lent authority and facilitated advocacy. Combined with clinical experience, these attributes facilitated care delivery and were critical to dealing with challenges. Thus, they were an important aspect of ***performing clinically***, IDENTIFYING AS AN ARMY NO and COPING WITH CHALLENGE. As NO identified challenges to nursing care that arose from either the organisation or environment, their responses were informed by knowledge arising from ***working with the Army family*** and their adeptness at manipulating principles of practice for a positive effect in terms of care. Therefore, IDENTIFYING AS AN ARMY NO who was a clinically competent leader was the primary means by which **CARING UNDER FIRE** occurred. Key attributes epitomising the NO included the triad of courage, compassion and caring.

Teamwork was a significant aspect of deployment. It was a concept integral to ***working with the Army family*** and ***reconciling with the threat***—with the team providing security. Teamwork was also a part of ***working with other cultures*** and essential to managing high workloads, with nurses central to *building and supporting the team*. The team could be a multidisciplinary healthcare team or health platoon. As part of a team, nurses found themselves *providing emotional support* to colleagues, team members and their patients, while dealing with their own emotions. This required a high level of EI.

Despite giving casualties every chance of survival, sometimes they could not be saved and NO found themselves *dealing with death*. The care of dying and deceased patients was a nursing role, and one NO undertook for several reasons. NO aimed to give patients dignity, while valuing the privilege to care for the dying and to support others who found the process of dying difficult to handle. At the same time, NO needed to reconcile their own thoughts of soldiers dying in combat.

Managing ethical dilemmas was an equally important aspect of **CARING UNDER FIRE**. Ethical challenges were a characteristic of the IAC environment and NO found they encountered a range of challenging situations, including opposition to some of their care decisions from ***working with other cultures***. Identifying and ***managing ethical dilemmas*** required NO to have ethical intelligence, remember they were humanitarians, have the compassion and courage to act, be strong at *advocacy* and have adequate clinical experience and practice at ethical challenges to know what they needed to do. However, a lack of clinical experience meant not all NO were able to demonstrate these qualities to the extent required. IDENTIFYING AS ARMY NO gave nurses the added qualities of the officer, which supported their capacity in defending humanity and morality and ***managing ethical dilemmas.*** Being an officer promoted engagement with the Army when providing a moral counterpoint to military decisions that affected healthcare delivery. At the same time, NO managed the duality of Army officer and nurse to avoid moral disengagement.

Two subset issues related to ***managing ethical dilemmas*** as part of **CARING UNDER FIRE** were *dealing with the enemy* and *humanitarian victims*. *Dealing with the enemy* intersected the three processes of **CARING UNDER FIRE**, RESPONDING TO THE ARMED CONFLICT ENVIRONMENT and IDENTIFYING AS AN ARMY NO. The enemy were an inherent part of military conflict and, at times, as demanded by international law, they required care. This meant NO needed to be mentally prepared to provide care to someone who may have killed Australian soldiers who were part of the broader Army family. This was especially challenging when 'green on blue' events occurred, because these incidences tended to occur inside the traditional safety of the perimeter fence. Simultaneously with *dealing with the enemy*, nurses needed to cope with related security issues and alternate viewpoints on care delivery. As humanitarians who provided unbiased care, at times NO

were ***working with other cultures*** who expressed antipathy toward those who delivered care to the enemy and the manner in which others treated the enemy became a source of ethical dilemmas.

Humanitarian victims inevitably occurred as a consequence of conflict and NO frequently found themselves required to deliver care, while experiencing the simultaneous challenge of mission guidelines. MED ROE determined what assets would be required to support Australian forces and what (and how) assets could be used for humanitarian victims and local forces. Thus, limits to care ultimately meant care delivery was inequitable compared with that delivered to allied soldiers, further requiring the NO to ***manage ethical dilemmas***.

COPING WITH CHALLENGE was a critical ability underpinning mental preparation for the personal, military and clinical challenges NO experienced in **CARING UNDER FIRE**, IDENTIFYING AS AN ARMY NO and RESPONDING TO THE ARMED CONFLICT ENVIRONMENT. The environment was unpredictable, dangerous, emotionally and physically tiring. A strong thread of ***being resilient*** ensured nurses were able to respond to challenges and bounce back, moving forward to the next challenge. A pragmatic approach, *talking it out* through debriefing and support networks, and self-awareness supported resilience. Part of ***being resilient*** involved *saying goodbye* to family before departure, to patients who had died or left to go home, and to colleagues and the deployed environment when the nurse returned home.

6.3.3 Returning Home

When nurses deployed, they had an individual idea of what IDENTIFYING AS AN ARMY NO meant. Somewhere along their journey through armed conflict, most of them believed their experiences on deployment coalesced into ***finding a new sense of self***. Armed conflict tested their clinical and military acumen and their ability to cope mentally. It was a place wherein IDENTIFYING AS AN ARMY NO made complete sense.

Although they had physically left the armed conflict behind, nurses proceeded to experience a period during which they continued COPING WITH CHALLENGE by processing their memories of the conflict, IDENTIFYING AS AN ARMY NO and **CARING UNDER FIRE**.

They learned to let go of the negative thoughts and find a positive way forward. By beginning a process of ***learning to live with the new self***, the person they had become because of their experiences shaped their personal view of the world, people and their professional abilities.

COPING WITH CHALLENGE by ***learning to live with the new self***, involved *dealing with frustration* over circumstances such as finding they were not allowed the same degree of autonomy in practice when they returned to Australia, compared with what they had experienced in IAC. In addition to ***being resilient*** and *dealing with frustration*, the coping process also required NO to reconcile their experiences. A sense of having performed well on deployment was essential for a positive pathway forward. A process of adjustment was required to fit their new self-view into the world they had returned to, which tended to clash with the world they had left. These NO had learned to live with very little and value the privilege of a life without conflict. They no longer stressed over small issues, seeing greater value in the bigger picture and what they could do for others. The lessons NO took from their deployment became part of their preparation for the next time they deployed. The gap between one deployment and the next was when they started '*refitting to fight*', which was a process of readying for the next battle.

6.4 Case Study: Sally and Hamish

To illustrate how this theory would operate in practice, the following case study is an abstract, composite example that represents the participants' collective experience through the fictional story of two Army NO. The experiences described in this case represent important issues associated with deploying to IAC, including the commonalities and differences between deployment experiences. Neither of the two characters represent participants in this study.

6.4.1 Background

Sally was an ARES nurse with 19 years as an advanced practice ED nurse and additional ICU clinical experience. She was working as a clinical support nurse in ED and casually in ICU in the year prior to deployment. She had been in the military for 11 years and every year went on a field exercise to a role 2 (small hospital with basic surgical and ICU capability).

Sally was deploying to work with the US in an ICU of a role 3 (Neurosurgical capability) hospital.

Hamish was an ARA nurse who had graduated as a nurse six years earlier. He joined the Army as an undergraduate and gained two years of graduate experience in a civilian hospital (orthopaedic, neurology and non-specialist ED) before working solely for the military. His first year in the military primarily involved course attendance and the next four years he had been a Platoon Commander, frequently providing support to field exercises. During this four-year period, he worked for four weeks per annum in the garrison primary health care facility. He was deploying to work in a role 1 (resuscitation and primary health care facility) as Platoon Commander with the ADF. The role 1 he would be working in was located about 40 kilometres from the role 3 Sally was going to.

6.4.2 Preparation

When Sally received notification that she would be deploying, she asked for advice on what she needed to do before departing, so that she would be prepared. The Army told her to keep working, let her employer know and advise her family. She would need to be ready to undertake a week of force preparation training prior to leaving. Sally's ***attitude*** was one of *being proactive*, to get her personal life in order before deploying. In *preparing her own headspace*, Sally had spent many years working with trauma and children in mixed caseload ED, so believed she was as clinically ready as she could be—although she had a sense the trauma could be worse than anything she had previously seen. She was very keen to deploy to test herself, get a sense of what being an Army nurse in IAC was all about and be there to help Australian soldiers. She started to think about what she might see and how she would cope with this. To ***develop as much knowledge and skill*** as she could, Sally focused on asking others for advice about what she needed to take for personal comfort and trying to identify someone who could tell her what the deployed clinical setting was like. She started doing as many ICU shifts as she could.

Hamish was on a field exercise when notified he would be deploying. Hamish's ***attitude*** was one of relying on the Army to know what he needed to achieve prior to deployment. He worked out he would have a week between finishing in the field and attending force

preparation training, which would be his PREPARATION FOR DEPLOYMENT. Although he did not consciously see it as *preparing his own headspace*, he thought about how lucky he felt to have obtained a deployment and was glad he had no family other than his parents to worry about. Like his ARA colleagues, he felt deployment was what he was training for, and he spent a lot of time training in a field role 1 when on exercise to be ready to deploy. He personally prepared the same way he would for field training and did not ask for extra clinical time because he was undertaking tasks in the field (military exercise). Aware he might see trauma he had no direct prior experience of, he went back through Army course notes as a way to ***develop knowledge and skill***.

6.4.3 Deployment

Sally and Hamish departed Australia together and arrived in their country of destination three days later at about 0300h, after transiting via another country where they received initial briefs. As they landed and walked across the runway in full body armour, weapon and pack, a siren sounded. Both realised what it was. Sally felt it was a surreal experience, pitch black, sirens and being hustled to a long tunnel of concrete tubes, to sit and wait for what turned out to be a mortar attack to finish. Hamish felt a sense of excitement. This was their first experience of RESPONDING TO THE ARMED CONFLICT ENVIRONMENT.

As Sally sat waiting, she ***reconciled with the threat***, mentally reminding herself of what she had prepared herself for and that she was safe in a bunker, someone else was protecting the base and that she had a job to do. She jumped each time she felt the percussion and felt a little strange holding a weapon that was loaded. Apart from that, she figured it was too late to worry. Next to her Hamish considered how everything he had trained for was finally occurring. He had ***reconciled with the threat*** through years of supporting the infantry and carrying a weapon was a distinctly familiar activity. He was clear on why he was there and was not concerned about the threat.

Eventually they left the bunker, wishing each other well as they went their own ways. Sally went through the process of finding her accommodation, which reminded her of a shipping container. She was glad she liked camping; it was sparse and cramped, with one other person living there. Her experience of ***dealing with austerity*** had commenced. Subsequently, she

received a brief on drills in the event of another attack and then went to bed (after carefully putting her weapon beneath her mattress). Waking up in the middle of the night, choking in talcum powder fine dust, Sally realised the window she had opened to cool the room down had allowed a dust storm to blow in. She lived with the air-conditioner on for the rest of her deployment.

In the meantime, Hamish went to another part of the base to await a helicopter ride to his destination. He lay down against his pack and went to sleep, used to ***dealing with austerity***. At about 0500h he boarded a Blackhawk and enjoyed the early morning trip through the dawn, revelling in the feeling of low flying over the desert. A small part of him was conscious of the risk and he kept his eye on the ground. On arrival to his final destination, Hamish carried his equipment to his 'room'—a tent similar to what he had lived in most of the previous year in the field on exercise—and left everything except his armour and weapon.

On her first morning, Sally found her way to the hospital for a work briefing. With a helicopter in the background as she walked to the hospital, Sally was to discover this would be a constant noise in her life for the duration of deployment. At the hospital, she stashed her weapon and began her introduction to **CARING UNDER FIRE**, quickly discovering she would not be working in ICU; she would be in ED. Initially confronted, she realised ED was an area she had a lot of experience in, so ***performing clinically*** would be relatively easy.

Sally's orientation involved discovering she was one of two RN per shift, the rest of the team were US medics and doctors. Thus, she was ***working with other cultures*** with no other Australians. There were ten beds and, apparently in the US, the RN did not look after patients—they were there to document and give drugs. This was a significant role change to her Australian experience and the patient to nurse ratios were high, meaning the workload would be significant if it became busy. Sally decided to give it time to see what happened when patients came in, before deciding if she needed to (and could) negotiate changes to how she operated. Sally realised equipment was basic, there was a lot of dust and it was already hot at 0700h in the morning. ***Dealing with austerity*** clearly meant thinking about the impact on her practice; however, she was comfortable with basic approaches to trauma care and felt she could adapt to what was available. Unable to find medications, she asked and was told

they came individually from pharmacy for each patient, prepared as requested. Sally had her doubts as to how that would work.

Whereas Sally was getting her head around ***working with other cultures***, Hamish met the Australian team he would be working with—a doctor and three medics, none of whom he had previously met. They received security briefs, including drills in the event of an attack, and then went to the 'clinic' for a work briefing. At the clinic, Hamish found a similar set up to the role 1 in the field at home, put his weapon in the rack and started the process of **CARING UNDER FIRE**. This entailed talking to the team, working out who was doing what and having a chat to the doctor to gain their thoughts as to how they would 'run' things. Thus, he started his own process of *building and supporting the team*. During this time, Hamish discovered they would be providing on-call support to the co-located role 2 US hospital ED. Eventually, all of their patients would transfer to the role 3 Sally was working in. There was limited support and the Australians would be working on their own. The ED setting was different to what he knew, but he figured he would have time to work it out.

On day two Sally experienced her first MASCAS. With no warning, a US Chinook helicopter delivered 12 critically injured patients to the ED. All beds filled; there were two on stretchers out the front of the ED until space was available. A couple of RN came to help, but Sally still found herself swamped by patients, few staff and no idea where to start when ***performing clinically***. Many surgeons turned up and she discovered they were part of the trauma team in the US. Pharmacy gave out drugs one by one, which significantly slowed down events, complicated by a whole range of new drug names and imperial measurements. The nurse working with her picked one patient and stayed with them, as was their practice. Sally worked on the other patients, determined to give them all a chance of making it to theatre. Several hours later, when all were in surgery or ICU, Sally sat outside on a sandbag and reflected.

As she had not achieved what she wanted to, or would have back in Australia, Sally realised she needed to change her mindset if she were to help her patients and survive both personally and professionally. In COPING WITH CHALLENGE, in an austere setting with high casualty numbers and the alternative work practices of her colleagues, she decided on a proactive approach to moving forward and ***being resilient***. Using her knowledge of what was needed, she *advocated* for her patients, first speaking to pharmacy. Pharmacy suggested they

re-locate to the ED during a MASCAS, establishing pre-determined orders ‘to go’ that would be issued to Sally as she determined they were needed.

To manage the large number of patients who needed timely assessment and processing to theatre, Sally decided to take a mobile approach, moving around multiple patients at once using her trauma knowledge to anticipate care requirements and direct staff if needed. Implementing her clinical *leadership* skills, Sally made it her purpose to help the surgeons get the patient on the ‘table’ as quickly as possible; thus, starting her own process of *building and supporting the team*. MASCAS subsequently occurred on a reasonably frequent basis. However, the process established with pharmacy improved processing times and US surgeons were happy to collaborate and accommodate the new approach if it meant they delivered their patients to theatre faster.

On the same day as Sally’s first MASCAS, 50 kilometres away at the role 1 Hamish was busy seeing a moderate amount of primary health care, thus starting his process of ***performing clinically***. Hamish discovered none of his team had previously seen trauma or worked much outside of primary health care and no one had any paediatric experience, so he hoped they would not see children. He continued *building and supporting the team* by practising resuscitation drills.

On day four, Hamish did his first on-call shift in the ED. Halfway through they received a critically injured gunshot victim with a head injury. As they worked on the patient, Hamish realised he felt completely out of his depth. He had never seen a patient like this and was just following orders from the doctor, who was also inexperienced at trauma. Later that evening Hamish reflected on the day, realising he did not have the experience needed and that he should keep that to himself while trying to gain more knowledge, allowing him to better support the doctor and provide effective guidance to the medics.

Hamish’s process of COPING WITH CHALLENGE meant he spent the rest of his deployment in survival mode, using any opportunity he could create to obtain experience at the hospital with the support of specialists. Opportunities were severely limited, but he gained enough experience to help build his confidence to the point where he felt he had gained the baseline experience he believed he should have possessed before deploying. He never felt

able to anticipate care, constantly learning on the run and struggling to advocate because he lacked knowledge to defend his position. Hamish considered himself lucky not to receive any patient who died, so there was no requirement for *dealing with death*, although he had prepared himself for this eventuality.

About three weeks into her deployment, Sally experienced her first patient who died in the ED. Thus began her encounters in *dealing with death*. She rapidly discovered that her colleagues had no prior experience with dying or deceased patients and therefore felt unable to help with the task of caring for them. From that point on, as part of *building and supporting the team*, Sally cared for the dying patients as part of ***performing clinically***, never allowing them to be left on their own, washing their faces as a way of telling herself that at least their mothers (although they would not know it) would be pleased to know someone cared. This role also became a way she was COPING WITH CHALLENGE, insofar as it helped Sally make sense of her role in the conflict.

During the months of her deployment, Sally encountered a significant amount of appalling trauma, finding that, despite her prior trauma experience, there was a lot to learn about blast injury and gunshot wounds. Child *humanitarian victims* were common, but Sally generally felt comfortable looking after them because of her prior experience. However, she felt sad at the realisation they would probably not survive once they had to leave the hospital. When others found it difficult to work with injury, Sally gave them an ear to talk to, offering them *emotional support*. Mortar attacks were common and she became used to throwing on her armour while she continued working, telling herself that if it came through the roof there was nothing she could do. She had ***reconciled with the threat*** and hoped those firing the mortars were inaccurate. The worst thing about the armour was that it was hot and heavy.

Simultaneously, Hamish was encountering a number of significant trauma cases. With no prior experience, they were all a very steep learning curve. Hampered by significant inexperience, he discovered what ***dealing with austerity*** meant for his ability to deliver good nursing care. He saw children on a few occasions and, although uncomfortable looking after them, did so because his medics became distressed at caring for one who was critically injured. To help them deal with the emotional effects of managing both trauma and children, he had debriefing sessions each day, thus *providing emotional support*. Mortar attacks were

a rarity and there were no local forces working on base, so Hamish was comfortable that the risk of 'green on blue' attack was minimal.

One day, mid-way through their deployments, Sally and Hamish caught up at the role 3 base, after he had escorted a patient for further investigation. Sally wanted advice on how to approach issues she had identified when *dealing with the enemy* and providing care to enemy combatants. She felt Hamish might understand the situation better because he had more military experience. Sally explained that enemy soldiers came in cable-tied by the hands, blindfolded and pushed from behind. Although she understood and had no time for what they had done, she found this an unnecessary and degrading way to treat a patient. She was, however, unwilling to challenge the soldiers who escorted the enemy, carrying weapons. She was not sure if it was a battle worth fighting, despite ***managing ethical dilemmas*** as part of **CARING UNDER FIRE** being something she was otherwise prepared to do. She was still able to deliver them the care they required. At every opportunity, she advocated for her patients and, if she felt unsure about the ethics of a situation, sought advice from a senior US nursing colleague.

Hamish explained that the combat forces saw the situation differently, but agreed with Sally that it was not their place to judge the patient. Rather, they had an obligation to give unbiased care if the person was brought in for treatment. He told Sally about the enemy patients he had cared for on two occasions and how *dealing with the enemy* became a problem when he was directed to treat allied forces first. Hamish was aware this was not ethical but, with no prior experience at ***managing ethical dilemmas***, he did not know how to question a direction from a higher rank in another force, especially as he was working in their hospital. In the end, he said nothing, a decision that would haunt him for the rest of his deployment and beyond. He did not like what the enemy had done to Australians, but he felt it was not his position to judge them—that as a nurse his role was to be impartial and to provide **CARE UNDER FIRE** to the enemy if that was what was required. In his mind, if a soldier brought the enemy in for treatment, they should not then show their displeasure at the care given by the nurse. It was confronting to be challenged for doing his job and delivering care without question. However, he felt too inexperienced to advocate or use his officer status. He felt unable to demonstrate the clinical *leadership and advocacy* he felt was warranted.

Somewhere, early in her deployment, Sally realised that although she had been IDENTIFYING AS AN ARMY NO from the time she arrived, she was in a setting where it all made sense. She was **CARING UNDER FIRE**, ***managing ethical dilemmas***, challenging her clinical skills, displaying the best clinical *leadership* she could and was there for the dying. Despite ***working with the Army*** for a number of years, she suddenly realised what it meant when people referred to the Army ***family***. At the same time, Sally found it an exciting challenge to be an Army officer while also being a nurse, using her officer status to lend authority when needed to help her patients. She had never really understood what being an officer meant and, more importantly, how it could enhance her role as a nurse. The experience of RESPONDING TO THE ARMED CONFLICT ENVIRONMENT by ***dealing with austerity***, ***working with other cultures*** and ***reconciling with the threat*** reinforced what being a nurse in the Army was all about. Keeping her weapon close and living almost daily with mortar attacks and a constant flow of helicopter traffic bringing large numbers of critically injured patients, produced a defining sense of identity. For her, the clinical work was her reason for being, but her military experience shaped what it meant to be a nurse in the Army. Sally realised she had ***found a new sense of self***.

Hamish had a clear idea of what it meant IDENTIFYING AS AN ARMY NO and ***working with the Army family*** before he deployed, because this was his full-time job. However, because of his experiences on deployment, Hamish realised his sense of identity had changed. Struggling to fulfil some of the clinical aspects of his role, and consequently lacking what he thought was the level of clinical *leadership and advocacy* he needed to display, he ***found a new sense of self*** by realising what he needed to do clinically to be an Army NO.

Hamish was COPING WITH CHALLENGE throughout his deployment, not as well as he would have liked, but he found ways to improve his skill set and meet the clinical demands of the environment. When he arrived home, he wanted to undertake more study, work clinically and develop his leadership capability. He was willing to self-reflect and had a good *support network* at work, although he could not talk to them about what he realised his clinical deficiencies were. Hamish had to carry that burden alone. In the small amount of downtime after getting home, the team gathered together for a bit of fun to ‘decompress’.

Hamish entered the conflict feeling and ***being resilient*** but left feeling exhausted. At the end of his deployment, Hamish *said goodbye* to the place, leaving on the same plane as his team.

Sally was COPING WITH CHALLENGE throughout her deployment, whether it be austerity, the threat, other colleagues, severely injured patients, the heat, dust or food. She felt as though coping was something she had built into her practice and personal approach to life. Although she faced difficulty, taking the opportunity to self-reflect, *building support networks* at work (because there was limited time to relax) and laughing when she could, helped her coping. She went into the conflict feeling and ***being resilient*** and left it feeling stronger, albeit very tired. At the end of her deployment, Sally *said goodbye* to the place, the people and the conflict. She was ready to go home.

6.4.4 Returning Home

Sally returned to Australia on a different flight and arrived at her home airport alone. She caught a taxi to see her parents. For several months, Sally felt a little strange and had a sense of disconnectedness. There were no sirens, no helicopters, no pagers, the bed was soft and there was space in her room. Over about a year, she processed the thoughts of her deployment, deciding that she had done a good job in the circumstances because, in an austere environment, the nature of care needed to change. Sally learned to ***live with her new sense of self***, having gone home more adaptable, decisive and faster than when she had left. There were moments where she needed to *deal with frustration* over the loss of autonomy and collaboration—nowhere at home would allow her to do what she did on deployment. Sally reassessed her life, made a few new decisions about her career and eventually felt that she was ready to go again if the opportunity arose. She had 'refitted herself to fight' and Sally felt her Great Aunt (Army nurse) would have been proud—although it was unlikely she would have tolerated handling weapons.

Hamish returned to Australia and his Army base with his team. He noticed the silence for about a week and realised he kept waiting for the pager to go off. It took him a couple of years to process how he felt about his deployment, deciding that he had not done the job he thought he was capable of and should have done. Although he was unable to forget failing to defend his patients, ***being resilient*** he decided to use the experience as a reminder of what he

needed to achieve to support his corps before deploying again. He never again wanted to be in the position of not having the necessary experience to give his patients the care he felt they deserved.

To remedy the situation for future deployments, Hamish learned to ***live with his new sense of self*** by undertaking study, working in a clinical environment regularly and eventually leaving the ARA for the ARES. He hoped to return to the ARA once he had consolidated his clinical base. Because he remained on a learning curve clinically, he never found a need to *deal with frustration*. He had lost nothing, instead gaining new skills by becoming more adaptable and decisive. Hamish eventually 'refitted himself to fight'. Several years later, he headed off to a humanitarian deployment, feeling more confident and able to fulfil what he believed the role of an Army NO **CARING UNDER FIRE** required.

6.5 Conclusion

This chapter illustrated how the GT of caring under fire operates. The extent to which a nurse can deliver care depends on their ability to undertake the role of Army NO, respond to the dictates of the IAC environment—especially of a clinical nature—and cope with the challenges entailed in these processes. The latter includes their ability to return home, process their experience and prepare for the next deployment.

A nurse such as Sally with significant clinical experience was able to adapt to the demands of the clinical environment, despite significant challenge and a need to adapt to the military setting. She used her experience to overcome adversity for the benefit of patient care and the team she worked with. The result for her was a sense of a job well done. Conversely, as Hamish's story showed, military experience was not enough to compensate for clinical inexperience. After realising he lacked the skill set, he struggled to care as he believed he should, a struggle that ultimately affected how he felt about his deployment. He went home tired and feeling a sense of not having done a good job, although he felt pleased at being able to learn on the run to improve what care he could deliver. This demonstrated a sense of determination to overcome adversity.

This purpose of this case study was to demonstrate how clinical experience in particular—but also military experience and personal preparation—play a significant role in the readiness of an NO to deploy to IAC and deliver care. Moreover, it reinforces how their experiences on deployment affect how they process their experiences when they return home to refit for the next round. In the next chapter, the focus is discussing these findings in the context of the literature.

Chapter 7: Discussion

7.1 Introduction

After identifying that little documentation exists to explain the experience of Australian Army NO in the extant context, this study used GT methodology to rectify this gap in knowledge of what the contemporary Australian Army NO experiences in armed conflict, both personally and professionally. Previous chapters have outlined the findings of this study, the emergent theory and how NO managed both practice and the surrounding environment.

The purpose of this chapter is to discuss these findings in the context of the literature, to clarify existing knowledge against what this study discovered. Using three of Harrison, Birks and Mills' (2021) domains for transitioning to professional practice, the discussion will explore the findings under the headings of organisational (military), clinical and personal readiness. The fourth domain of Harrison et al. (2021) is professional readiness and will not be covered separately in this chapter. This is because NO professional readiness is a combination of clinical and military acumen, meaning that the NO role is a conflated role concept. Chapter Eight will conclude with a review of the problem that led to the inception of this study, linking this to what is now known because of this research and providing recommendations for future research.

7.2 Preparation for Deployment

When asked about their deployment to IAC, NO emphasised a need to be prepared before deploying. Preparation was the readying phase of the deployment cycle, thus discretely separate from the deployment phase. Personal, clinical and military preparation were all considered essential to being able to perform effectively and cope with organisational, clinical and environmental demands once 'on the ground' in an IAC. Importantly, most of their thoughts about preparation were derived from hindsight; after returning home, NO reflected against the backdrop of a deployment about what worked, what did not and why. Some NO realised they had initially been unaware of what was required, subsequently recommending NO be aware of and proactive in addressing their deficiencies so they could maximise their chance of succeeding on deployment.

As described by Harrison et al. (2021), practice transitions, such as to a deployed IAC setting, can involve a reality shock that may lead to doubt and a sense of disorientation, all of which affect the individual's nursing capability. The more prepared a nurse is, the more they are able to mitigate the risk and consequences of reality shock. Given a range of factors, which are outlined throughout the following three sections, the level of preparation NO achieved in each key domain of personal, clinical or military readiness was variable. Levels of preparation influenced how effectively NO were able to navigate and negotiate difficult circumstances once deployed, especially in the area of practice reality.

IAC challenges were significant for all NO. Those NO who felt they performed well because they were well-prepared, were overall positive about what they achieved. Unprepared NO faced challenges in coping with the consequences of IAC and delivering effective care, with some left feeling a degree of inadequacy about the care given but generally satisfied about what they were able to achieve under duress. In a similar vein, Almonte (2009) noted that preparation optimised readiness and the sense of accomplishment nurses felt about deployment. The value of leaving deployment with a sense of accomplishment is discussed with regard to personal readiness.

Preparation tended to inform many of the themes identified through this study, establishing narratives that ran the course of the deployment cycle and shaped the returning home experience. What nurses from this study learned became lessons for future deployment, closing the gap between preparing for one conflict and preparing for the next. These findings build on previous discoveries and reinforce the importance of being well-prepared for deployment. Frequently nurses tended to identify this need after they returned home and reflected on their experiences (Almonte, 2009; Andersson, Dahlgren, Lundberg, & Sjostrom, 2007; Goodman, Edge, Agazio, & Prue-Owens, 2013; Griffiths & Jasper, 2008; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010).

7.3 Military (Organisational–Industry) Readiness

Military readiness refers to the preparedness of an individual to work effectively within a military organisation, to understand its purpose and the environment in which the military operates and to identify what the organisation expects of the individual. This section focuses

on what this study has revealed about what constituted military readiness for NO, why it was important, how it was achieved and analyses how the militarisation of nurses has influenced their role and identity.

Although aspects of military influence on nurses' lives have been described in studies examining deployment (Biedermann et al., 2001; Finnegan et al., 2015 Germaine & Lounsbury, 2007; Griffiths & Jasper, 2008; Haynes-Smith, 2010; Kelly, 2010; Parish, 2007; Rushton et al., 2008; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010), the process of nurses adapting to the military has not. Therefore, as a byproduct of investigating the process of deploying to IAC, this study presents an understanding of what this adaptation process involves. There were two essential components to NO developing military readiness. The first was to develop an appreciation for the unique demands made by the Army system on their life, achieved through socialisation to the structure, culture, language and purpose of the military organisation. The second requirement was to work out what it meant to be an NO, with the military readiness component essentially about identifying and managing organisational influences on practice to maximise patient outcomes.

7.3.1 Army Acculturation and Militarisation

The process of socialising to the military required acculturation, a term used in cross-cultural psychology to describe how someone moves towards a culture and becomes part of it—developing psychological characteristics compatible with that particular culture (Fung, 2012; Lonner & Malpass, 1994). For NO, it was necessary to acculturate to a point where they could understand what the military wanted of them and how the organisation influenced clinical practice. Simultaneously, NO developed coping mechanisms that functioned in response to familiar organisational structures. Familiarity and a sense of comfort with the military was important for mitigating acculturative stress, which occurs when an individual is exposed to a different culture or dangerous environment leading to stressors (Lonner & Malpass, 1994).

For NO, this meant learning how to comply with security structures, such as the carriage and use of weapons, reconcile with mission guidelines and recognise the characteristics and

influence of the Army 'family' on their lives. It was also important to appreciate the unique legal demands of the system, which included authority to direct subordinates and work out how to operate in the austere environment, which was the more common deployed Army setting. Extrapolating the domains of organisational readiness established by Harrison et al. (2021), the abovementioned requirements illuminate what it meant for NO to be ready in military terms, including the challenges around achieving this objective, complementing understanding of what adapting to the military means.

The discovery that military readiness among NO was inconsistent and employment status tended to influence where NO found themselves on the military readiness continuum, is a finding about military adaptation that has no direct external reference in the literature. However, the finding that a key driver of military readiness was duration of exposure to the military and Army training reflects, in part, the time aspects of practice readiness (Benner, 1984; Harrison et al., 2021). Equally, where the permanently employed tended to be well-prepared militarily, ARES NO demonstrated the value of both length of service and the application of a positive attitude to maximising engagement with the military—and, therefore, being well-prepared. Regardless of employment status, NO lower on the military readiness continuum relied on pre-deployment Army training as a way to elevate their preparedness.

Associated with this unique knowledge about NO military readiness is the consequence for NO of deploying with variable levels of awareness about the culture of the Army, familiarity with weapons and security structures and socialisation to the concept of command. For NO who deployed with inadequate levels of military understanding, there was an increased risk of security breaches, frustration and acculturative stress associated with having to learn on the run how to 'be green'. In Lonner and Malpass' (1994) terms, these NO lacked the organisational familiarity to mitigate the stress produced by a relatively unfamiliar organisation in a dangerous environment. Although the experience of deployment filled any knowledge gaps about the influence of the Army, it was not without difficulty for the militarily unprepared, who struggled with aspects of military influence on their practice and personal life.

7.3.1.1 Mission

Understanding the Army mission provided NO with guidelines about the purpose and scope of a particular deployment, which was important to both expectation management and to working effectively with the organisation. The military mission in IAC was not primarily to deliver healthcare and all health-related activity needed to nest carefully within the broader mission of prosecuting military action and associated risks. Moreover, mission guidelines were designed to ensure a mission did not inadvertently undermine the view locals had of their health system by delivering care the local system could not support and it was also essential to effectively manage resource constraints arising from supply limits. Thus, healthcare decisions in accordance with mission guidelines determined who would receive care and to what extent.

By virtue of the Nursing and Midwifery Board of Australia Code of Conduct (NMBA, 2008, 2018a), NO instinctively expected healthcare delivery would still align with the notion of equity, no matter who was requiring care. This established a point of tension between mission guidelines and the nursing code of conduct, which required reconciliation in advance of deployment through socialisation to mission purpose. NO who were acclimated to the military, and understood mission purpose, were able to achieve this reconciliation, albeit with an element of difficulty when faced with the reality of humanitarian victims. As Agazio and Goodman (2017) have explained, military nurses must always achieve a fine balancing act, managing humanitarian care in the context of the primary mission to care for war fighters.

NO who were lower down the military readiness continuum—who were unaware of, or not prepared for, the reality of working with mission guidelines—believed that because they had to deny care altogether or deliver inequitable care to civilians, the mission clashed with what they believed was equitable healthcare. This theme of needing to understand the mission to work effectively with the military and avoid personal frustration or distress resonates with studies examining the war in Vietnam and, more recently, during a humanitarian mission (Almonte, 2009; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). The general implication is that nurses need to prepare for the reality of inequitable care as part of their acculturation, so that they are able to cope mentally and clinically with inconsistent care

delivery—noting that the experience of deployment will also influence how they cope on returning home.

7.3.1.2 Reconciling with the Threat

The experience NO in this study had of a surrounding threat provides insight into how they managed to live with this phenomenon, enhancing understanding of a relatively under-researched issue. Specifically, these NO dealt with the risk posed by the threat by using a range of mental strategies, including finding out where the threat was, what security structures kept it at bay and how to behave on a personal level to maintain safety. Where Griffiths and Jasper (2008) suggested perceptions of distance cushioned the sense of threat, permitting an element of detachment from the reality of war (citing McManners, 1994), Australian nurses viewed the situation differently, largely because of circumstance. A mobile 'frontline' and a reality of regular close attacks on bases meant the idea of distance offered inconsistent comfort. In these circumstances, a sense of protection came largely from knowing the perimeter was secure and a range of internal security structures existed. Notwithstanding this, there were NO who worked in armour while attacks were in action.

For another group of NO who participated in this study, the perimeter turned out not to be secure and they were exposed to a relatively new phenomenon in the risk of a 'green on blue' attack—where the threat came from inside the perimeter from supposedly friendly forces. In this instance, neither the comfort of distance nor the safety of being inside the wire existed. To manage this situation, nurses prepared themselves pragmatically for the eventuality and applied a persistent wariness to their interactions with local forces. This is a unique finding, not identified or discussed in previous literature, raising implications for how NO prepare to maintain personal safety while delivering care in an unbiased manner.

Socialisation to weapons was a part of the Army persona and an organisational requirement to manage a threat. This process began on entry to the military and gained a heightened sense of purpose on deployment. From a starting point of discomfort for some, overall weapons became easier to handle. Their persistent presence, requirement to practise regularly and surrounding threat increased familiarity and comfort. This accentuated a positive aspect of militarisation and helped the NO overcome any barriers, without detracting from their

primary role of caring for the sick and injured. Nurses had a clear sense of purpose within an organisation focused on the weapon—they focused on repairing the effect weapons produced and walked a fine line between complying with international law and carrying a weapon in self-defence. As with most other findings in this study around nurses and their military socialisation, this finding is unique, demonstrating the absence of literature in respect of NO and military requirements such as weapons. It provides a degree of understanding about how NO reconcile with a weapon, despite its role in producing the injury nurses treat.

7.3.2 Identifying as an Army Nursing Officer

The process of transitioning to and identifying as an Army NO was not comprehensive. The military emphasis was on aligning with the broader organisation and learning what it meant to be an Army officer in the general sense. This process was highly structured. However, as described throughout the findings chapters, there was a complex interplay of organisational barriers that prevented NO receiving specific socialisation to their role—including a perception by nurses that the Army does not understand them. This is important, because NO needed to locate and hold the delicate position of non-combatant nurse (and leader) in a military organisation, a process requiring understanding by the Army as to how they fit in. The finding that NO did not receive specific socialisation to their role concurs with a similar finding in a study of British military nurses (Griffiths & Jasper, 2008), despite nurses in both the Australian and UK military forces supporting troops for over 100 years.

For the NO who participated in this study, being able to care for those injured during conflict, particularly soldiers who were fighting battles, was an honour. It was also a reflection of their humanitarian philosophy. Participants viewed their primary purpose as cleaning up the aftereffects rather than fighting in the conflict. There was no suggestion that they perceived a professional conflict in serving as nurses for an organisation for which injury was an inherent risk and byproduct of a business dealing with conflict. This point gives rise to two important issues.

The first issue relates to external perceptions of people who are members of the military and the second to how nurses fit within the military. In their review of military sociology, Durango, Benavides, Castillo and Arrieta-Lopez (2022) observed that military membership

can be viewed as directly supporting war as a tool for resolving conflict, which at first glance may seem a reasonable conclusion and one which contradicts the ethos of nursing. However, as von Clausewitz (1832) has noted, it is an assumption that a person's membership determines their attitude, rather than their actions. Moreover, it can be argued that in the modern age, non-combatant supporting elements to a defence force do not directly contribute to fighting and are well protected by international law (e.g., Geneva Conventions, 1949), opening the door to accepting that a military member may not exist solely for the purpose of supporting war.

Further, there is nothing in the Nursing and Midwifery Board of Australia Code of conduct for nurses (NMBA, 2008, 2018a) that expressly forbids military membership. Thus, it was how the NO acted and positioned themselves, rather than the organisation they worked for, which was important—especially if they were to maintain obligations to the code of conduct for nurses (NMBA, 2008, 2018a). Although they were military members, NO provided care regardless of the patient source, separating themselves from war as a tool and focusing on their role in repairing its effects by aiming to ensure all participants in a conflict received the healthcare they were entitled to under international law.

This suggests NO used several mental strategies to maintain a focus on their role in repairing the consequences of conflict, while simultaneously reconciling with conflicting agendas (between fighting wars and delivering healthcare). In juxtaposition to the nurses in Griffiths and Jasper's (2008) study, who felt conflicted by what they perceived were dual nurse and warrior roles, Australian Army NO provided insight into how they reconciled with the perception of opposing positions. They viewed themselves as a nurse in the position of an officer (one role) who held a weapon for the sole purpose of self-defence.

This study identified key components of the Army acculturation process specific to NO, elucidating what they needed to achieve when adapting to their organisational role and the singular entity of NO. This included identifying how the two professional identities (nurse and military officer) were complementary and how they conflated as the role of NO. Doing so meant understanding the demands of each, how to de-conflict tensions and how to use each to the benefit of the other; thus, reconciling any duality. One example of this is how a nurse could use the qualities of an officer to promote clinical leadership and advocacy. NO

had to reconcile differing priorities between those who prosecute a war and those who clean up the subsequent injury, and to work out how to apply nursing within the Army context.

The other challenge for NO, compared with combat officers, was their non-combatant status by virtue of their primary nursing role and protected health status (Geneva Convention, 1949). In addition to extant obligations to the code (NMBA, 2008, 2018a), non-combatant status posed implications for how they acted in a military sense, requiring nurses to be clear on how they met military demands without breaching their status. This included, for example, accepting the need for weapons as part of their right to self-protection under the Geneva Convention (1949), thus continuing to fulfil the role of a nurse, rather than becoming a warrior. Therefore, mentally, the NO needed to subsume the Army officer combatant beneath their nursing non-combatant status.

This study provides insight into how NO achieved and maintained the delicate balancing act of non-combatant in a combat organisation. One of their challenges was learning to understand how the uniform NO wore blinded others to the different status of an NO. Simultaneously, the NO needed to learn how to deal with demands counter to their protected status. This included learning how to defend their clinical and ethical obligations as a nurse, in addition to their moral obligations as an officer. This was a challenge to achieve and there is further discussion on ethical dilemmas in the section on clinical readiness.

7.3.2.1 Progressive Militarisation

This study demonstrated that a lack of either clinical or military acumen made it hard to maximise the NO role. Military knowledge was essential for working and functioning in the organisation. Equally important was the necessity for NO to be practice-ready because military readiness was not enough to overcome clinical deficiencies.

In an historical analysis of the first one hundred years of Australian Army nursing, Bassett (1992) noted that Australian nurses became increasingly militarised over that period. After 1991, nurses became fully militarised and were expected to meet the same baseline weapon and fitness standards of all Army personnel. As with all Army personnel, nurses entered a hierarchical system with the authority to dictate all facets of their professional lives. This

study illustrates three consequences of this militarisation for ARA nurses: a largely non-clinical primary role, limited ongoing practice and insidious development of a falsely low expectation of how much clinical experience they needed to deploy.

In the twenty-first century, the primary role of the NO is administration and supervision—prioritisation of non-clinical tasks and training is more important than clinical practice and decisions about how much clinical practice NO will acquire, and where, are made largely by non-nurses. The result is limited clinical time for the permanently employed (ARA), because ARES NO usually work clinically on a permanent basis. Regardless of employment status, the NO job role promotes administrative capability over practice and requires NO to prepare others for deployment, at the expense of themselves. This occurs on a background of many nurses joining the Army with a practice foundation consisting of only a few years full-time experience if recruited through the undergraduate system (an important recruitment pathway).

It appeared to NO that the Army had a simplistic view of nursing and thought it knew what nurses did but demonstrated a lack of understanding about nurses by sacrificing ongoing practice development and skills maintenance. The Army focus was overtly on militarisation and military readiness over clinical performance, fitting nurses into the predominant organisational paradigm of a combat model for their role, which is a training path the Army understood. A culture of combat readiness may have acted as an unconscious barrier to appreciating the needs of healthcare professionals, while simultaneously driving their militarisation.

Additional influences promoting militarisation over clinical effect included the suggestion that the organisation thought a doctor would be available and appropriate to guide inexperienced nurses and compensate for skills NO may not have. This is despite role and professional differences, the separation of nursing as a professional entity since the 1800s and the reality that doctors could also be inexperienced. This traditional attitude to nurses, where there was a desire to subsume control of their behaviour to within medicine (Bassett, 1992), remains extant, albeit at a subliminal level and possibly because of the structure of military health. It is equally true that nursing has evolved over the last 100 years, with

ongoing debates about the nature of nursing and what nurses do (Harrison et al., 2021), complicating the ability of non-health organisations to understand the nursing workforce.

In another new finding, the Army view that NO did not need ongoing clinical practice and were ready for deployment if they met military requirements, appears to have produced an unintended effect—the development among ARA nurses of a false expectation that, despite a lack of consolidated clinical experience and minimal ongoing experience or currency, they were ready to deploy. This perception also affected NO who completed a specialist qualification and considered they were ready with no further clinical consolidation in their new area of practice. Low to absent levels of ongoing clinical placement time meant exposure to civilian nursing standards that could act as a source of reflection was often non-existent. Combined with this lack of external stimulus, NO accepted the Army view—over time developing a self-perpetuating culture of low expectation with regard to a need for clinical practice. This effect was most pronounced among nurses recruited via the undergraduate system because they had the least exposure to civilian expectations of practice.

With regard to the background of Bassett's (1992) research, this study suggests—via another new finding—that the effect of overt militarisation has been to take NO away from their primary clinical role, thus eroding the clinical effectiveness of nurses who depended on the system for their clinical development and capability. This, in turn, affected patient care and the personal life of the nurse. Ironically, where military sociology has aimed to better integrate military and civilian environments (Durango et al., 2022), militarisation of NO has had the opposite effect.

There were several consequences to the relative level of inexperience among some deployed NO. As was the case for their military nursing forebears, once deployed, NO who discovered they were clinically unprepared were forced to adapt as quickly and as best they could (Bassett, 1992; Biedermann & Harvey, 2001; Biedermann et al., 2001; Rushton et al., 2008; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). Moreover, contrary to an internal Army view that they could learn on the job, there was no one to guide them on deployment, leaving them up to their own devices to sort out their clinical ability. Further, they found that clinical inexperience significantly inhibited their ability to advocate and demonstrate clinical leadership, key traits of the NO. This left them unable to maximise their

nursing capability in the pursuit of quality care. Using a military analogy, this was the same as deploying an infantry soldier with a low level of tactical understanding, less ammunition than their colleagues and lower capacity to maximise what they could achieve with the ammunition in their possession.

A secondary effect for the inexperienced was the level of stress they encountered trying to cope and compensate, something that affected the NO personally. The emotional stress of deployment was heightened, which is akin to a finding by Biedermann et al. (2001). Of concern are findings by Baker, Menard and Johns (1989), Scannell-Desch and Anderson (2005) and Ayala and Carnero (2013) that more experienced nurses were less likely to develop burnout or post-traumatic stress disorder (PTSD). This suggests that experience offers protection when coping with deployment and that inexperience is likely to contribute to adverse personal consequences.

Expectation by military organisations that simply being a nurse meant nurses could adjust to the clinical demands of war and, therefore, deploy clinically unprepared, is a recurring theme across the breadth of Australian Army nursing history and the history of countries such as the US (Bassett, 1992; Biedermann & Harvey, 2001; Biedermann et al., 2001; Rushton et al., 2008; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). Combined with other findings from this study—that military readiness predominated over clinical preparation—this suggests a perpetual misunderstanding by military organisations as to where and how nurses nest within the system. This produced confusion among nurses as to what they should be doing and frustration around what they could be doing.

What this study contributes regarding this ongoing issue of inexperienced military nurses being deployed is twofold. The first is detail on the overt effect of increasing militarisation; the second is reinforcement of the idea that the Army did not realise NO may face situations they were not ready for—either because they lacked knowledge and skill, or because they possessed a skill set that did not match what they would be dealing with in an IAC. A system with an unacknowledged blindness to the concept of clinical experience relegated clinical readiness to a second order effect, driving the deployment of inexperienced nurses in the twenty-first century. Consequently, four decades after the war in Vietnam and the findings of Biedermann et al. (2001), Australian nurses in this study were still facing the same issue

of clinical unpreparedness—an issue that, given the erosion of clinical effect by overt militarisation and a culture of low expectation, may be worse now than it was 40 years ago.

7.3.2.2 Finding a New Sense of Self

Through the process of exploring participant experiences in IAC, concepts of Australian Army NO identity emerged, providing new insight into how NO perceived themselves. This can be largely understood in terms of Tajfel and Turner's (1979) social identity theory, which describes how individuals identify with a group. In this study, participants demonstrated significant positivity and pride in their status as an Army NO. Their use of proactivity to improve their readiness prior to deployment and to counteract organisational barriers could be described as social competition (Tajfel & Turner, 1979). Nevertheless, because of persistent inhibitory organisational barriers, success at being professionally ready was individual rather than on a group level.

Since Bassett's (1992) work, these are the first perceptions of contemporary Australian Army NO identity development that have been captured. For organisational reasons, NO did not receive specific socialisation to the clinical and ethical aspects of the role, and the role they were prepared for often differed to the experience of deployment. The Army socialisation process emphasised militarisation of the nurse (to officer), rather than promoting adaptation to the NO role. Ultimately, development of the NO identity occurred in varying degrees, dependent upon the Army training at a given point in time, employment status, clinical experience and attitude of individual NO. Thus, NO went on deployment with variable views on who they were, what being an Army NO meant and what they needed to do.

The experience of deployment as NO with the military fundamentally shaped a refined sense of self and professional identity. As a consequence of their transition into IAC and subsequent challenges, all NO in this study perceived a degree of transformation in who they were and what they needed to do when deployed as a 'military nurse'—in each case the subset was 'Army Nurse'. Nursing on deployment was a place where the military nursing identity made sense. A similar process of transformation was described by Levasseur (2003)—who examined the experience of nurses in Vietnam—as the forging of an authentic professional

identity in response to war. A transformative experience was also observed by Rushton et al. (2008) when studying nurses who deployed to the first Gulf War.

In studies by Biedermann (2017), Rushton et al. (2008) and Scannell-Desch and Doherty (2010), authors found that camaraderie and closeness developed between nurses and their military colleagues during deployment. This study revealed a similar finding, while simultaneously enhancing understanding, by demonstrating how this process occurred and how it contributed to coping on deployment (coping is discussed in the final section on personal readiness). From a position of recognising the Army's unique social construct and needs during preparation training, and establishing a sense of the Army community, deployment had a catalysing effect. The experience of working with the Army family and its way of doing business offered a sense of familiarity, structure, safety and support in an unfamiliar and dangerous world, which in turn had the effect of adding to the repertoire of protective factors NO used to cope with their deployment. The emotional connection between the NO and Army was heightened, affirming a sense of 'family' and their identity within the family. Adversity promoted a sense of closeness and solidarity and the team worked together to protect each other. NO saw the effect of injury on the 'family', feeling a sense of loss they may not have felt in a hospital in Australia.

In summary, this study has revealed new understanding as to how the military can influence both personal and professional experiences, with a reciprocity between the Army and individual not found with non-military organisations. Thus, readiness to work with the military is essential to personal and professional functionality. The military readiness process requires acculturation to both the organisation and NO role, with militarisation having a distinct effect on NO identity, role and practice.

7.4 Clinical Readiness

Whether they deployed in a leadership or clinical role, an ability to respond to the practice demands of IAC was the primary concern of the NO for whom nursing was the purpose of their existence in the Army. Clinical demands involved a threefold challenge: having a level of overall clinical readiness adequate to meet the scope of practice required for the situations they experienced, being able to respond to the environmental influences on care delivery and

demonstrating an ability to manage associated ethical implications. In addition, an ability to lead clinically facilitated the delivery of care. The purpose of this next section is to focus on the reality of the deployed environment and to analyse what level of clinical readiness was required to meet the nursing demands of an IAC zone.

7.4.1 Deployed Clinical Landscape

7.4.1.1 Dealing with Austerity

The deployed landscape was challenging and unpredictable. Dangerous and austere conditions were a constant in the IAC environment, with potentially low supply leading to high demand for resources. This placed a number of possible physical restraints on care, with familiar resource-dependent approaches to care translating poorly to the austere environment. Therefore, to deliver care, NO needed to mitigate the effects of limited resources, which primarily meant possessing a low reliance on technology to assess, interpret and decide, plus an ability to adapt practice in accordance with principles.

The NO needed to be able to 'go basic', keep it simple and utilise only what they absolutely needed to deliver care. This, in turn, placed pressure on their clinical judgement and involved time-critical decision-making. A number of authors have described similar IAC challenges, providing a clear context for analysing the military nurse experience (Biedermann et al., 2001; Goodman et al., 2013; Lindblad & Sjostrom, 2005; Sadhaan, Brown, & McLaughlin, 2022; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). There is also a correlation between the findings of this study and aspects of disaster nursing competence, where nurses also find themselves in austere and potentially dangerous environments (Fletcher, Reddin, & Tait, 2022; Harthi, Thobaity, Ahmari, & Almalki, 2020; ICN, 2019). In a similar finding to Scannell-Desch and Anderson (2005), NO in this study concluded that nurses graduating in the twenty-first century might struggle with meeting the demands of the austere space. This is because the technology revolution has invaded healthcare, producing reliance on equipment to shape clinical assessment and, thus, affecting clinical reasoning. Nurses would therefore face increased difficulty with adapting to non-technology dependent skills—in terms of both skill and clinical judgement—if pre-deployment training did not prepare them.

Bearing in mind the nature of the IAC environment, several authors have identified the importance of possessing a mindset that is responsive to changing situations (Rahimaghaee, Hatamopour, Seylani, & Delfan, 2016; Rivers et al., 2013; Rushton et al., 2008). To further understanding of what this means in the context of Australian NO, this study elucidates some of the skills NO required to achieve adaptation of care. Underpinning their ability to adapt was adaptive intelligence, a concept described by Sternberg (2019) as the ability of the mind to change in response to new demands, to adapt to a new environment or situation. This required underlying knowledge and a well-developed mental flexibility, permitting decisiveness. For NO, adaptive intelligence initially supported acculturation to a system not focused on healthcare and, subsequently, their transition through IAC.

In the deployed clinical environment, adaptive intelligence was required when responding on the run to a casualty influx in an austere setting where people and resources were limited, or to a base that was under attack while care was being delivered. Importantly, the ability to respond was predicated on possessing the clinical judgement to recognise what was happening and prioritise and decide quickly, without focusing on a task-oriented process. This required knowledge, skill and clinical experience. In an example of what Sun Tzu, the ancient Chinese military strategist, would have described as planning for alternate eventuality to adapt to changing circumstance and seize opportunity (Cleary, 1991), this study also demonstrated how responding rapidly to changing circumstances was maximised by prospective planning of alternate clinical COA. This, in turn, reduced the stress associated with having to identify a plan in the midst of a time-critical situation. Prior exposure to austerity in a non-conflict setting (such as remote Australia) facilitated coping because it gave the NO understanding of, and practice at, preparation and alternate planning and an early warning of what might occur on deployment.

7.4.2 Caring Under Fire

7.4.2.1 Performing Clinically

In a similar finding to Biedermann et al. (2001), Scannell-Desch and Anderson (2005) and Scannell-Desch and Doherty (2010)—who studied nurses deployed to Vietnam, Iraq and Afghanistan, respectively—NO in this study experienced levels of patient trauma not

previously witnessed. Improvements in aeromedical retrieval techniques, and the consequences of both weapon capability and military tactics, produced trauma on a potentially large scale. Resurgence of the IED as a weapon of war revealed its destructive effects in the form of extensive traumatic injury, with multiple traumatically amputated limbs and profound head injury common. A learning trajectory on the nature of blast injury occurred for all nurses, with the curve steepest and most challenging for the inexperienced who had little to no exposure to trauma. The physical senses were assailed by the sight and smell of destroyed human flesh and the destruction of mainly young lives.

This study supports previous findings that the nature of trauma seen in IAC produces stress for nurses working with injured patients and that prior experience is essential to promoting coping (Biedermann & Harvey, 2001; Biedermann et al., 2001; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). Because the time-critical nature of patient injury was combined with reduced resource availability—including lower staffing levels and higher patient to nurse ratios—NO needed to be able to work autonomously and deliver care to patients often close to death, meaning that the usual approaches to trauma care needed to vary. The imperative was to deliver the patient to the OT as quickly as possible. This meant NO developed a level of speed they had not previously utilised.

7.4.2.1.1 Dealing with Death

Patient death was an inherent risk in the deployed IAC environment and a challenge for those caring for the dying patient. Dealing with the dying patient before and after death is an integral aspect of nursing practice and a privilege (Hodge & Varndell, 2018). This does not mean it was without difficulty for the NO, rather a process requiring emotional adaptation through clinical experience. The value of prior experience ensured the NO was able to manage the complexities of a dying patient in IAC, where emotions were more heightened and ethical challenges around dying existed.

Advancing understanding of the NO experience with dying patients in an IAC setting, this study sheds light on how NO viewed and coped with the process. What has been learned is that NO used several strategies to create a mental comfort zone for dealing with and accepting the dying process—the concept of mental comfort zones is explained in the section on

personal readiness. Before deployment, NO prepared 'their headspace' by contemplating where the dying patient fitted into their role and accepting that death was an unfortunate byproduct of conflict that they hoped not to see. To deal with and accept the risk of death, NO used three primary strategies. Specifically, they considered it was a privilege to care for dying soldiers and civilians; that everyone should be given a chance to survive while accepting there were limits to what could be achieved; and, most importantly, that patients deserved to die with dignity. At the same time, by accepting they could not save everyone, NO knew there was a point at which they needed to let a person go.

Complicating the process of dealing with death, like their US counterparts (Agazio & Goodman, 2017; Scannell-Desch & Doherty, 2010), NO experienced ethical dilemmas. For Australians, the main challenge was around a perceived inequitable approach to death by other forces. They found it difficult to hear patients spoken about inhumanely or to see patients left to die alone unless an NO chose to stay with them. The reasons for this inequity and implications for NO preparation are covered at the end of the clinical readiness section. Notwithstanding unexpected ethical dilemmas, the main message shared by NO was that preparation to deal with issues such as death, particularly of young solders, is critical. This linked their experience with previous findings, revealing a recurrent theme for military nurses (Scannell-Desch & Anderson, 2005).

7.4.2.1.2 Building and Supporting Teams

In a new finding, as an apparent extension of their caring role, NO found themselves providing emotional support beyond their patients—to their health colleagues and their patients' military teams (e.g., other soldiers). The reasons were varied. Frequently the experience of the dying patient was something other healthcare providers struggled with and, more commonly, it was part of the daily process of supporting a team and keeping it together under duress. Importantly, the ability of nurses to manage this demand required a high level of EI. Moreover, there is no evidence from participants that this extension of their role had a negative effect on their wellbeing. In fact, the opposite may be true.

In studies by Finnegan et al. (2015) and Rushton et al. (2008), the importance of cohesion, preparation, collaboration and communication among teams was identified. This study

develops this concept by providing detail on why the team was important to Australian NO and how they worked through team-building with other cultures. Overall, an emphasis on the team existed in the minds of NO as part of the general military approach to how they stayed safe and achieved the mission. Professionally, NO understood teamwork in the context of Australian hospital-based work, which places an emphasis on a multicultural model to ensure inclusivity and diversity—both among patients and staff (Hodge & Varndell, 2018). Thus, NO were experienced at and expected to have a central role in building and maintaining a team.

On deployment, because demand often outstripped supply in terms of people and resources, especially in hospital settings, NO found themselves fulfilling team-building roles and collaborating to get the job done. NO working as Platoon Commanders focused on a smaller team with a primary healthcare and resuscitation focus. Thus, the team-building context varied but the objective remained the same.

7.4.2.1.3 Working with Other Cultures

A primary challenge with team-building was inter-cultural relations, especially when deploying to work embedded with another culture. From the familiarity of the Australian healthcare system and its model of multiculturalism and diversity, a number of NO deployed to work with another force. They found themselves working with people from varied cultural backgrounds, an exciting, challenging and, at times, unpleasant experience. They were exposed to a range of cross-cultural issues, including alternate views on who should receive care and differing opinions on how care should be delivered.

This finding resonates with explorations of the nursing experience during the wars in Vietnam, Iraq and Afghanistan, where cultural challenges occurred when working with allied forces and civilians (Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). At the same time, this study illuminates how Australian Army NO managed the process and integrated with their counterparts in other forces. Despite military acculturation, which promoted engagement with the Army and to some extent with other military forces, cultural competence was needed to manage collegial interactions, decisions about care and team-building activities. The term cultural competence is yet to be clearly defined but, according

to the American Psychological Association (DeAngelis, 2015, p. 64), it can be described as an ability to 'understand, appreciate and interact with people from cultures or belief systems different from one's own'. Clinical experience enhanced cultural engagement because it made adaptation and critical analysis of a clinical position easier.

An acculturation process underpinned learning to work with others, with the onus on the NO to adapt because they were essentially on someone else's ground, where different rules predominated. Key strategies used effectively by NO were an overt willingness to see the other side, be pragmatic and be open to learn new things. They applied an outward empathetic view to their interactions. Although these strategies worked for all, clinical inexperience made the process more difficult because of a general lack of knowledge and experience in working with a range of nurses from different backgrounds, and a lack of confidence in their own actions, especially where differences in health practice and health structure existed.

Eventually NO acculturated towards their counterparts, finding points of commonality, particularly when nurses picked up the language of the allied force and were able to spend time with them after work. However, this took time and, in the interim, a number of NO found themselves on what Cleary (1991), citing Sun Tzu, called heavy ground—they were deep inside unfamiliar territory. At times on their own (as Australians) in an unfamiliar system, NO were learning on the run and dealing with significant stress caused by points of tension over their presence, different ethical viewpoints (discussed later) and adverse views of Australian approaches to care (e.g., Australians washed their patients too much) and, in particular, who should receive care and how. For example, an NO was told to alter their standard of care when caring for the enemy.

A second cultural issue concerned the patient cohort that comprised war fighters, local forces, humanitarian victims and enemy. The IAC environment produced a diverse and complex array of casualties, including Australian and allied force personnel, local security forces and civilians; thus, exposing NO to a range of language, political, cultural and ethical issues. The care of this varied and vulnerable patient population falls under the umbrella of transcultural nursing, which requires nurses to demonstrate cultural competence.

To be culturally competent, a nurse needs awareness of their own worldview and how this may differ to others, be interested in understanding the culture of others and know how to implement care that is acceptable to a patient while achieving an identified clinical outcome (Hodge & Varndell, 2018). It also requires insight and the EI to see a situation from another's perspective—to adapt care to meet cultural requirements where possible. More recently, this is referred to as culturally safe and respectful care (NMBA, 2018b).

According to Leininger's 1991 culture care theory, culturally congruent care will produce better outcomes in terms of compliance, reduced stress and overall wellbeing for the patient (Anderson & Boyle, 2008; Leininger, 2008). However, as this study highlights, achieving this in the IAC setting was a challenge, because the threat was mobile, the nature of enemy action was insurgency and some children were coerced into supporting enemy activity. NO needed to apply a persistent wariness to their interaction with all personnel and patients, which established a natural barrier to truly culturally congruent and safe care.

Australian NO received some cultural orientation during pre-deployment training, although, in retrospect, it was not enough to cover clinical transcultural issues, especially when complicated by the ethical dilemmas associated with caring for humanitarian victims or the enemy. It is unclear whether the Army assumed NO would be instinctively able to care for other cultures without additional training, although this is likely considering the previously identified misunderstanding about the NO workforce. As this study reveals, culturally congruent care is important but to achieve this in the IAC setting, where a threat potentially hovers on the periphery of all interactions, is tough. Thus, specific training on how to deliver transcultural nursing in IAC is required.

7.4.2.1.4 Children

A particularly exigent area of concern in the transcultural patient cohort was the potential to care for children as part of the broader IAC reality. This is a recurrent theme in the literature, with several authors identifying this as an area of concern for military nurses on deployment (Almonte, 2009; Finnegan et al., 2015 Freyling, Kesten & Heath, 2008; McGuigan et al., 2007; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). Mission preparedness played a potential role in providing an early warning to NO that they might

need skills in the care of children, thus enabling adaptation to the challenges. However, not all missions clearly identified the likelihood of child victims, with the primary mission to care for soldiers pre-eminent. In reality, children could be presented for care as part of the bigger international and conflict picture. Therefore, in keeping with the previously identified theme of clinical unpreparedness, most NO deployed without any paediatric experience, then found themselves having to expand their scope as best they could to deliver safe care. In itself this was stressful and drew heavily on coping mechanisms.

A secondary draw on the ability of NO to cope with the care of children concerned related ethical dilemmas (discussed in more detail later in this section), an issue also identified by Almonte (2009). As exposed in this study, attempts to deliver effective care were juxtaposed against the reality that patients arrived vulnerable from malnutrition and were then—because the conflict had damaged local infrastructure—discharged to a lower level of care (local nation healthcare institutions or home). In response to Goodman et al.'s (2013) observation that there is scant literature on the topic of providing care to host nations during armed conflict, these findings add to what is known about this under-reported issue. Many of these children died because ongoing care was not available. Consequently, some NO experienced acculturative and moral distress, complicated by perceptions of inequitable care and mission unpreparedness, with potential implications for how they coped both generally and when they returned home.

7.4.2.1.5 Clinical Leadership and Advocacy

This study illuminated a reciprocity between the nurse and Army, with leadership a key element of this exchange. Leadership is integral to NO capability, to ensure the delivery of care and compassion in healthcare (Finnegan et al., 2015). This includes the courage and conviction to advocate for patient care. To maximise leadership potential, NO needed to reconcile the nurse and officer facets of their role, insofar as both aspects influenced leadership in the clinical military context. In reality, several factors inhibited achieving this outcome.

For most NO, leadership was practised in a general military sense, such as being a Platoon Commander. Further, low levels of clinical practice meant some NO had little experience at

making robust clinical decisions in response to complex situations—decisions that were grounded in knowledge and practice. Moreover, a lack of socialisation to the NO role, and specifically what clinical leadership meant in a military setting, ensured NO needed to follow a self-driven journey on how to lead clinically in response to varied situations.

In similar findings to other researchers—who identified deployment as a driver for improved organisational and leadership skills in military nurses—the IAC environment encouraged NO clinical leadership development through necessity (Rushton et al., 2008; Finnegan et al., 2015). To adapt rapidly to the clinical demands of IAC and to lead others, NO used their clinical acumen, conflict management ability and communication skills. Thus, what they could achieve as clinical leaders ultimately depended on clinical knowledge and experience. This meant the less experienced NO struggled to provide clinical leadership, to defend a clinical position and advocate. However, this study also demonstrated how sheer determination to learn on the run enabled some NO to overcome major issues. Admittedly, they did not reach maximum capacity and experienced very high levels of stress that may have led to post-deployment challenges.

Leadership is a way to exert influence and is closely linked to the concept of autonomy in practice. Key aspects of professional autonomy include independence in decision-making, utilising one's own competence and controlling outcomes (Lyons, 2002; Pursio, Kankkunen, Sanner-Stiehr, & Kvist, 2021). In turn, independence, and thus the capacity to be autonomous, relies heavily on knowledge and experience. One of the challenges identified in this study was that although a number of NO were able to achieve a significant level of professional autonomy and clinical leadership they had not experienced in Australia, others achieved more autonomy by virtue of their circumstance rather than ability. These NO were physically separated from other NO, making decisions and leading, but not advocating or maximising outcomes because they lacked knowledge and experience.

Advocacy is an important characteristic of the nurse–patient relationship, which is essentially about protecting the vulnerable patient, ensuring they are safe guarded and have a voice in their health experience (Foley, Minick, & Kee, 2000). By extension, advocacy informs the nursing role of moral agency, to ensure a patient's best interests are considered (Freyling et al., 2008). In the military setting, it is important to note that a war fighter (soldier) is

inherently in a dependent relationship with a hierarchical system that may inhibit their willingness to speak up—further complicating the challenges a soldier will face when extremely vulnerable because of injury. Foley et al. (2000, p. 504) described the nursing role in a soldier's care as the patient's 'last line of defence'—a very appropriate term for the context.

In keeping with these ideals and the findings of other authors (Biedermann, 2017; Rushton et al., 2008; Scannell-Desch & Doherty, 2010), this study demonstrated the commitment of NO to the care of military personnel, especially those who were part of the 'family'. Advocacy for military personnel was usually not taxing, because they were fed into a system that ensured rapid treatment and retrieval to a higher level of care. However, the role of advocacy became apparent when dealing with the dying patient.

This study highlighted the level of commitment and compassion needed to care and advocate for humanitarian victims and the challenges associated with doing so. Humanitarian victims were highly vulnerable because of the complexities of the power relationships in a conflict zone, mission guideline limits on care and the state of the local health infrastructure. Who they were related to could either promote or inhibit their care. Therefore, nursing advocacy for access to care was vital. In the military IAC setting this situation required NO to overcome initial shock at inequity, have the knowledge to affirm the right to care, the ability to negotiate how this would occur and the courage to advocate for these requirements. In a similar finding to Finnegan et al. (2015), NO realised humanitarian victims often lacked a voice and needed someone to defend their right to care, noting that this depended on mission guidelines.

The most complex and challenging situation was when NO tried to provide care to the enemy. NO unequivocally did not like what the enemy had done but, rather than judge, they demonstrated support for the principle of international law and impartiality in healthcare. In this situation, the enemy were injured, apprehended and a source of information, and therefore completely dependent on advocacy to receive care. NO found themselves not only trying to advocate for care but facing significant antipathy and, at times, intimidation in response to their position. This type of situation was also identified in several other studies examining the Iraq and Afghanistan conflicts (Agazio, 2010; Agazio & Goodman, 2017). As with leadership, advocacy was severely constrained in NO with limited clinical experience.

7.4.2.2 Scope of Practice

When NO in this study described the challenges encountered during the process of delivering care, they clearly articulated a range of abilities needed by nurses to perform effectively. It was important, for instance, that clinical judgement was well-developed, so that they could identify and respond to changing events, cope with the tempo, demonstrate clinical leadership and advocacy and have the strength to enact difficult decisions. It was also essential that NO could go beyond task orientation to manipulate principles of practice (such as how to apply infection control), demonstrate flexibility, adaptability, decisiveness and act with speed. Nurses needed to be capable of looking outwards to see the bigger picture in terms of long-term goals of care and to juggle the management of trauma, children and culturally diverse and vulnerable populations. This included judicious use of a reduced range of the usual resources, such as IV fluid or wound dressings. These points resonate with those noted by Richardson, Ardagh, Grainer and Robinson (2013) who examined nursing during an earthquake, where nurses discovered they were required to be innovative in their practice, to cope with limited resources. Ultimately, NO had to ration care to seriously compromised individuals, without sacrificing key care elements. It was necessary to be able to do all of this without guidance and support, to operate alone if required, guide others and work effectively under duress, including where there was an active threat.

All of these elements coalesced as a complex, high-pressured, fast-paced, emotionally charged, ethically challenged and potentially volatile care situation, which NO needed to possess the capacity to manage and adapt to. They also needed to work with fewer resources (people and equipment), a complex cultural environment and time-critical issues. This image of the IAC environment, and the necessity for nurses to be able to manage consequential clinical and ethical demands, reflects a similar picture revealed by other studies examining conflict, setting the scene for identifying the level of practice required for NO to deploy to IAC and manage clinically (Biedermann et al., 2001; Filliung & Bower, 2010; Finnegan et al., 2015; Goodman et al., 2013; Lindblad & Sjostrom, 2005; Scannell-Desch & Doherty, 2010; Smith, 2008). Using the Benner (1984) and Curley's (2007) Synergy models, this study uses a bipartite approach to determine, given the findings, what level of practice and

characteristics NO needed to achieve two foundational goals: meet the clinical demands of the environment and provide a safe environment for patient recovery.

7.4.2.2.1 Benner: A Framework for Understanding the NO IAC Level of Practice

To provide a framework for grounding the knowledge and skill described above, this study has adapted the Benner (1984) model of practice and its precursor, the Dreyfus model (Dreyfus, 2004). This approach to identifying and contextualising the scope of practice required by Army NO has not previously been undertaken. Building on the work of Dreyfus (2004), Benner (1984) essentially argued that expertise is derived from experience—with clinical ability developing with practice as a nurse tests their skill with real patients (McHugh & Lake, 2010). Years of experience play a part in practice development, with the first four levels considered to fall within a five-year full-time equivalent timeline, as indicated in Table 3. Notwithstanding this, true transformation to an advanced practice level requires a combination of focused practice and self-reflection, not just experience over time (Bathish, Wilson, & Potempa, 2018; Bobay, Gentile, & Hagle, 2009).

Each level of the Benner framework essentially reflects gradual development of knowledge and practice, from rule-driven to flexible application of care principles. The use of rules to perform applies to the Novice; the use of learned procedures in the presence of an underdeveloped knowledge base and limited leadership is the Advanced Beginner; whereas Competent refers to the task-oriented nurse who aims for goal achievement (Dale et al., 2013; McHugh & Lake, 2010). The nurse who is able to rapidly prioritise, predict outcomes and see beyond the immediate to the whole picture—and adapt practice to changing circumstances—is likely to be Proficient (Dale et al., 2013). The Expert nurse is intuitive in their appreciation for an entire situation, does not waste time on pointless actions and can recognise the unexpected (McHugh & Lake, 2010).

Table 3: Benner Levels of Practice and the NO IAC Scope

Level	Characteristics
5 Expert	Proficiency plus years to gain expert status Mentor, highly skilled, high-level analytical ability Intuitive, *decisive, parsimonious—can identify problem and solutions rapidly without need to go over ineffective alternatives* Deep understanding of whole situation; *flexible,* highly proficient *Builds and leads teams, creates change, highly collaborative*
4 Proficient	5 years or more of practice in an area of specialty (or general nursing) *Problem solver, sees whole situation in terms of long-range goals* *Adaptable—expects typical events in a given situation and can modify plans* *Developing a capacity for mental flexibility* Decision-making—*able to rapidly prioritise* as aware what is important and what is not Can *identify solutions to complex problems and implement care quickly and effectively* *Can lead a team or work on own, developing collaboration*
3 Competent	2–3 years of practice in an area of specialty (or general nursing) Methodical, efficient, coordinated, confident care—task-oriented towards goals Conscious, deliberate and carefully considered planning—has to work through options Care completed in usual timeframe; lean leadership Requires support to care for complex patients Requires guidance—mentoring; needs to work in a supportive team
2 Advanced Beginner	1–2 years of practice in an area of specialty (or general nursing) Uses learned procedures and tools; requires support and cues—needs to work in a supportive team and have a mentor Efficient and skillful in elements of care—not holistic; slow implementation of care, unable to manage complex patients
1 Novice	Student Scaffolding required, no discretionary judgement, no experience Lacks confidence to demonstrate safe practice; requires constant cues, prolonged care implementation

Source: Adapted from Benner (1984).

To ground the NO IAC experience within Benner's approach, Table 3 summarises key Benner model attributes. Those characteristics of the Benner model that match those described by study participants as essential to practice in IAC, have been identified in *red italics*. This creates an image of where deployed clinical practice sits on the Benner scale, the nursing attributes required and the time (full-time equivalent) needed in clinical practice. To work unsupervised in an IAC zone with complex, unstable, culturally diverse patients and

a complex austere environment with culturally diverse colleagues, would require NO to be a minimum of Proficient.

A Competent level NO would need a well-supported deployed environment and a team able to provide a relevant level of guidance and supervision. This level would apply to recent graduates of postgraduate (PG) specialty courses who, immediately after graduation, are working in a supported familiar environment with experienced nurses allocated to complex patients and leadership roles. At this stage, application of the Benner (1984) framework would suggest the PG nurse is Competent (within specialty), depending on prior specialty experience and ability to manage complex patients without assistance.

7.4.2.2.2 Safety and Synergy

The Benner model provided the first step in a process of evaluating from the study findings what NO needed to achieve during preparation to deploy to meet the clinical demands of their patients. The second challenge is to consider how a safe environment could be created by NO in IAC. Curley (2007) describes creating safe passage for patients as establishing a 'synergy' between the characteristics of the nurse and those of the patient. In other words, the nurse must have the knowledge and skill to care for specific types of patients, reduce the risk of complications and recognise and respond to deterioration. Therefore, given the IAC environment and complex, vulnerable, often unstable and unpredictable, injured patients, NO require a high level of critical thinking, clinical judgement, decision-making, clinical vigilance and the ability to resolve multiple dynamic problems. At the same time, they need to deliver care, respond to diversity, be highly collaborative and know how to work within the broader system.

Designed for critical care practice (which suits the average patient in an IAC), the Synergy model uses criteria to determine a level of harmony between nurse competence and patient need, with Competent to Expert levels of care (Curley, 2007). Competent is the minimum standard needed to achieve acceptable synergy in a controlled civilian critical care setting (Freyling et al., 2008). However, the complexity encountered in IAC requires a higher level of knowledge, skill, accountability, influence, moral agency and systems thinking—thus, NO who are Proficient on the Benner scale. Using the Synergy model, and with the goal of

establishing a dynamic image of deployed NO capability, Table 4 outlines a comparison of typical IAC patient and environmental characteristics against the nurse characteristics required to provide effective and safe care. As with the Benner model, the use of *red italics* highlights those aspects of the Synergy model that resonate with circumstances and characteristics described by study participants as occurring in the IAC setting.

Table 4: IAC Synergy Model Characteristics

IAC Patient and Environmental Characteristics	Nurse Characteristics Required for Synergy
Complex trauma Frequently unstable Vulnerable Frequently unpredictable Resilience tested by profound injury Usually unable to participate in care or decision-making Limited resource availability (including technology & communication) *Low physical resources need to be offset by nurses with high knowledge and skill*	Clinical judgement—reasoning and decision-making, critical thinking and global awareness of situation *[Collects and interprets complex patient data; immediate grasp of the whole picture; recognises patterns and trends that may predict the direction of illness]* Clinical inquiry—resolution of problems at bedside *[Can question practice]* Caring practices—flexible, adaptable, decisive, knowledgeable Able to respond to significant diversity *[Can identify impact on patient and tailor environ to meet needs]* Advocacy—moral agency—*[Able to take a stand and give voice/ act as moral agent]* Facilitation of learning—*[Able to teach patients from a variety of backgrounds, from the perspective of the patient]* Collaboration—builds and supports a team Systems thinking—recognises links across a system *[Able to see beyond the unit to operate at a system level—facilitating change—improving interfaces]*

Source: Curley (2007), Freyling et al. (2008).

The expansion of scope of practice requires appropriate support for such scope to develop while patient safety is maintained. This is important to understand, because the IAC environment exposes NO to a highly complex, unstable clinical situation with limited support. If they are not ready for the clinical demands, and unable or unwilling to respond by expanding their scope, both the NO and the patient are likely to suffer in terms of outcomes. Experienced nurses who deployed were still required to expand their scope of practice to respond to challenges they encountered; however, they did so utilising existing knowledge and skills, and adaptive mindsets, with a positive sense of accomplishment. They were advanced practice nurses who tested and adjusted their repertoire of experience and skill in a new setting.

Conversely, a problem revealed throughout this study was deployment of NO with inadequate levels of baseline clinical experience, or levels of specialty experience that were lower than desired. They did not possess the level of advanced practice they subsequently recognised was needed, coping by choice and determination, albeit with significant difficulty. While deployed they expanded their scope, striving to reach a more acceptable baseline, but were never able to achieve the range of expertise they believed was necessary, seeing this as unfair for both the patient and the NO.

7.4.3 Managing Ethical Dilemmas

A small body of work on the subject of ethical dilemmas in IAC, particularly from a nursing perspective, has emerged from the Iraq and Afghanistan conflicts (Agazio & Goodman, 2017; Bradshaw, 2010; Nathanson, 2013; Smith, 2005). Notably, and perhaps unsurprisingly, IAC environments increase the likelihood of moral dilemmas not prevalent in or observed during peacetime (Griffiths & Jasper, 2008; Smith, 2005). This study builds on those findings to reveal more about the characteristics of the deployed ethical environment to understand the challenges NO experienced when making ethical decisions in practice, why their voices fell silent at times and the consequences of failing to achieve ethical objectives.

7.4.3.1 The Deployed Ethical Landscape

During the preparation phase of the deployment cycle, NO prepared themselves mentally for the ethical issues they suspected might occur during deployment. This process was enacted from the perspective of their practice in Australia and the systems and frameworks that supported ethical decision-making, including the ICN Code of Ethics (2021), which was previously incorporated into the Australian Code of Ethics for Nurses (NMBA, 2008). NO deployed with a particular view of what ethical care and conduct meant, including equity, impartiality, respect, kindness, safety and putting the patient first.

Once deployed, NO encountered a professional landscape vastly different to that of their peacetime practice, where values did not easily align with the hostile and complex nature of IAC. The ethical frameworks NO understood—and that were intrinsically embedded in their approach to clinical inquiry, judgement and decision-making—did not translate neatly into the IAC environment, especially when working with other cultures. This made decision-making difficult, potentially adversarial and, at times, impossible. Southby (1987, p. 674) described this as the wartime environment adding a level of 'professional strain'.

The physical environment was austere and dangerous, and the healthcare system focused on moving patients through quickly and returning them either to the frontline or home. Humanitarian victims were a largely secondary consideration and the provision of care to the enemy was not necessarily in accordance with the 'care' component. Mission guidelines and available resources usually determined and shaped who received care, what type and how much. This was in comparison to clinicians making the decision according to equitable access to healthcare in line with clinical and ethical principles. The mix of patients was potentially volatile, with soldiers treated alongside injured locals or enemy. Fewer staff overall meant fewer people to consult with; sometimes this meant the NO was on their own. Events could move quickly, leaving little time to consider a situation before having to make a decision and attempt to act on it.

In this already difficult environment, NO discovered people behaved in unexpected ways. They realised that not everyone believed their peacetime ethical framework had relevance in conflict or that others simply had a differing cultural ethical reference. Some of the people

they worked with, either in healthcare or other military personnel, did not believe in the concept of impartiality. Given the actions of others, ethical care was not applied uniformly across the range of patients NO cared for. Caring for the enemy could produce hostile reactions from others or challenge a nurse's own impartiality.

Justifications for behaviour seemed to be about which side of a conflict people were on and how they perceived the other side. Thus, in armed conflict, morality seemed to be a matter of position and partisanship. This aligns with the idea of ethical relativism (ADF, 2021), which is essentially justification for variations in ethical behaviour from the accepted norm—to align with one's own view or as a reaction to surrounding events. Some NO observed these justifications being used to pressure others to agree and normalise toward an alternate norm. This was accentuated by pressure on NO from the military family to 'take their side'; opposition to such pressure could draw unwelcome responses that were hard to stand up to and cope with. This resonates with a study by Agazio and Goodman (2017), who identified similar adverse pressures and barriers to ethical decision-making, including pressure from 'the family'(military).

Smith (2005) suggested that the nature of professional ethical conflicts in IAC are different to the peacetime environment because the ethical landscape shifts in response to competing military imperatives and obligations. In keeping with this suggestion, NO found that, at times, some non-clinicians thought it was acceptable to use healthcare as a means to achieve a military mission. Other non-clinicians argued the primacy of the mission (which may have been an example of ethical relativism) as a way to sideline the NO ethical viewpoint. The response to NO who found the courage to resist military personnel trying to take precedence over healthcare obligations in legal and ethical terms, was intense and unpleasant. In addition, a more insidious and distressing practice was the use of guilt (in the 'family' context) to encourage NO to see why a particular use of healthcare for the purpose of a military agenda was acceptable. This practice was an attempt to pervert the NO position and sway them from their ethical stance, rather than view them as a potential moral counterpoint.

Ultimately, ethical decisions were made in a complex environment of self, team, judgement and moral motivation. The heightened emotions of an IAC appeared to produce and perpetuate ethical dilemmas, simultaneously exposing a tension between the agendas of

clinicians and non-clinicians because of inherent role differences that were not always reconciled in advance. Griffiths and Jasper (2008, p. 95) argue that this is because 'respect for humanity and the value of life become lost amid the hatred' of various participants in a conflict. The view of NO in this study was that humanity was at the heart of what they did, perhaps suggesting that some people, such as NO, exist to ensure humanity is remembered during IAC events.

7.4.3.2 Ethical Decision-Making in Practice

In the interest of protecting patients, the purpose of an ethical code is to clarify the parameters of clinical decisions (Kelly, 2010; Nathanson, 2013), with the ICN Code of Ethics for Nurses (2021) identifying the ethical standards and values to which Australian NO were held to account. To make and implement ethical decisions in accordance with this framework, NO needed a sound moral compass they were able to defend. To make decisions that did not fully comply with an ethical stance at home, such as confidentiality, NO also required principle-based acute clinical judgement that permitted flexibility in decision-making. To implement decisions, they needed to be able to navigate the professional landscape and negotiate an outcome, including how to negotiate with members of other cultures and when to back down. Ultimately, NO needed to reconcile clinical ethics with organisational competence, to demonstrate leadership, autonomy and advocacy and portray a tried and tested ethical understanding given clinical experience.

This study identified several interrelated barriers to NO being prepared for and able to manage the ethical dilemmas they encountered. A lack of socialisation to the NO role reduced ethical readiness in general. Secondly, the absence of pre-deployment related clinical ethical training meant NO deployed unprepared for military ethical issues. Similarly, a need for experience in ethical decision-making prior to deployment was identified by Agazio and Goodman (2017), Almonte (2009), Tschudin and Schmitz (2003), as well as in a study about preparing for ethical challenges during disasters (Johnstone & Turale, 2014). The third problem related to the role of clinical experience in developing and implementing ethical decisions because, as Tschudin and Schmitz (2003) have explained, it is not enough to be able to argue an ethical position—the nurse needs to be capable of implementing it.

Experienced NO with developed clinical and ethical acumen found their ethical frameworks seemed to get lost in transition and translation to IAC. Their normally robust ethical position was complicated by military authority and working with other cultures who challenged their stance, leaving the NO unsure of how to act. Thus, ethical objective achievement for this group was variable; sometimes they failed because they lacked the authority to act, not because they lacked the courage to speak up or the experience to know what was right and how to negotiate an outcome.

Inexperienced NO possessed a moral compass and courage but lacked the confidence to act, felt out of their depth and unable to adequately defend patient safety. This resulted from them working at a more prescriptive level of practice and being less experienced in negotiation. For those who felt they failed to stand by what they knew was ethically correct, moral distress was a likely outcome. Under pressure to comply with military objectives and support the 'family', their lack of clinical experience meant they were also more at risk of inadvertently compromising reputation—of the Australian Army, for whom they worked, or the Red Cross, which they wore. In this setting, strength and courage (one of the pre-eminent values of an Australian Army officer), were paramount to resistance and holding firm to an ethical position. These attributes were demonstrated by NO in this study, with one NO—when pressured to implement healthcare in order to achieve a military agenda—standing firmly behind international law while acknowledging their obligations to the Army.

This study has illuminated some of the reasons why the NO voice—speaking for the rights of their patients—could be silenced on deployment. Hierarchy, competing agenda, intimidation, working alone (as Australian) and therefore having no one to consult with, time, fear, insecurity, a need to act quickly or a lack of authority to act when exposed to another force's behaviour, were all barriers to solid and sustained ethical practice. Nonetheless, if they possessed clinical experience, compassion, EI and ethical intelligence, effective communication, courage, conflict resolution skills and authority to act, at times it was still possible to achieve a desired ethical outcome in the care NO delivered.

7.4.3.3 Moral Distress, Drift and Disengagement

Moral distress is a condition where an individual does not act upon moral judgement in a situation where they have responsibility for a moral outcome (Fry, Harvey, Hurley, & Foley 2002). It is not the same as burnout, which may occur as a problem of mental wear and tear over time, although, as Fry et al. (2002) have pointed out, moral distress could contribute to burnout. Moral distress was an outcome for those NO unable to provide the safe and equitable care they believed was required. In their own minds, they transgressed because they could not protect their moral centre by doing what they believed was right (O'Connor, 2015).

Factors likely to increase the risk of distress for NO included a bureaucratic organisation (in this case the military), decisions that involved producing harm (such as blindfolding patients), having a sensitivity to the moral aspects of care and having a subordinate role in care delivery thus leading to a sense of disempowerment (Fry et al., 2002). To avoid the risk of moral distress, NO needed to be aware of their heightened sensitivity to moral needs given the nature of their profession, find a position of influence by virtue of their rank and role and be able to appropriately resist direction to undertake actions they disagreed with.

As at least one NO in this study found, moral distress was aggravated by working in an unfamiliar environment and culture. This was because of separation from their usual support systems and being surrounded by alternate and, at times, adversarial viewpoints (Fry et al., 2002). Therefore, it is essential NO embedded with other forces are aware of the ethical challenges they may face and have strategies prepared for overcoming problems. Several NO in this study were able to do this, albeit not necessarily without significant challenge. Some NO were unable to find a position of influence and experienced moral distress for a period.

These findings are supported by other studies, such as those examining the war in Vietnam, humanitarian missions and, notably, in relation to the US experience in Iraq, where nurses experienced moral distress, sometimes over caring for the enemy (Agazio & Goodman, 2017; Almonte, 2009; Scannell-Desch & Doherty, 2010). However, unlike their US counterparts, although Australian nurses did not like what the enemy had done, they did not experience distress while caring for them. Rather, in a finding that links the views of NO to their roles in the military and reconciliation with military purpose, they felt distress over how non-

nurses treated NO for providing care. Australian nurses gave the impression of having an outward view, expecting to care for everyone and to do so without fear, favour or question. This finding demonstrates the importance of attitude when dealing with ethical issues and poses a point of self-reflection for combat forces who deliver enemy for care and then judge NO harshly for delivering that care.

A secondary benefit of a strong moral compass that the nurse could self-regulate, was how it enabled the avoidance of moral drift and moral disengagement. Moral drift occurs in situations where an individual drifts away from an accepted moral position, creating their own justification for behaviour and finding an ethical position relevant to them (ADF, 2021). If that drift goes so far as to disconnect from seeing someone in human terms, it becomes moral disengagement (ADF, 2021). If a clinician becomes complicit in or collaborates with unethical behaviour such as torture, or stands by silently, they are morally disengaged (Reichert, 2019; Smith, 2005). This became a concern for the US in Iraq, notably because of activities occurring at Abu Graib prison and the role of US healthcare providers in torture (Smith, 2005). As Smith (2005) has argued, in this instance, clinicians were exposed to the risk of moral disengagement because the power of armed forces and time (sustained exposure to IAC) drained the bank of moral capital individuals deployed with. This was aggravated by dehumanising actions (such as using a number not a name) that distorted the consequences and attribution of blame—the enemy patient was responsible for their own circumstances and perceived as less human than others (Reichert, 2019).

Although moral disengagement did not appear as an issue for participants in this study who witnessed dehumanising acts—for example, referring to injured locals by a number, or cable tying and blindfolding enemy then pushing them along from behind—understanding the mechanisms by which disengagement could occur would be valuable in ensuring it does not become a future issue. This would be especially important if working with other forces. Therefore, a key finding is twofold. NO who deploy to an IAC must be experienced clinicians with a mature moral compass, who can protect their moral centre and who can make and defend clinical decisions, particularly those involving ethical choices. In addition, they all need practice at applying ethical frameworks in difficult circumstances because even

experience can fail in the face of unfamiliar situations, military power and objective and personal threat.

Although NO deployed with what they thought was adequate preparation to manage ethical dilemma, many ultimately found they were unprepared. This was largely because their experience at managing ethical challenges occurred in the relatively stable landscape of peacetime Australia, where there was the time and resources to work through ethical dilemmas. A number had limited clinical experience and no pre-deployment training on managing ethical issues. The risk to NO of failing to stand up for their ethical position and their patients was moral distress, which may persist beyond deployment. This is similar to a finding by Almonte (2009) that unresolved reactions to circumstances leads to distress, disconnectedness and, in some instances, long-term problems.

7.5 Personal Readiness

7.5.1 Coping with Challenge

These findings have demonstrated how knowledge and skill underpinned coping with the clinical and military demands of the IAC environment and, therefore, NO professional survival. Previous sections detailed the challenges NO coped with on deployment and, to some extent, provided details on how they went about this in specific circumstances. The purpose of this section is to discuss the broader picture of how NO coped—to survive personally, support their professional performance and reintegrate when they returned home. This section completes the picture of why, when and how NO deploying to IAC approached their mental readiness.

Existing literature provides a small eclectic range of information on the subject of nurses coping with military deployment and the consequences of armed conflict. This identifies factors such as compassion fatigue (Kenny, 2008; Peterson-Owen & Wanzer, 2014), the effects of stressors (Almonte, 2009; Hammelman, 1995, Smith, Halcomb & Moxham, 2015), coping (Biedermann et al., 2001; Germaine & Lounsbury, 2007; Haynes-Smith, 2010; Kelly, 2010; Parish, 2007; Rivers et al., 2013; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010), resilience (Schok, Kleber, & Lensvelt-Mulders, 2014; Sinclair & Britt,

2013) and PTSD (Feczer & Bjorklund, 2009; Gibbons, Hickling, & Watts, 2011; Lev-Wiesel, Goldblatt, Eiskovits, & Admi, 2009; Skramlik, 2017; Smith et al., 2015).

In this study, the coping strategies used by Australian Army NO to manage complex and potentially distressing experiences are embedded within a concept called 'coping with challenge' that forms part of the GT caring under fire. There are four main concepts that describe coping with challenge: mental comfort zones, distress tolerance, resilience and post-deployment reconstruction. Together these concepts and associated strategies provide a new approach to understanding how these NO coped with challenge during IAC.

7.5.1.1 Mental Comfort Zones

Emerging from the interview process, 'mental comfort zone' is a term describing how NO psychologically approached deployment. A mental comfort zone is a psychological state where the person feels safe and in control (Page, 2020). Although this produces a sense of calm, a mental comfort zone can also be viewed as stagnating growth, unless the individual is able to work through fear to learn and grow (Page, 2020). In this study, a mental comfort zone provided a safe place to think, cope and respond to significant surrounding risk. It expanded as the NO gained more knowledge of the environment and the demands they needed to respond to.

As discussed in the findings, when they were readying to deploy, NO realised that they needed effective coping strategies for immediate implementation. They proactively prepared their headspace, initially using limited information combined with experience. NO thought about why they were going, what might be seen, how they would respond and how they could gain knowledge and skill to improve practical coping. They established a clear personal and professional purpose for going to IAC, encompassing ideas such as 'resolving the consequences of war', 'being there for our soldiers' and, in most cases, developing an understanding of the mission. Studies on the war in Vietnam and the Gulf Wars reveal similarities, with nurses stating that it was essential for coping to know why you were deploying and to be committed to caring in the face of difficult circumstances (Rushton et al., 2008; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). Thus, a

clear purpose and commitment were influential factors in a nurse's resilience to both adversity and the overall experience.

Within their mental comfort zone, NO established initial parameters for action, delineating limits—such as for ethical decision-making. As the reality of deployment was a need to 'hit the ground running', pre-planned actions were important to rapid and appropriate responses, while also learning about the environment. With the IAC clinical and ethical space proving to be different to what they had prepared for, NO needed to adapt to the realities of conflict, while still holding true to professional behaviour. Adaptive intelligence played a role, with NO required to cope with fast moving events, learning very quickly to improve response times, decisiveness and transition to IAC. Whereas factors influencing adaptation and coping—such as flexibility and positivity—have been identified in examinations of armed conflict since Australia sent nurses to the Boer War (Bassett, 1992; Biedermann et al., 2001; Scannell-Desch & Anderson (2005), Scannell-Desch & Doherty, 2010), the idea of adaptive intelligence explaining how NO coped is new.

The perspective NO took on what they could control was also important to mental comfort zones. NO who realised they could not control everything, and worked out their area of influence, coped personally with the relative danger and unpredictability of the environment. An ability to cope then became a protective factor contributing to resilience. The NO who were unable to accept less than they were used to having in Australia—such as clinical resources—or were unable to identify alternate plans, experienced significant stress. This supports the findings of Schok et al. (2014) who, when examining how military personnel make sense of war, noted that a perception of being in control allows the individual to adjust and therefore improves coping.

7.5.1.2 Distress Tolerance

In studies of nurses who went to Vietnam (Scannell-Desch & Anderson, 2005), Iraq and Afghanistan (Scannell-Desch & Doherty, 2010), the authors found that nurses coped with the transition into and through conflict using strategies such as humour, diversional activities and inner strength. These practices can be discussed under the heading of distress tolerance. Distress tolerance is the term used to describe the process of managing emotional distress to

avoid being overwhelmed by a situation (Tull, 2020). In general, this includes techniques such as distraction, mentally improving the moment, radical acceptance and self-soothing. Because, in reality, the latter was extremely hard to achieve, NO relied on other strategies.

The use of distraction (taking the mind off feelings) was achieved by keeping busy (no idle mind) or focusing on the patient—that is, focusing on what is going on inside the tent, not what was happening outside. However, as events inside could be the main driver of distress, NO also mentally reminded themselves of why they were there and the job they had to do. In addition, NO maintained situational awareness to avoid being caught off guard. All applied an element of radical acceptance to get their job done and accept their role in the conflict. However, radical acceptance did not fully nullify the risk of moral distress or the anger some felt over issues they thought they should have been able to control, such as the negotiation of ethical dilemmas.

To mentally improve the moment, some NO compared themselves to soldiers 'outside the wire', injured patients and humanitarian victims. For others, it was events such as 'Chocco Tuesday' that allowed them to take time out from the pressure of patient care. Humour was used to buffer negative experiences. All NO aimed for positivity, a feeling enhanced each time they coped with a situation and gained a sense of achievement. Admittedly that sense of achievement was relative—sometimes it became a matter of doing what they could, rather than everything they would have liked to do. This is akin to a finding by Rushton et al. (2008) that nurses created professional meaning from what they did, despite hardship, thus justifying their actions.

7.5.1.2.1 Support Systems and 'Talking it Out'

The use of support systems to cope with deployment, particularly through colleagues, has been described in several studies (Biedermann et al., 2001; Rivers et al., 2013; Rushton et al., 2008; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). The challenge for NO in this study is that although they universally considered support systems important, they could struggle to establish them. The main reasons were posting as a single NO to a platoon or embedding with another culture. In addition, technology was not necessarily available as a source of access to remote support. Despite the challenges, most

NO found ways to receive support from their work team or other colleagues. They managed this through informal debriefing with each other and after-work activities during limited downtime. Some NO remained isolated (working as NO without other NO colleagues). This influenced their ability to cope with challenging situations because they had no one to talk to about situations such as ethical dilemmas.

In studies of deployment by US nurses to Vietnam, Iraq and Afghanistan, the authors identified that nurses felt that sharing and talking to each other were essential to surviving (Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). These authors also suggested that nurses should keep talking until they no longer needed to. Talking to each other allowed NO to discuss what they had experienced and how they resolved their problems, essentially sharing potential answers to challenges. However, for a range of reasons, although NO talked about some things with each other on deployment, they tended not to deal with their personal thoughts of the IAC experience until they arrived home. Thus, delaying the processing of their own experiences to focus on others. NO were constantly busy dealing with casualty numbers, supporting their team, getting ready for the next unexpected event and working long hours. They were often the person others turned to.

Approximately half of the NO who participated in this study had partners or children in Australia. For a few, this became a point of stress about halfway through their deployment. They used the Army 'family' and their own sense of purpose for being in IAC as a source of strength when working through these moments of distress. Family as a source of stress was investigated in a study by Hammelman (1995) who identified some interesting, and perhaps confounding, findings about how gender, rank and family structure influenced the effects of stressors. According to Hammelman (1995), females were less affected, lower rank was affected less (than higher rank such as an officer) and single parent families coped better (Hammelman, 1995). At the same time, Ayala and Carnero (2013) found people with children were more likely to experience emotional exhaustion. However, the number of NO in this current study who identified family as a point of stress was low, they covered both genders, all were officers of a similar rank and not all had children.

7.5.1.3 Resilience

In light of the findings in this study, it would be reasonable to expect NO may have struggled to cope both during and after the IAC. Their experience of danger, injury and ethical conflict was arguably traumatic and some deployed inexperienced for their roles, thus aggravating their stress. They supported others emotionally, while tending to cope with personal feelings on their own, carrying the burden of dealing with death and providing care to the enemy no one else wanted to care for.

Despite these challenges, this study portrays how this group of NO ultimately survived and thrived, strengthening their resilience. Dry, wryly humorous and pragmatic at interview, they were fundamentally proud of many of their achievements. There were moments of cynicism and several admitted to lengthy post-conflict periods of adjustment when they returned home. However, without exception, as revealed throughout the findings, all NO in this study demonstrated a range of characteristics and attitudes that depict a distinct resilience to the experience of armed conflict.

Resilience is both an ability to maintain a stable state of mind over time despite adversity, and an ability to bounce back stronger, as a result of healing any psychological wounds and taking control of life (American Psychology Association, 2022; Bonanno, 2004; Schok et al., 2014; Sinclair & Britt, 2013). To identify and explain factors contributing to resilience, resilience theory focuses on the strengths demonstrated in response to rising above adversity—by people and the systems that operate around them (Van Breda, 2001). Thus, resilience theory offers a useful way to determine which factors are internal to the NO and what the organisation offers in support of their resilience.

Resilience is part of the dialogue, within the small amount of international literature looking at the experience of military nurses. However, there is an overall lack of exploration of the topic and nothing explicit about what might protect nurses from trauma. Lev-Wiesel et al. (2009) compared the resilience of nurses favourably to that of social workers, suggesting personal potency was important. By revealing how NO demonstrated a range of protective factors that supported their resilience, this new finding from the current study starts to fill the gap in knowledge. Key character traits and abilities described throughout the findings include

adaptive mindsets, ethical intelligence, EI, compassion, courage, caring and self-sacrifice. Sacrifice was implied by situations such as forfeiting personal comfort, being at risk of harm or preparing a force of thousands at the expense of their own preparation. Sacrifice of physical safety as a consequence of going to an IAC setting was also identified by Rushton et al. (2008).

Strength was found in being clinically prepared, which aligns with findings by Scannell-Desch and Anderson (2005) that having solid clinical skills and maturity in life were important to general coping (not just to performing clinically). The implication to be drawn from this is that if NO do not have to worry about their level of readiness to perform clinically, they can focus on coping with such stressors as the surrounding conflict, distance from family and experiences such as caring for humanitarian victims. Professional and personal competence are therefore interlinked.

Whereas resilience is a normal part of adaptation to survive, a positive view of the future is needed to promote adaptation in the face of adversity (Schok et al., 2014). NO described maintaining a forward-looking view despite surrounding events, at times feeling despair but not allowing it to take over. Further, to withstand traumatic experience, self-enhancement is essential (Bonanno, 2004). Sinclair and Britt (2013) have described this as possessing a positive view of the self. Conversely, as Schok et al. (2014) have noted, a negative view of the self was influential in the development of PTSD. NO described a sense of self-enhancement when they talked about having a sense of purpose, using their NO status to find a position of influence over patient care, being positive about the future, promoting NO as a group (corps) and revealing how they felt about their performance on deployment. Gibbons et al. (2011) noted that a strong sense of purpose contributed to mitigating the adverse psychological impact of stressful events.

At the time of participation, NO in this study were generally optimistic, no longer stressed over the small (situations), had greater confidence in themselves and saw the world in a bigger, more personal way. All are now stronger and less afraid; most are more grateful. In similar findings, Rushton et al. (2008) and Scannell-Desch and Anderson (2005) found that a nurse could be strengthened by their experience of IAC. Moreover, Schok et al. (2014) reported that military veterans were more positive than negative in their thoughts post-

conflict, experiencing greater self-confidence while also realising their world was bigger than it had been before deployment.

7.5.1.3.1 Compassion Fatigue

There was no evidence in this study that NO experienced compassion fatigue. Not yet clearly defined, compassion fatigue is most likely to involve a drain on compassion after sustained empathetic sharing, with a subsequent inability to demonstrate sensitivity towards others (Kenny, 2008; Peterson-Owen & Wanzer, 2014). In nurses, the risk then becomes inappropriate decision-making, such as poor ethical choices, or a failure to deliver care because they have no empathy left to give. Peterson-Owen and Wanzer (2014) have argued that military nurses are at high risk of compassion fatigue because of the dangerous environment, age of combat troops they care for and a high demand for their emotional support and empathy by those they worked with and cared for. They also thought the potential residual stress from not processing their own thoughts might aggravate compassion fatigue. Bonanno (2004) disagreed, arguing that not thinking about what had happened until someone gets home promotes resilience (during their time in the conflict).

As the NO in this study faced all of the abovementioned challenges, why did they not demonstrate compassion fatigue? The answer may lie in Peterson-Owen and Wanzer's (2014) six main areas of activity identified as influencing the risk of compassion fatigue: psychological distress, a sense of helplessness, fear, empathy, loss of purpose and an inability to recognise own needs. NO demonstrated ongoing distress tolerance and did not dwell on their experiences until they came home. None felt truly helpless and fear was well controlled, even when they treated the enemy—largely because they felt protected and were doing their job. A few found themselves inexperienced to advocate, which left them morally distressed, but not unable to act in some way or lacking in compassion.

NO demonstrated a sustained level of empathy in reaction to surrounding events. In fact, it could be argued that the worse the situation as they defended (or attempted to) the right of patients to care, the stronger their empathy seemed to be. Inherent requirements of their job to advocate for patients, lead clinical teams, be humanitarian and lead ethically, seem to have supported ongoing empathy and ensured an ongoing sense of purpose. All found a way to

balance their own needs with the priorities of others, although some sacrificed the self to ensure others were cared for.

7.5.1.4 Post-Deployment Reconstruction

At the end of their deployment, NO said goodbye to colleagues, patients and an environment they had learned to live with before taking the physical journey home to Australia. The psychological phase of their return home was longer, more varied and, in most cases, would test their resilience. On return to Australia, NO found a once familiar environment had become vaguely foreign. They had a new perception of the world, which was bigger than when they had left for deployment and, for many, their priorities had changed. Therefore, returning to Australia and reintegrating had a number of challenges, including the need to learn to live without ever present conflict.

Difficulties associated with adapting to a non-conflict environment are described by a number of authors who examined military nurses in conflict from Vietnam to the present day (Finnegan et al., 2015; Kenny, 2008; Rivers et al., 2013; Rushton et al., 2008; Sadhaan et al., 2022; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010). Perhaps equally important is the reality that the challenge of returning home and reintegrating can be as traumatic as the deployment itself (Rivers et al., 2013).

For some NO, there was an initial reverse culture shock, as they encountered environmental silence, comfortable living arrangements, no immediate threat, no weapons and people they had not seen for many months. As the NO was the person with a new viewpoint, the onus was on them to reintegrate themselves into everyone else's life. Participants did not articulate any concerns about having to do this but the potential for conflict with family and friends existed, as described by Rivers et al. (2013). At the same time, they started to reflect on where they had been, and what they had seen and done.

7.5.1.4.1 Frustration

As NO worked through their deployment memories and went back to work, many—despite an overall positive view of deployment and feeling lucky to live in Australia—started to experience a sense of frustration and professional loss. Their skill base and, on occasion,

scope of practice had expanded, yet they no longer possessed the same autonomy or scope as they had in IAC. Moreover, others around them did not demonstrate the same sense of urgency, speed of action or ability to foresee and plan for unexpected events. Participants were also less stressed over the small things in life. This situation established a tension point between the NO and the perspectives of Australians who had not deployed. These findings are similar to those of authors studying nurses who served in wars from Vietnam to Afghanistan (Biedermann et al., 2001; Gaylord, 2006; Rivers et al., 2013; Rushton et al., 2008; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 201).

Frustration arising from the transition back to Australia and adjusting to non-combat life was compounded by events in the military and civilian environs, leading to NO feeling undervalued and under-utilised. Aggravating their sense of frustration was the perception by NO that their colleagues were not being enabled for future deployments. As previously mentioned, in the military context, the people making decisions about NO were not nurses and did not demonstrate to NO that they understood nursing readiness requirements or capability. For NO who had struggled and not performed as well as they would have liked, frustration over a lack of autonomy was perpetuated by a vague sense of inadequate achievement on deployment, particularly in areas such as ethical practice. The extent of loss they had witnessed was a source of anger and frustration for some.

Another driver of post-deployment frustration was learning to live with a new sense of self. NO returned to Australia with a refined and enhanced sense of what being an Army NO meant. However, their view of the Army NO was not understood by many of their Army and civilian colleagues, a finding congruent with that of Rivers et al. (2013). Consequently, all NO began a process of developing a post-war identity as part of their reintegration and ‘refitting to fight’. This involved working through a number of challenges, including those entailed in the poor fit between their Army NO identity forged in conflict and the society they had returned to. Individual and variable, this process was inter-connected with issues of autonomy and other aforementioned points of irritation.

This post-deployment challenge around identity is newly reported in the Australian context. Extrapolating the work of Elliott, Chargualaf and Patterson (2017), it can be argued the military nursing identity persists whether on exit from the military or when deploying home

to a non-conflict military setting. In the Elliott et al. (2017) study, there was a significant period of personal and professional reconstruction when a nurse left the military and integrated to a civilian environment. This resonates with the experience of a number of NO in this study who returned home with a clear and enhanced sense of who they were as Army NO, only to discover it did not align with their civilian practice (or all aspects of their military practice at home), leaving them feeling a sense of loss. This was more pronounced in ARES NO, who returned to civilian hospitals. Subsequently, each NO mentally reconstructed who they had become to fit in with society and avoid friction.

In keeping with the findings of Rivers et al. (2013), reintegrating was a process NO needed to work through. Although the Army had specific post-deployment psychological evaluation requirements, the reintegration timeline was individual rather than Command driven. Each person learned to deal with how they reacted to the non-combat environment and people at home. Some NO took a lot longer than others and most NO found talking to others who had deployed helped, although this opportunity was not readily available to all. This finding also resonates with the findings of Rivers et al. (2013).

7.5.1.4.2 Post-Traumatic Growth

Several NO took years to overcome identity challenges, loss of autonomy, anger at what they had seen and feeling unprepared for their deployment. Further, for a range of reasons outlined throughout this thesis, they did not necessarily feel official organisation-driven debriefing was a setting in which they could talk or that there was a formal avenue through which they could share lessons learned. In their post-deployment years, NO built on their new appreciation for life by focusing on their relationship with others and new work possibilities. Although none left the military, a few changed their employment status and all focused on finding ways to advance Army health. Eventually, they bounced back stronger than when they deployed, suggesting they experienced post-traumatic growth (PTG) as opposed to the pervasive and prevalent notion of mental damage because of war.

PTG is a theory developed by Tedeschi and Calhoun (1996) to explain positive psychological transformation following trauma that people may initially have struggled with. The process of PTG is stronger following extraordinary trauma and involves developing a new

understanding of the world, self, relationships and meaning of life (Tedeschi & Calhoun, 1996). According to Schok et al. (2014), PTG involves individuals processing experiences to find benefits rather than taking a negative outlook. It has also been suggested that resilience is inferred in people who demonstrate PTG (Feczer & Bjorklund, 2009), although it is important to note that PTG and resilience are not synonymous. PTG occurs after someone has struggled to remain resilient. According to Tedeschi and Calhoun (1996), women are more likely to find positive benefit from trauma, which may partly explain evidence of PTG in the female-dominated profession of nursing (Collier, 2016; Lev-Wiesel et al., 2009).

There is a great deal of literature on the likely prevalence and risk of PTSD, which has an unquestionable place in a study of military personnel and their experiences (Feczer & Bjorklund, 2009; Gibbons et al., 2011; Sinclair & Britt, 2013; Skramlik, 2017). In relation to NO, according to Feczer and Bjorklund (2009), it was argued in studies of the war in Vietnam that care of the dying was central to the traumatic experiences of nurses and the primary cause of PTSD. However, for NO in this study, providing care to the dying was a source of strength and purpose, a way to focus their empathy and feel pride at what they managed to accomplish. Gaining strength from traumatic experience (particularly as a nurse) was described by Lev-Wiesel et al. (2009), who examined Israeli military nurses; this strength may explain how NO were able to remain resilient or successfully achieve PTG.

Several authors have found there has been an overt emphasis on vulnerability and pathology (e.g., PTSD), at the expense of personal growth (Bonanno, 2004; Richardson et al., 2013; Scannell-Desch & Anderson, 2005; Van Breda, 2001). There are several potential consequences from a singular focus on a deficit-based approach to mental health post-IAC. Coping with adversity can become unique rather than normal, institutional solutions to building resilience are not considered and clinicians assessing the returned combat veteran are more interested in looking for problems than strengths (Van Breda, 2001).

During routine post-deployment psychological assessment, NO experienced a problem-based approach to mental health assessment—a situation triggering frustration they did not previously have. Those doing the psychological testing assumed that losing a patient was traumatic (in the PTSD sense), especially if the event was remembered, and so they would request the NO return for follow up. This assumption did not consider that remembering

patients who died may be a normal process for nurses in managing the emotional impact of such an event. Importantly, as Bonanno (2004) has noted, there is evidence that clinical intervention during normal adjustment processes may actually be harmful. He argued that normal reactions to adversity should not be pathologised because this may undermine resilience (Bonanno, 2004). NO in this study suggested that post-deployment testing should consider what is normal for NO before determining what is abnormal, to avoid inducing unnecessary frustration.

7.5.1.4.3 Refitting to Fight

During the 'reset' period, which occurs between deployments, the process of learning to live with a new sense of self, construct a post-conflict identity and grow, took time, personally and professionally. All NO reassessed their life in some way, each one making a decision that involved improving the future for nurses. Keen to share their experience and reveal what NO do, participants wanted to ensure those who follow them are militarily, clinically and personally ready. They were concerned that NO who deployed in the future may not fully appreciate what being ready meant and that being positive was essential. These ideas of positivity and sharing lessons resonate strongly with other studies about the experience of military nursing in armed conflict over the last 50 years (Biedermann et al., 2001; Goodman et al., 2013; Griffiths & Jasper, 2008; Rushton et al., 2008; Sadhaan et al., 2022; Scannell-Desch & Anderson, 2005; Scannell-Desch & Doherty, 2010).

Despite wanting to share their lessons, most participants felt the Army system did not adequately acknowledge the challenges NO faced. This was perhaps because of the previously discussed lack of understanding about nursing and how it nests within the military. Scannell-Desch and Doherty (2010) and Rivers et al. (2013) have noted similar concerns by nurses returning home from deployment to Iraq and Afghanistan, suggesting that there is an element of ongoing failure by military organisations internationally to adequately identify and share lessons learned by military nurses in IAC. In turn, a lack of acknowledgement by military authority can produce a sense of disaffection with this attitude to nurses, complicating reintegration when the nurse returns home.

On the back of the two previous sections discussing military and clinical readiness, this section has linked professional readiness to being personally ready for IAC—to cope during deployment, subsequently process thoughts of armed conflict experience and manage other effects such as perceptions of identity. Thus, the combined experience of preparation and deployment influenced how NO felt when they returned home. This ultimately depended on how they generally believed their deployment went, whether they met their own expectations and what stressors they faced.

7.6 Conclusion

This chapter discussed military, clinical and personal readiness in the context of the literature. However, existing literature is largely silent about nurses and their preparation to work with the military or why this might be important—perhaps because their existence is lost beneath the prevalent soldier paradigm. This chapter revealed the importance of military acculturation, socialisation to the NO role and balancing this with clinical readiness, providing understanding about how the NO can safely nest within a military organisation while meeting professional nursing obligations (NMBA, 2018a).

However, it was up to the individual to reconcile any duality between nursing and military purpose, insofar as a lack of organisational understanding about NO and what they do, combined with an overt emphasis on militarisation over clinical performance, inhibited socialisation to their role and clinical readiness. Deployment had the effect of both enhancing NO identity development and highlighting the scope of practice needed for NO to practise safely and effectively in IAC. Resilience was central to the strategies NO used when coping with a range of challenges—from preparation, through deployment to returning home. In the next chapter, this thesis concludes with a brief on how this study has contributed to what is known about Australian Army NO, the quality of the findings, recommendations for the future and any study limitations.

Chapter 8: Conclusions

8.1 Introduction

Given a background of little documentation to explain the experience of Australian Army NO, this study used GT methodology to advance understanding of what the contemporary NO experiences in IAC, both personally and professionally. The result was a theory that describes the NO approach to care delivery while they reconcile with the surrounding environment, clarify their military professional identity and cope with associated challenges. This chapter summarises what this study has contributed to understanding of the topic, evaluates the study's quality, provides recommendations for future research and identifies limitations of this work.

8.2 Contribution to the Literature

8.2.1 What is Already Known About the Topic

This study was undertaken because very little was known about Army nursing since its inception in the Crimea over 160 years ago. As evidenced by the small body of relatively recent literature described in Chapter Two, there is limited knowledge of the nursing experience in Korea and the war in Vietnam, nothing on Rwanda and a paucity of information on the contemporary experience of nurses who deployed this century to the Middle East wars. Most available literature focuses on the two world wars.

Despite suggesting a potential tension between the dual roles held by nurses when employed as NO, the available literature identified but did not explore the progressive militarisation of nurses. Clinical readiness to deal with the nature of trauma as it occurs in armed conflict—including the risk of moral distress if NO were not ready for the guidelines established by a mission—was identified as a chronic issue. Various challenges with transitioning into and out of conflict have been identified in previous work (Rushton et al., 2008; Scannell-Desch & Doherty, 2010).

8.2.2 What this Study Adds

This study provides a narrative on the contemporary Australian experience in recent Middle East conflicts and serves as an important historical account in the history of the RAANC. Importantly, it has taken this narrative and used it to produce a theory that explains what deployment entails and how NO processed challenges to survive their deployment.

This study takes Bassett's (1992) recognition that nurses had been progressively militarised and illuminates how this has influenced NO identity, role, practice and capability within the Army. For a range of interrelated reasons, an important influence has been the erosion of clinical readiness and the development of an internal culture where the expectation of what is 'ready' is lower than an equivalent civilian benchmark. Moreover, this study suggests that the extent to which nurses have been militarised has been to the detriment of their clinical capability—shifting them further towards non-nursing activity—thus undermining the nursing effect the Army wants from NO. In addition, the findings reveal the potential impact a lack of clinical readiness may have on the coping capacity of individual NO.

Preparation for IAC was framed using the domains of readiness by Harrison et al. (2021). The scope of practice required by NO in IAC has been integrated into the Benner (1984) and Synergy models (Curley, 2007) to highlight clinical readiness requirements in terms of knowledge, skill and the time it would take to obtain a proficient level of practice. This process established a base for considering future NO development and clinical practice needs. This study also exposed the nature of ethical dilemmas NO encounter in the modern combat environment and, in particular, revealed how the ethical frameworks NO deploy with do not translate easily to the deployed environment. This situation is aggravated by a lack of clinical and life experience, as well as a lack of training in ethical decision-making in an adverse environment.

From a suggestion of tension over dual roles, this study provides a view of how Australian Army NO reconcile the duality of nurse and officer and synthesise a singular identity (NO). Simultaneously, the study describes the identity and role of contemporary Australian Army NO and what they do to provide care during IAC. There are explanations of how they navigate and negotiate difficult professional terrain without specific socialisation to the NO

role, how they work with the Army family and other cultures to provide effective care and how they ultimately reconcile with the threat.

Findings about NO resilience revealed a range of protective traits, including mental adaptability, courage and compassion. There is an implication that inherent nursing nature might mean the NO can find demands for them to use their emotional capacity in support of others, to be a source of strength (a positive effect). In turn, paradoxically, there was for many a further conferred benefit in feeling more resilient as a result. Importantly, there is the suggestion that experience plays an important part in how successful a nurse may be in surviving and growing as a result of their deployment.

In an era when deficit-based approaches to mental health and assumptions about negative effects of trauma predominate, this study reveals a link between NO and the phenomenon of PTG, supporting the idea NO may possess certain innate characteristics that promote resilience and growth in the face of trauma. These are important findings, revealing how NO survived and ultimately thrived in an environment of conflict.

8.3 Quality of the Developed Theory

It is important to evaluate a theory to establish trust in the quality and accuracy of research findings. As described in Chapter Three, there are seven criteria used to evaluate rigour in Glaserian GT. The theory must fit the data, be workable, relevant and modifiable in response to changing circumstance. In addition, it should be understood by those to whom it relates, provide an element of generalisation so that theoretical principles can be used in variable situations and allow the user a sense of control over day-to-day events (Glaser, 1978). As an evaluation of this study, a brief description of how this GT study achieved each of these requirements is provided in Table 5.

Table 5: Evaluation of Study Using Glaserian Canons for Quality

Canon	Example
Fit	A number of mechanisms demonstrated fit. Supervisors oversaw each stage of the research process. In Phase 2, participant checks were used to test interpretations and conclusions, giving Phase 1 participants the opportunity to comment on the authenticity of the interpretation and theory to their experience. During all phases, memos provided a reflection of my personal beliefs and values. Newly recruited Phase 2 participants were also able to provide their thoughts on how well the theory fit their own experiences of deployment. These processes ensured the data fit the emergent theory.
Workability	Workability of the theory was identified in Phase 2, when both Phase 1 and Phase 2 participants reported on whether the final theory reflected their view of being an Army NO in IAC. The inclusion of new participants in Phase 2 strengthened the workability of the theory, as some had deployed to a different operation to Phase 1 participants and over a longer timeframe.
Relevance	Relevance was demonstrated in two ways: by reviewing all data evidence and avenues of thought that led to conclusions as the study progressed and through the input of participants in Phase 2.
Modifiability	For this study, as explained in Chapters Four to Seven, themes such as clinical readiness have remained constant throughout history, with only the context, precipitating factors and conditions changing. Thus, the theory is modifiable in response to changing context.
Understandability	To evaluate understandability, it will be necessary to undertake further research to identify the extent to which other healthcare providers and non-healthcare military personnel understand Army nursing, from the theory.
Generality and control	The theory is based on principles that can be applied in any setting NO work in. This permitted an element of generality insofar as events change with time but the requirement to nurse in the midst of conflict does not.

8.4 Implications of this Study

The findings of this study establish a baseline for understanding the environment in which contemporary NO work and highlight challenges to nursing practice. Rather than overtly challenging the small amount of existing literature, these findings extend our knowledge of both the military environment in which NO work and IAC to which some NO will deploy. In particular, we now possess an understanding of how militarisation can affect nurses through a theory of caring under fire. Our awareness of the impact of IAC on clinical practice is greater, particularly in the context of both modern combat and the profession of nursing.

The issue of moral readiness has been revealed, which was previously largely absent from historical discussion. The personal readiness of NO has been placed in a framework for understanding how NO manage their mental health while deployed, both personally and professionally.

Some concepts were new and others were a variation on an existing theme—a theme that was, admittedly, not fully articulated in existing literature. Although we now have a greater understanding of the challenges NO experience, this updated knowledge has revealed new questions that require further exploration. Using the domains outlined in Chapter Seven—of clinical, military and personal readiness—the newly exposed questions, of both a practical and theoretical nature, are:

- Why is a lack of clinical readiness a persistent theme in Army nursing and what can be done to rectify the situation?
- What are the implications for the future of Army nursing of the findings regarding the unintentional consequences of the progressive militarisation of nurses?
- Does the theory of caring under fire provide other healthcare providers and non-healthcare military personnel with an understanding of Army nursing, particularly the NO?
- Why does clinical leadership not receive consideration as an important aspect of clinical practice within the military?
- Why is moral readiness a relatively newly considered challenge in Army nursing and what can we do to adequately prepare NO?
- Why were NO able to demonstrate resilience to high demands for their emotional support and to the general pressures of the IAC environment?
- How can NO use the findings and theory to better prepare for and cope with deployment to IAC?

8.5 Recommendations

As a result of the findings, this study offers nine recommendations. These are summarised in Table 6 and detailed thereafter.

Table 6: Summary of Recommendations

Area	Recommendation
Practice and Education (training)	1. Implement an advanced practice evaluation tool aligned with the Benner Proficient level of practice and Synergy requirements. 2. Develop NO clinical leadership capacity through training and clinical experience. 3. Develop NO ethical leadership by including ethical case-based training as part of NO specialist career courses and pre-deployment training.
Policy	4. Review clinical readiness standards against the requirement to be Benner Proficient. 5. Promote access for specialists (e.g., ICU, ED, OT) to the part-time service category (SERCAT) employment option. 6. Consider a clinical pathway to the rank of Lieutenant Colonel (LTCOL) to promote clinical leadership and recognition of advanced practice.
Research	7. Explore the nature of resilience in NO. 8. Examine healthcare provider ethical–moral readiness for working in IAC. 9. Strengthen the theory by examining other deployments to armed conflict and humanitarian missions, and the experience of NO who have left the Army.

8.5.1 Recommendation 1

Implement an advanced practice evaluation tool aligned with the Benner Proficient level of practice and Synergy requirements.

An advanced practice evaluation tool would provide a standardised understanding of the NO clinical role in IAC and a way to guide NO development. As described in this study, with most NO finding themselves unprepared for IAC over the last 100 years, alignment with the Benner and Synergy requirements for readiness to practise in IAC (Chapter Seven) would assist in redressing this perpetuating practice challenge. This would subsequently improve the NO and patient experience.

8.5.2 Recommendation 2

Develop NO clinical leadership capacity through training and clinical experience.

This study identified that clinical leadership training is largely non-existent for NO in the Army and is subsumed beneath general military leadership or assumed to be a byproduct. There may also be a potential lack of understanding as to what clinical leadership is—in particular, the role of clinical acumen and the experience required to develop this capacity. Clinical leadership ability may also be affected by the level of available clinical experience. To address the problem, clinical leadership requires both a well-developed clinical practice foundation and specific training. It is recommended that the process of preparing nurses for their role in terms of clinical leadership is examined, including how NO can be taught to utilise their officer status to support clinical decision-making. It is also recommended that clinical leadership training is incorporated into basic health training

8.5.3 Recommendation 3

Develop NO ethical leadership by including ethical case-based training as part of NO specialist career courses and pre-deployment training.

A key finding of this study concerned the ethical challenges NO experienced and the differential between ethical dilemmas in Australia versus those in the IAC setting. This distinction was aggravated by clinical leadership challenges that could undermine ethical leadership. To that end, ethical case-based training that is true to the experience of recent conflict is a necessary addition to both career development courses and pre-deployment training. Because the nature of ethical dilemmas in IAC requires a solid understanding of and ability to manage complex problems, it is not enough to do last-minute training. This capacity is best built over time.

8.5.4 Recommendation 4

Review clinical readiness standards against the requirement to be Benner Proficient.

To ensure NO are ready for practice in IAC, it would be valuable to review existing Army clinical readiness standards, which detail training and clinical practice requirements to be ready to deploy, against the Benner Proficient standards discussed in Chapter Seven.

8.5.5 Recommendation 5

Promote access for specialists (e.g., ICU, ED, OT) to the part-time service category (SERCAT) employment option.

To address findings from this study regarding the clinical readiness of NO, a strategy of drawing on existing clinical experience, in addition to developing the practice of the less experienced, would offer a sustainable pathway to a strong NO workforce. Currently ARA have access to part-time status, offering them the ability to develop clinical capacity over time. As the majority of ongoing clinical experience, including clinical leadership, exists in the ARES, the recommendation is to consider how this group might also access part-time status to develop militarily and strengthen the clinical capacity of the permanent military.

In acknowledgement of the study findings that military readiness is also essential to effective deployment, it is suggested that, in addition to employment course completion, a minimum period of ARES service be established as criteria for ARES entering part-time ADF employment. Offering part-time status for NO from either the ARA or ARES would provide significant benefit in terms of advancing the overall clinical capability of NO, while simultaneously advancing clinical leadership capacity.

8.5.6 Recommendation 6

Consider a clinical pathway to the rank of Lieutenant Colonel (LTCOL) to promote clinical leadership and recognition of advanced practice.

In addition to recommendations 1 through 5, offering a clinical pathway to the rank of LTCOL would enable NO the opportunity to develop significant clinical ability, role model

and mentor clinical development within the corps and connect strong clinical experience with strategic level professional development. This would offer the Army a stronger NO workforce, improved retention, greater clinical capability, advanced advocacy and ethical leadership and a greater level of proficient to expert patient care. NO would have a professional pathway beyond administration that is in line with the foundations of the broader nursing profession (clinical care). Finally, there would be a clearer alignment between the pathway for medical practitioners and that of NO that recognises the value of nursing and nursing clinical leadership.

8.5.7 Recommendation 7

Explore the nature of resilience in NO.

This study revealed how NO coped despite generally increased demands on their emotional strength, often in isolation from other nurses. Concepts such as distress tolerance, mental comfort zones and how they approached post-deployment reconstruction, all provide a framework for understanding what NO did to protect their mental health and continue providing patient care. This raises a number of questions: Does the inherent nursing nature mean that NO draw strength from their ability to share their emotional capacity (a positive effect)? Does this ability paradoxically support resilience? Is this effect dependent on underlying personality and clinical experience? Would a nurse who is struggling clinically have an emotional reserve to share with others and would they be more at risk of compassion fatigue?

To recognise the potential implications for the NO, their coping strategies and ability to protect themselves against emotional trauma, it is important to understand what effect others' demands for emotional support might have on NO. Therefore, a broader examination of NO resilience would provide valuable information as to how NO coped—such as by drawing on protective factors innate to nurses—and what this may offer in terms of useful strategies for developing resilience in non-military nurses.

8.5.8 Recommendation 8

Examine healthcare provider ethical–moral readiness for working in IAC.

The IAC environment NO found themselves in during the Iraq and Afghanistan conflicts saw them encounter a range of significant ethical issues, an experience that resonated with findings by US military nurses who worked in the same setting. Most prevalent was the risk of moral distress, despite the reasons for this distress in Australian NO differing to those of some of their US counterparts. Although moral drift and disengagement were not issues for NO in this study, they remain a risk in future situations. Given the risk of unresolved or poorly managed ethical situations for both NO and patients, it is highly recommended that further research is undertaken to explore the nature of clinical ethical issues, how they differ to and are influenced by combat ethical issues, the role of NO in making ethical decisions and how to best prepare all healthcare providers to be ethically ready for IAC. Moreover, the potential role of NO in supporting robust ethical decision-making in the healthcare space should be explored.

8.5.9 Recommendation 9

Strengthen the theory by examining other deployments to armed conflict and humanitarian missions, and the experience of NO who have left the Army.

The theory is focused on nursing in the IAC environment. However, it incorporates general aspects of the militarisation of nurses and their clinical, moral and personal readiness to deploy. It is, therefore, potentially transferable to non-IAC settings. To confirm this transferability to the environments an NO may deploy to as a clinician, it would be useful to test this theory on NO who have deployed to humanitarian operations, as well as other non-IAC settings.

In addition, because this study used currently serving NO as participants, it is important to examine the experience of those NO who have left the military to establish whether their experience resonates with the theory or offers alternative views on the challenges of deployment and strategies used to cope with these.

8.6 Limitations

Ideally, when implementing data collection in Glaserian GT, field observation would be used (Artinian et al., 2009; Glaser, 1978). However, given both the risk associated with being in a conflict zone and lack of access to observe military activity, this study utilised interviews. In addition, because there was a need to travel around the country for interviews, on occasion several interviews were conducted within a short timeframe, without the opportunity to fully transcribe between them. This did, however, allow for emerging concepts to be integrated into subsequent interviews.

Because this study relied on recollection and retrospect, there was the potential for time to affect participants' memories and thoughts. For instance, a participant may be more likely to go through a process of raw regurgitation of thoughts if an interview is soon after deployment. Over time, as NO process their memory of deployment, there might be a shift in how they view their experience.

Because this study focused on a sample of actively serving NO at the time of participation, there was no examination of NO who have left the military and are covered by the Department of Veterans Affairs (DVA). Their reasons for leaving and how these may relate to deployment experience could therefore not be explored. This does, however, establish an opportunity for future research to examine the experience of NO who are no longer serving.

Traditionally, being an insider in research is considered a challenge to the researcher's ability to separate their self from analysis. However, being an outsider does not automatically confer immunity to prejudice (Dwyer & Buckle, 2009). Assumptions about the Army arising from an outsider with feminist or pacifist perspectives could alter research outcomes as easily as an insider who fails to keep their inside knowledge out of the findings. To that end, as described in Chapter Three, I used the methods entailed in Glaserian GT to keep myself open to new and emerging ideas while minimising the effects of my own experience on the study.

8.7 Conclusion

This chapter has summarised how this study has contributed to the literature, evaluated the study's quality, provided recommendations for future research and identified implications and limitations. This study makes a significant contribution to the literature while simultaneously demonstrating the persistence of themes observed over the course of military nursing history. At the same time, the findings from this study elicit new questions about the role and functioning of NO in IAC, raising implications for future research, policy and practice and setting the scene for future developments in NO readiness.

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Appendices

Appendix A: Recruitment Flyer

RESEARCH PARTICIPATION ADVERTISEMENT

An exploration of how Australian Army Nurses function, practice in and survive war

Participants are being sought for a research study investigating the experiences of Australian Army Registered Nurses (RN) deployed to war.

The study will explore the modern experience of deployed Army RN deployed by looking at: how the Army and armed conflict influence nursing practice, what strategies RN use to prepare for deployment and when practising in an armed conflict zone, and the impact on nursing practice when they return home.

If you are an Army RN who deployed in a nursing role on Operation Catalyst, Iraq or Operation Slipper, Afghanistan, we would be interested in hearing from you.

Participation in this project will require you to participate in a semi structured interview, which is expected to take between 45–60 minutes. The location will be one mutually agreed between you and the researcher.

You will be asked questions about your experience of deploying to armed conflict, delivering nursing care, the strategies you used during your deployment to manage any challenges you faced, what you experienced when you came home and what you would like to share with other RN about going to war.

There may be follow up activity after the interview, where the researcher may contact you to clarify a point or obtain further detail.

Participation in this study is completely voluntary and you can withdraw from the study at any time.

At this point in time approval has been given for Nursing Officers posted to FORCOMD to be involved in the study. The study will continue up till 2019, allowing any NO posted to FORCOMD during this time to participate.

This project is being conducted by Jane Mateer as part of a research degree through ACU. If you would like to participate, please contact Jane on the following email address:

Appendix B: Plain Language Sheet and Consent Form 1

Australian Government
Department of Defence

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Title	**A theory of modern Australian Army nursing in armed conflict**
Protocol number:	810 – 15
Principal Investigator:	Jane Mateer Dr Alicia Evans Professor Brian McKenna Dr Val Goodwin Dr Narelle Biedermann

This form tells you about this research study and explains the processes involved with taking part. Knowing what is involved will help you decide if you want to participate in the research. Please read this information carefully. Ask questions about anything that you do not understand or want to know more about.

Participation in this research is entirely voluntary; there is no obligation to take part in the study, and if you choose not to participate there will be no detriment to your career. If you decide you want to take part in the research project, you will be asked to sign the consent section. You will be given a copy of this Participant Information and Consent Form to keep.

The study

This study is being conducted by Jane Mateer and will form the basis for a research degree at Australian Catholic University under the supervision of academics at ACU. Jane is a Reserve Australian Army Nursing Officer; however she is conducting this research separately from her Army role.

This study aims to investigate the contemporary experiences of Australian Army registered nurses (RN) deployed to and practicing in an armed conflict zone. By exploring the modern experience of Army RN deployed to conflict it is hoped this study will provide a foundation for the future development of Army RN practice by: developing an understanding of how the Army and conflict influence nursing practice, identifying strategies RN use in order to prepare for their experience of deploying to and practicing in conflict zones, and identifying strategies used to deliver care in a conflict zone. We would also like to know if the experience of armed conflict affects the Army RN in their non-conflict zone practice. In essence, we would like to know about your experience of nursing with the Army whilst in an armed conflict.

Who can participate?

For this research study we are interested in speaking to current or ex serving Army RN who deployed as a nursing officer on Operation Catalyst, Iraq or Operation Slipper, Afghanistan.

What will participation involve?

Participation is completely voluntary. You are not under any obligation to take part.

- If you choose not to participate there will be no detriment to your career.
- If you agree to participate, you can withdraw your participation in the study at any time without adverse consequences. All you need to do is contact the researcher in writing by email and your withdrawal will be immediate.
- As the researcher may be flying interstate to conduct an interview with you, you are requested ~~required~~ to give at least 24hrs notice of your intent to withdraw your participation.
- It is important to note that at the time you withdraw, if any information you have previously given to the researcher has been analysed, it will remain part of the study. The reason for this is that this study will be using a process for analysing the information you provide, which deeply embeds that information into ideas about Army nursing. Therefore, it will be not be possible to remove information after analysis has occurred. However, your future participation will cease. In this study, analysis occurs immediately after each interview.
- Current serving personnel will be deemed to be 'on duty' whilst participating in the research.

Participation in this project will require you to:

- Participate in an interview, which is expected to take between 45 – 60 minutes and will be digitally audio recorded to assist the researcher in documenting what is shared in the interview.
- You will be asked to discuss only unclassified information
- You will be asked questions about your experience of deploying to armed conflict, delivering nursing care, the strategies you used during your deployment to manage any challenges you faced, your experience of nursing when you returned home and what you would like to share with other nurses about going to armed conflict.
- Interviews will be conducted in a mutually convenient public or Defence location, negotiated between you and the researcher. The location will be one in which you can talk to the interviewer privately and shared information will remain confidential and secure.
- There may be follow up activity after the interview, either by phone or in person, where the researcher may contact you, in order to confirm that the have faithfully interpreted what you have said or to explore areas where more detail is required.

The conduct of this research will be monitored by the researcher's supervisors and the human research ethical committees (HREC) who have approved this study.

Benefits

There are no expected immediate benefits to you from this research. However, possible benefits may include: the opportunity to contribute to establishing a clearer understanding of the challenges faced by Army RN, including the realities of armed conflict; what an Army RN does as a unique subset of the nursing profession and assisting with creating a foundation for future research which can look at improving patient outcomes based on evidence based Army RN practice. The main benefits of this research are to future military RN and the wider community.

Are there any risks in participating?

Whilst it is not envisaged you will experience distress from being interviewed, should distress occur as a result of sharing experience with the researcher, the following will occur. The interview will be stopped to give you time to collect your thoughts. If you are unable to continue the interview will cease and you will be offered support to deal with any issues which may arise through referral to a support service. IMSICK, the All Hours Support Line and the Defence Family Helpline are available if you are currently serving. Contact details for the Veterans and Veterans Families Counseling Service (VVCS), Beyond Blue or Life Line will be available for all participants. The researcher will give you a list of the available organisations and their contact details, and assist you in making contact.

Even if you do not become distressed during the interview, at the end of the interview all participants will be given an information sheet listing counseling referral services, in the event you experience distress at a time after the interview.

If you declare any alleged illegal activity which may have occurred on a deployment, the researcher, who remains subject to mandatory reporting obligations as an RN and as a Defence member, may be required to report this if it has not previously been reported. Therefore, you are advised to avoid self incrimination if mentioning alleged illegal activity.

Privacy and Confidentiality

You will be given a pseudonym, so that information obtained in this study is de-identified, to everyone except the researcher who conducts the interview. The pseudonym key will be stored securely on the researcher's computer and in a locked filing cabinet, to which no one else has access. You will also not be identified by rank or rotation.

When the researchers supervisors review the information obtained during interview, your confidentiality is maintained because the information is not identified by real name. Therefore, only the researcher will know who gives which answers.

The results of this study will be produced as a thesis and subsequently published in both military and nursing literature; however you will not be identified and there will be no way of identifying individual responses in any reports or published articles. Any personal data collected will only be used for the purpose of this study. All data will be archived securely for seven years after the study is published and treated as confidential material. After seven years all data will be destroyed, including hard copy, audio and electronic files, and the pseudonym key.

~~A nominal roll of study participants will be provided to the Australian Defence Human Research Ethics Committee (ADHREC) for the sole purpose of facilitating the tracing of participants should anything untoward develop in the future that may be related to this study. This information will be stored in the protocol file, will only be accessible to the ADHREC secretariat and may assist the future health care of individual study participants.~~

If you participate in the study and would like to find out the results, then please let Jane know at interview and provide a forwarding email address or other contact details.

Human Research Ethical Review

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies. The ethical aspects of this study have been approved by the Human Research Ethics Committee at Australian Catholic University (ACU HREC) (review number 2015 xxxx), the Australian Defence Human Research Ethics Committee (ADHREC) review number 810-15) and the Department of Veterans Affairs Human Research Ethics Committee (DVA HREC) review number 2015 xxxx)

Guidelines for Volunteers

A copy of the ADHREC Guidelines for Volunteers is attached and is also available at http://www.defence.gov.au/health/shc/ddhrc/adhrec/forms.asp#Adhrec.

Dissemination of Research Findings

It is anticipated that the results of this research study will be published and presented in a variety of forums. Information provided in any publication or presention will be delivered in such a way that you cannot be identified, except with your permission.

Concerns or Complaints

Should you have any concerns or complaints about the manner in which this project is conducted, please do not hesitate to contact the primary researcher, Jane Mateer, on

Or you may prefer to contact the HREC who have reviewed this study at the below addresses.

ADHREC
Executive Officer
Australian Defence Human Research Ethics Committee
CP3-6-037
PO Box 7911
Department of Defence
CANBERRA BC ACT 2600
AUSTRALIA

Telephone: (02) 6266 3807
Email: ADHREC@defence.gov.au

ACU, via the Office of the Deputy Vice Chancellor (Research)

Manager, Ethics
c/o Office of the Deputy Vice Chancellor (Research)
Australian Catholic University
North Sydney Campus
PO Box 968
NORTH SYDNEY, NSW 2059
Ph.: 02 9739 2519

Fax: 02 9739 2870

Email: res.ethics@acu.edu.au

DVA HREC

DVA HREC Secretariat
Department of Veterans' Affairs
PO Box 9998
CANBERRA, ACT 2600

Email: ethics.committee@dva.gov.au

Who is organising and funding the research?
This research project is being conducted by Jane Mateer and the Australian Catholic University. There are no financial benefits to any member of the research team undertaking this study (other than their ordinary wages).

Australian Government
Department of Defence

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Appendix C: Interview Guide

Demographics

Operation	
Year	
ARA or ARES	
Role	
Gender	
Years in Nursing (Civ)	
Years in the Military	
PG Qualification	

Prompts

1. Describe your experience of preparing for and deploying to a war zone
2. Challenges and how they were dealt with
3. Clinical decision-making
4. Advocacy
5. Being both a nurse and an officer
6. How do you feel about your deployment now?

Appendix D: Plain Language Sheet and Consent form 2

Australian Government
Department of Defence

JAMES COOK UNIVERSITY AUSTRALIA

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Title **Caring Under Fire: A theory of modern Australian Army Nursing Officers in armed conflict**

Protocol number: 810 – 15

Principal Investigators: Jane Mateer
Prof Melanie Birks

This form tells you about this research study and explains the processes involved with taking part. Knowing what is involved will help you decide if you want to participate in the research. Please read this information carefully. Ask questions about anything that you do not understand or want to know more about.

Participation in this research is entirely voluntary; there is no obligation to take part in the study, and if you choose not to participate there will be no detriment to your career. If you decide you want to take part in the research project, you will be asked to sign the consent section. You will be given a copy of this Participant Information and Consent Form to keep.

The study

This study is being conducted by Jane Mateer and will form the basis for a research degree at James Cook University under the supervision of academics at JCU. Jane is a Reserve Australian Army Nursing Officer; however she is conducting this research separately from her Army role.

This study aims to investigate the contemporary experiences of Australian Army Nursing Officers deployed to and practicing in an armed conflict zone. By exploring the modern experience of Army nurses deployed to conflict it is hoped this study will provide a foundation for the future development of Army Nursing Officer practice by: developing an understanding of how the Army and conflict influence nursing practice, identifying strategies nurses use in order to prepare for their experience of deploying to and practicing in conflict zones and identifying strategies used to deliver care in a conflict zone. We would also like to know if the experience of armed conflict affects the Army Nursing Officers in their non conflict zone practice.

The study is now in its second phase, where information previously provided, has been incorporated into a theory which explains the experience of being an Army Nursing Officers in armed conflict. In phase two we are asking nurses to tell us whether the theory resonates with their experience on deployment, so we can confirm or modify the content.

Who can participate?

For this research study we are interested in speaking to current or ex serving Army nurses who deployed as a nursing officer on Operation Catalyst (Iraq) or Operations Slipper or High Road (Afghanistan).

What will participation involve?

Participation is completely voluntary. You are not under any obligation to take part.

- If you agree to participate, you can withdraw from the study at any time without adverse consequences. All you need to do is contact the researcher in writing by email and your withdrawal will be immediate.
- At the time you withdraw, any information previously given to the researcher will remain part of the study. The reason for this is that this study will be using a process of anlaysing the information you provide, which deeply embeds that information into ideas about Army nursing. Therefore, it will be not be possible to remove information already synthesised into the analysis.
- If you choose not to participate there will be no detriment to your career.
- Current serving personnel will be deemed to be 'on duty' whilst participating in the research.

Participation in this phase of the project will require you to:

- Review a summary of the story (theory) developed from phase one, to determine the extent to which it resonates with your experience on deployment. This will be undertaken using an online platform (Qualtrics). It is expected to take about 30 – 45 minutes or your time.
- You can alternatively choose to participate in an interview if you prefer to discuss your experience face to face with the researcher. Interviews are expected to take between 30 – 45 minutes and will be digitally recorded to assist the researcher in documenting what is shared in the interview.
- You will be asked to discuss only unclassified information
- You will be asked questions around your experience of deploying to armed conflict as a Nursing Officer, delivering nursing care, the strategies you used during your deployment to manage any challenges you faced, your experience of nursing when you returned home and what you would like to share with other nurses about going to armed conflict.
- If you participate in an interview, it will be conducted in a mutually convenient location, negotiated between you and the researcher.

The conduct of this research will be monitored by the researcher's supervisors and the human research ethical committees (HREC) who have approved this study.

Benefits

There are no expected immediae benefits to you from this research. However, possible benefits may include: the oportunity to contribute to establishing a clearer understanding of the challenges faced by Army Nursing Officers, including the realities of armed conflict; what an Army RN does as a unique subset of the nursing profession and assisting with creating a

foundation for future research which can look at improving patient outcomes based on evidence based Army nursing practice. The main benefits of this research are to future military RN and the wider community.

Are there any risks in participating?

Whilst it is not envisaged you will experience distress from participating, should distress occur as a result of sharing experience with the researcher during an interview, it will be stopped and you will be offered support to deal with any issues which may arise through referral to a support service. IMSICK, the All Hours Support Line and the Defence Family Helpline are available if you are currently serving. Contact details for the Veterans and Veterans Families Counselling Service (VVCS), Beyond Blue or Life Line will be available for all participants. The researcher will provide contact information for all support services, both at the end of an interview, and on the survey platform if you participate online.

Privacy and Confidentiality

The information obtained in this study will be de-identified through the use of pseudonyms, to everyone except the researcher who conducts the interview. The pseudonym key will be stored securely on the researcher's computer and in a locked filing cabinet. Only the researcher will have access to the filing cabinet and computer files. You will also not be identified by rank or rotation.

All information obtained, both from interview or online survey, will be available to the researcher's supervisors, however confidentiality will be maintained as the data will be de-identified. Therefore, only the researcher will know who gives which answers.

The results of this study will be produced as a thesis and subsequently published in both military and nursing literature; however you will not be identified and there will be no way of identifying individual responses in any reports or published articles. Any personal data collected will only be used for the purpose of this study. All data will be archived securely for seven years after the study is published and treated as confidential material. After seven years all data will be destroyed.

If you participate in the study and would like to find out the results, then please let Jane know at interview and provide a forwarding email address or other contact details.

Human Research Ethical Review

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2018)*. This statement has been developed to protect the interests of people who agree to participate in human research studies. The ethical aspects of this study have been approved by the Departments of Defence and Veterans Affairs Human Research Ethics Committee (DDVAHREC) protocol number 810 – 15 and acknowledged by the Human Research Ethics Committee at James Cook University (JCU HREC).

Guidelines for Volunteers

A copy of the DDVA HREC Guidelines for Volunteers is attached and is also available at http://www.defence.gov.au/health/shc/ddhrc/adhrec/forms.asp#Adhrec.

Dissemination of Research Findings

It is anticipated that the results of this research study will be published and presented in a variety of forums. Information provided in any publication or presention will be delivered in such a way that you cannot be identified, except with your permission.

Concerns or Complaints

Should you have any complaints or concerns about the manner in which this project is conducted, please do not hesitate to contact the primary researcher, Jane Mateer, on

.

Or you may prefer to contact the HREC who have reviewed this study at the below addresses:

Departments of Defence and Veterans Affairs Human Research Ethics Committee

Telephone: (02) 6192 7821 or Email: ddva.hrec@defence.gov.au

JCU, via Helen Griffiths, Human Ethics Officer

James Cook University
Ph.: 07 4781 6575

Email: ethics@jcu.edu.au

Who is organising and funding the research?

This research project is being conducted by Jane Mateer and the James Cook University. There are no financial benefits to any member of the research team undertaking this study (other than their ordinary wages).

Australian Government
Department of Defence

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Appendix E: Qualtrics Content

QUALTRICS SURVEY CONTENT

What is your name? (This question is required so the researcher can connect your answers to a consent form—it is confidential to everyone else)

When did you join this study? (This is also a required question)

- Phase 1: 2016–2018 (initial interviews)
- Phase 2: just now (2020–2021)

Demographics

The following questions will be used to understand influences like military and clinical experience, on your overall experience of deployment.

What operation/s did you deploy on? [Select all that apply]

- OP Catalyst
- OP Slipper
- OP High Road

If you deployed on OP Catalyst, were you employed by the ARA or ARES immediately prior to your deployment?

- ARA
- ARES (CFTS)

If you deployed on OP Slipper, were you employed by the ARA or ARES immediately prior to your deployment?

- ARA
- ARES (CFTS)

If you deployed on OP High Road, were you employed by the ARA or ARES immediately prior to your deployment?

- ARA
- ARES (CFTS)

How many years had you been a registered nurse when you deployed to OP Catalyst?

- Less than 2 years
- 3–5 years
- 6–8 years
- 9–11 years
- 12–14 years
- 15–17 years
- 18–20 years
- More than 20 years

How many years had you been a registered nurse when you deployed to OP Slipper?

- Less than 2 years
- 3–5 years
- 6–8 years
- 9–11 years
- 12–14 years
- 15–17 years
- 18–20 years
- More than 20 years

How many years had you been a registered nurse when you deployed to OP High Road?

- Less than 2 years
- 3–5 years
- 6–8 years

- 9–11 years
- 12–14 years
- 15–17 years
- 18–20 years
- More than 20 years

How many years had you been serving in the Australian military when you deployed for the first time?

- Less than 2 years
- 3–5 years
- 6–8 years
- 9–11 years
- 12–14 years
- 15–17 years
- 18–20 years
- More than 20 years

What specialty/s were you practising in during any of your deployments? (Select all that apply)

- Perioperative
- Emergency Nursing
- Intensive Care
- Primary Health Care
- Ward Nursing
- Other

Did you possess a postgraduate qualification in your area of specialty when you deployed the first time?

- Yes
- No

Did you complete a postgraduate qualification after you returned from any of your deployments?

- Yes
- No

After which operation did you complete a postgraduate qualification?

- OP Catalyst
- OP Slipper
- OP High Road

In what specialty did you complete a postgraduate qualification?

- Perioperative
- Emergency Nursing
- Intensive Care
- Primary Health Care
- Ward Nursing
- Other

An introduction to the theory of caring under fire

Synopsis of the theory of Caring under fire was inserted here.

Questions about your experience

Preparation

To what extent is this story about preparation similar to your experience?

In what ways was your experience of preparation different to this story?

Deployment

To what extent is this story similar to your experience of deployment?

In what ways was your experience of deployment different to this story?

Returning home

To what extent is this story about returning home similar to your experience?

In what ways was your experience of returning home different to this story?

Final questions

What advice would you give to a Nursing Officer who was going to deploy to an armed conflict zone?

Do you have any other comments you would like to make?

Appendix F: DDVAHREC Ethics Approval

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