

INTRODUCTION

Modern nursing was ignited by public concern for the welfare of wounded young British Army soldiers. It was while attending wounded servicemen in the hostile territories and under dangerous conditions in the Crimea that Nightingale began to frame her concepts about nursing (Nightingale, 1859). Nightingale's focus on the triad of the person, health and the environment, remain central to modern definitions of nursing and military health doctrine. Nightingale's nursing leadership drove improvements in the care of soldiers; advancements that have had a significant impact in modern nursing in the areas of infection control, hospital epidemiology, and hospice care (Gill and Gill, 2005). During World War 1, military Nurses demonstrated extreme flexibility and resilience at clinical, physical, psychological and environmental levels, including caring for local nationals (Gerolympos, 1995).

Nurses themselves were at risk. Allied forces clinical faculties, including trains or ships, were regarded as fair game to the enemy (Harper and Brothers, 1918; Hay, 1953). Badly injured troops were positively influenced by the unruffled way the military nurses went about their duties, whilst the nurses were inspired by the performance, fortitude and cheerfulness of their patients. (Hay, 1953). Not least, while providing direct care for wounded Service personnel and managing the healthcare environment, military nurses were confronted with challenging ethical dilemmas. These issues remain part of the challenges facing military nurses and how they are addressed, and the nursing lessons learnt from the battlefield, can have significant positive influences on military and civilian nursing on a truly international scale.

BACKGROUND / LITERATURE

Within the British Armed Forces Defence Medical Services (DMS), military nurses form the largest registered clinical group (Development, Concepts and Doctrine Centre (DCDC), 2013). They are utilised from the point of wounding and throughout the rehabilitative pathway. In Afghanistan, the major hub for medical activity was Camp Bastion Hospital, which contained multi-national British, American and Danish clinical staff under British command.

Afghanistan conflict

An International Security Assistance Force (ISAF) comprising of British, American and other allied troops were deployed to Afghanistan (2001 – 2014) to support a NATO mission which included training the Afghan National Security Forces (ANSF) comprising of Afghan Armed Forces and Police. This conflict offers a typical example of the disparate casualty group that require expert nursing care, with patients drawn from ISAF, ANSF, local nationals of all ages including captured persons (CPers) (Simpson et al, 2014).

The foundations of modern medicine and nursing are directly correlated in caring for Service personnel in times of conflict and war (Gabriel and Metz, 1992; Finnegan and Nolan, 2012; NHS Choice, 2015). These developments continue from treating those injured in Afghanistan (Surgical Reconstruction and Microbiology Research Centre, 2015) where the signature serious injuries of the Afghan conflict was poly-trauma, with orthopaedic problems including amputations and associated injuries such as burns (Jansen et al, 2012) and traumatic brain injuries (Taylor et al, 2012; Brain Trauma Foundation, 2015). Approximately 10% of Intensive Care Unit admissions are paediatric casualties (Inwald et al, 2014).

The exemplary Bastion Hospital healthcare provision (Care Quality Commission, 2012; Stockinger, 2012) combined with superior body armour have resulted in lives saved where previously patients would have died (Hodgetts, 2012). Coalition patients are quickly repatriated to their home countries. The local population's onward progress, rehabilitation, community care and future treatments are into a local healthcare facility outside of the military's scope of influence.

Military nursing education and clinical development

Before a deployment, military nurses must successfully complete the clinical proficiency skill sets contained within the Defence Operational Nursing Competency (DONC) document (MOD, 2010). The DONC is a workplace educational booklet categorised at Levels 2, 3, 4, and provides a framework for professional progression and evidence of competency (Finnegan et al, 2015) (See Table 1). Once a nurse is identified for mobilisation, then their personal profile is evaluated and any shortfalls are addressed through individual tailored courses / training. Educational evaluation is completed during a 2-week pre-deployment programme including macro-simulation (Gaba, 2007), where personnel undertake War Zone casualty scenarios in real time. Evidence suggests that this model provides appropriate academic training for deployment (Finnegan et al, 2015).

Military nurse development in the pre-deployment phase is focussed on clinical competency and scope of practice. Clinical based military nurses' work in civilian hospitals and military primary healthcare centres. Those working in non-clinical environments are directed to obtain an appropriate clinical placement for a period of 10 days in every 6 months (MOD, 2008) together with 450 hours of registered practice and 35 hours of Continuous Professional Development (CPD) learning activity in the previous three years (NMC, 2011). Adequate clinical exposure can be challenging as nurses are not routinely exposed to War Zone levels of trauma. In particular, the Camp Bastion Hospital Ward had no peacetime equivalent, and this is where junior and inexperienced nurses were primarily stationed (Finnegan et al, 2015). For primary healthcare (PHC) and mental health (MH) nurses, there is requirement to function autonomously and adapt clinical practice in response to the dynamic operational requirement. The advanced military nurse practitioner has to function without immediate access to multi-professional support, no books or internet (Finnegan et al, 2015).

Registered nurse

All nurses, whether military or civilian, and whatever discipline or place of employment, are expected to be trustworthy, caring, and compassionate. They require the theoretical competencies to ensure safe employment within their designated scope of practice. This is underpinned by academic training, ethical commitment, social accountability and registration is maintained (Nursing and Midwifery Board of Australia, 2008; Department of Health, 2012; American Nursing Association (ANA), 2015).

On an international scale, professional codes detail four fundamental requirements of nursing to: promote health, prevent illness, restore health and alleviate suffering (International Council of Nurses (ICN), 2012) which requires intellectual, physical, emotional and moral processes. It involves providing advice, advocacy, management, teaching, and policy and knowledge development. Ethical values respect the dignity, autonomy and uniqueness of people (RCN, 2003), are annotated in ethical codes (ICN, 2012) and supported by a system of professional regulation (Nursing and Midwifery Board of Australia, 2008; Nursing Midwifery Council (NMC), 2015; ANA, 2015).

Characteristics and values

Nursing values include excellence, caring, integrity and diversity, holism, patient-centeredness and ethical practice (Larson et al, 2013). These key nursing values and characteristics are required for the formation of policy, the specification of services, and the development of educational curricula (Martin and Barresi, 2003).

Definitions of nursing, like nursing itself, are dynamic; constantly evolving to meet new needs and new knowledge. There are a number of definitions of nursing (Henderson, 1960; ANA, 1980; Royal College of Nursing (RCN), 2003; ICN, 2014) that include characteristics (Department of Health, 2012) professional code of conduct (NMC, 2015), advanced practice (RCN, 2012) and concepts of professional identity (Warren, 2013). These definitions primarily focus on nursing duties, in terms of roles and tasks. Johnson and Cowin's (2013) Quality of Nursing Instrument contains a number of areas of practice that together make up the concept of the 'good Nurse' including: caring, hardworking, empathic and understanding. However, the United Kingdom Central Council (UKCC) (1999) were sceptical about the usefulness of a definition, stating it would be restrictive.

Professional identity

The construction of professional identity refers to that aspect of identity that becomes paramount within the workplace, and could be seen as a core aspect of a person's sense of 'who they are'. The nature of professional identity is subject to constant change and development as the nurse undergoes initial training, enters the profession as a qualified practitioner and then acquires experience, advances their scope of practice skills and makes more difficult decisions.

A comprehensive review of the literature (Warren, 2013) revealed 46 instruments that had been used to measure the professional identity of nurses, or an acknowledged component aspect of that identity. Five core aspects of professional character are: making a difference to patient's lives; working in a team and being a role model; delivering excellent care, keeping in close contact with patients and being able to continuously develop, allowing learning which, in turn, improves care (Harmer, 2010).

In addition, there are numerous psychometric tools to identify nursing attributes including The Caring Dimensions Inventory (Watson et al, 2001), Self-Concept of Nurses Instrument (Arthur, 1995), and Team Understanding Scale (Rentsch et al, 1994). There are other intrinsic influences of socially acquired identity including: racial (Allchin et al, 2009), cultural (Hall et al, 2003), ethnic (Weinreich and Saunderson, 2003) gender (Aidman and Carroll, 2003), religious and moral (Todd et al, 2009). Vocational identity (Magnuson, 2000; Bennett 2010) reflects where a person feels drawn towards a specific career path, often described in terms of a sense of having been 'called to serve' (Holland et al, 1993; Robitschek and Cook, 1999; Gardner and Smith, 2014). This is often associated with a person entering the Ministry but is equally relevant to military nurses; many of whom it is not just a job but an outward expression of who they desire to be (Fejes and Nicoll, 2010).

Military nurse research

Griffiths and Jasper (2008) identified the duality of the defence nurses role as both a caring practitioner and a "Warrior Nurse." However, whilst there has been a significant increase in

military nursing research (Currie & Chipps, 2015), there have been few research studies assessing the effectiveness of the military nurses' operational role (Fry et al, 2002; Batham et al, 2012; Elliott, 2015, Kiernan et al, 2013). Despite a comprehensive search of the literature, no published empirical study was uncovered that explored the core characteristics and values required by military nurses in the operational arena. This paper presents a synopsis of the characteristics and values of a military nurse with the findings drawn from the first and only UK qualitative Defence nursing research undertaken on deployment; in this instance at Camp Bastion Hospital, Afghanistan in 2013.

AIM

The aim of the study was to explore the characteristics and values that are intrinsic to military nurses in undertaking their operational role.

THEORY

A constructivist grounded theory was selected (Charmaz, 2006, Silverman, 2013) to collect data secured in the samples world (Punch, 2010) to enable identification of the issues from the participant nurses' perspective. Constructivist theory indicates that the factors influencing a person's perception are not a uniform phenomenon, but take on a particular meaning influenced by environment, media, political views, local contexts and cultures (Silverman, 2001). This constructivist perspective indicates that defence qualitative research should be completed on deployment, rather than waiting for nurses to return home. However, this has not occurred prior to this operational nursing research study.

There is a requirement for analytical questions, (Charmaz, 2000), focussing on asking how, when and where the research population generate their descriptions. Such practical methodological guidelines demonstrate how the data can be utilised and analysed as the study proceeds, and identifies and establishes how the subject population cultivate knowledge and views. This model provides a medium that is positioned close to the data, is useful, and offers conceptual density, durability, and explanation (Glaser and Strauss, 1967; Charmaz, 2006).

Constructivist grounded theory has proven specifically appropriate for assessing Service personnel who were detached from their normal social constructs and family surroundings. In the few operational qualitative studies conducted within the British DMS that resulted in peer review publication; sample groups ranged between 12 and 19 personnel (Crawford et al, 2009; Batham et al, 2012; Kiernan et al, 2013; Finnegan et al 2014, Finnegan et al, 2015). In this study, evidence was obtained from deployed military nurses in order to gain new understanding of the characteristics and values required for military nursing, leading to the emergence of a new theoretical model.

METHOD

The research sample was a convenience cohort drawn from the 59 UK nurses based at Camp Bastion Hospital, Afghanistan during June and July 2013. Semi-structured interviews were conducted to collect information from 18 military nurses. The intent was to interview senior nurses in each department / ward as it was felt that they would provide the most insightful

information due to their experience and role, including their ability to compare and contrast with previous operational tours.

A well-defined interview schedule was a key component, with the aim of enabling a non-judgemental, open ended discussion focused on significant matters; with scope to explore unanticipated replies as they emerged. The schedule was constructed following significant consultation with clinical, military, lay personnel, members of the research team and a pilot study. The resultant interview schedule contained open questions that related to each other in a seamless, meaningful way. The full schedule is at Finnegan (2014a).

With approval of the UK's Permanent Joint Headquarters, the lead author deployed to Afghanistan to collect data. The visit was scheduled to correlate with the time that respondents had been at Camp Bastion for a 10 week period to ensure they had sufficient experience of their surroundings. The author had knowledge and education as a military mental health nurse and researcher which provided a foundation for completing the consultations with an understanding of the clinical and military nuances of language. The author had previous experience in Afghanistan and other conflict areas that present both unique fieldwork challenges and benefits; see Box 1.

Once at Bastion hospital, the author visited each hospital department, reviewed the study with staff and left a study participant information sheet to allow potential contributors to decide whether to accept or reject the offer to join in this voluntary research. Before the interviews commenced, respondents completed a short survey detailing demographic data, for example age, rank, operational experience.

The author then conducted the digitally recorded interviews. Participants' were interviewed once only due to geographical limitations, length of the researchers time in Afghanistan and restrictions regarding further operational access to Bastion Hospital. Due to the unique nature of this research; the details of the challenges, theory and methods have been published prior to this research paper with the aim of hopefully informing similar studies (Finnegan, 2014a; Finnegan, 2014b).

DATA

Interviews lasted between 17 and 70 minutes with a mean of 50 minutes and a SD of 12. The first author transcribed the interviews soon after the consultation, including some on the same day, thus providing an opportunity to pursue leads early. This was a time consuming activity but an advantage of the Bastion Hospital environment was the opportunity to commit totally to this study without distraction. Immediately after each interview, field notes were compiled that listed numerous factors including characteristics and values to provide insight into how these applied to particular activities, events, and groups. The field notes, combined with early and constant comparison of the interview data, whilst continuing to access background information from a multiplicity of resources aided the reframing of future interviews and analysis. Interviews continued and developed as new categories presented themselves and were sustained until the emerging categories were "saturated" (Charmaz, 2006). This was achieved when the interviews no longer produced new theoretical insight (Silverman, 2013).

Grounded Theory analysis was conducted (Charmaz, 2006), and qualitative coding utilised to discover and define what was happening and to shape the emerging theoretical framework. From the beginning, the initial then focussed line by line coding identified words and phrases that related to characteristics and values associated with the military, nursing and the literature with an emphasis on identifying emerging categories to inform analysis and generate concepts. All categories were then used consistently (Mays and Pope, 1995).

There was a consistent line of reasoning but this was not a linear study, with data collection and analysis occurring concurrently with emerging information being placed into relevant situational and social contexts. This identification of fit and relevance facilitated the exploration of emerging themes enabled by theoretical sampling that was strategic, specific and systematic (Silverman, 2013). This provided the information in this explanatory study of why something happened, and used this evolving knowledge to predict the characteristics and values required to function successfully as a nurse in this demanding environment, and potentially other military and civilian arenas.

However, how these categories relate to each other as an emerging theory only become apparent through axial coding that reassembled data that was splintered during initial coding to give coherence to the evolving theory. Authors scrutinised the data as a blind theoretical sampling exercise to ascertain comparators and differences. This resulted in a theoretical model to provide an explanation of the characteristics and values required, through accurately reflecting the respondent's interpretation of a wide range of emotions, behaviour, thoughts and beliefs. Whilst respondents commented on their experiences, the discussion section below is built on multiple rather than stand-alone attestations. Demographic data analysis was performed using SPSS Version 22.

RESULTS

The qualitative coding informed by memo writing, constant comparison of the data, and supervision resulted in the indication of 41 categories. These themes produced a story that reflected the interviewees' real-time perception and opinions leading to an evolving theoretical model comprising of four major clusters: personal values, military skills, scope of practice and clinical leadership. These theoretical groupings are responsive to the dynamic mediums of manpower, experience, motivation and satisfaction. Also by type of casualty and the associated ethical issues and futility. This model is presented diagrammatically at Figure 1 with the intent of portraying the relationships between categories to ensure accuracy and clarity. The interviews were conducted with nurses employed in a range of disciplines and the results reflect these differences. As an embryonic theory, the model will require further testing.

Demographic detail is in Table 2. There is no intent to draw quantitative inference from the results, and obviously caution needs to apply when examining small numbers. The aim is to provide clear detail of the research sample, inform other studies, and help readers understand exactly who was interviewed.

The findings are presented in the following discussion and are extracted from respondents' beliefs, and relevant quotes are utilised to illuminate this information. The few incidents when this the authors have added a view is supported by a reference. The discussion is presented under the heading of the theoretical model to enable an easy to read and seamless story, however this should not be read as undermining the complexity of the study nor the

theoretical development. Due to the sample, the findings are UK focussed, but these nurses were deployed with equal numbers of USA colleagues and evidence suggests that lessons learnt from War Zone nursing have both military and civilian international implications.

Ethics

Research information included detail of the measures taken to ensure anonymity by strictly concealing participant's names in reports and publications. Each volunteer was given 48 hours to consider their decision, and they understood that they could withdraw at any time. Information is being stored in accordance with the Data Protection Act (1998). Informed consent and UK Ministry of Defence Research Ethical Committee (MODREC) approval was obtained (Health Research Authority, 2014). Presentation of the findings is intended to protect anonymity of respondents who were referred to as AA, BB etc and no further information is disclosed.

DISCUSSION

Respondents stated that the operational nursing experience is different to anything they would encounter in the UK. The nursing care delivered within the operational environment was generally perceived as outstanding for all patients. Interviewees reported a sense of self-worth aligned to strong team integration as being significant positive factors. Personal benefits included being able to concentrate on patients and performing clinical tasks rather than administrative duties. Importantly, stress associated with poor manning is less, as there is always a full complement of appropriately trained staff, and there are only rare cases of staff reporting ill. Prior experience of this environment helped, and made the deployed military nurses less likely to be negatively psychologically affected by either the clinical presentation of casualties, high activity levels or the austere environment.

Personal values

Defence nurses are proud of their role and the necessity to provide nursing care, compassion, and kindness. A unique aspect of defence nursing is the patient population. ISAF, ANSF and local nationals that are predominately young men who have often suffered significant poly trauma injuries. There is requirement for nurses to have technical skills such as suturing and inserting cannulas, however because these skills can be performed by other employment groups, respondents reported that defence nursing requires much more than just clinical competencies. In all areas, there is an advocacy role and defence nurses need to be tenacious and back their judgement for doing what was perceived as right, caring, kind and compassionate.

“I think there is room for compassion, and there has been a couple of occasions here, I have gone toe to toe with a doctor over an incident with a child. The child died and the doctor wanted to crack on and operate with an Afghan mother while the child was dying and I refused to bring her to theatre. I feel absolutely no guilt whatsoever, for the very obvious reasons. 7 – 8 years old child would die within 30 minutes. The mother was not going to die of her injuries within 30 minutes and I just refused.” (JJ)

The nursing emphasis is placed on patient needs and determined through robust two way communication. However, respondents reported it being easier to look after British and American patients due to the common language. The local Afghanistan patient and their relatives were cited as being very quiet, undemanding, modest and humble. Their clinical presentation was different; for example showing few overt signs of pain. It is therefore deemed especially important to have awareness of the local population; their culture, values and beliefs and to develop robust communication streams even when using interpreters.

“So they will describe having a heavy heart, or a great pain. What they are describing is anxiety that is presented in a very physical way. They have a very strong belief in spirits, and fairies and ghosts. It’s like the Celtic traditions from the medieval times, and it is a case of understanding of these things that are out of our control. So we will try and do a lot of involvement, and with CPers, because once they are off the ground their lucky charms are taken off them. So what we do, we give them their lucky charms back, and we have also put into place that every time the Mullah comes around from the holy facility; we get them to bless the lucky charms to give to them.” (BB)

Military nurses attempted to develop a rapport, and worked diligently to build a strong, trusting relationship. Respondents learnt local greetings, and non-verbal communication and body language became particularly important. Therefore staff could generally determine basic care issues such as wanting a drink or to go to the lavatory. Nonetheless, detailed assessment and communication required interpreters, many of whom did not have a medical background. Therefore, there were concerns that patients' views were literally lost in translation, and the nurses had to tailor their communication appropriately; speaking slowly and being concise in what they are asking. Nurses also introduced techniques to ensure the correct message and information was being obtained; not just assessing the patient but the interpreter as well.

Nurses talked of quality care, helping each other, communicating with each other, reminding each other of what is expected, and recognising the qualities that nurses brought to the multi-professional team.

“Today we had a Cat A (Seriously injured casualty) come through, first thing one of the American medics did as he was waiting for the guy to move onto the trolley; placed a pad over the guys groin as he was naked. They are all thinking about their dignity, and a bit of compassion for these guys. It's a lovely thing, a real positive reinforcement in the teams.” (OO)

Captured personnel

Under the Geneva Convention (1949), Allied Forces have a duty of care for captured personnel (CPers) and these patients were routinely treated on the Ward at Camp Bastion. British casualties were normally evacuated back to the UK after 24 to 72 hours, but CPers were nursed for longer periods of up to 2 months; with the resultant development of nurse / patient bonds. This despite the fact that the CPers patient may have caused the injuries sustained by other patients.

“I think it's more difficult here looking after the CPers, especially the long term CPers. My experience with a chap who has been with us for 3 or 4 weeks, and likely to be with us for a considerable time more. I wouldn't say that you get attached to them, but you wonder what is going to happen when they eventually get released into the CPers system. I wouldn't say a heart string got pulled when I came in and he smiled and he shuck my hand, but it does affect you. You know that they are CPers, and you know they are the enemy, but you still have to provide the same level of nursing care.” (QQ)

In certain instances, nurses described wanting to prioritise care for British casualties. The author found it was a credit that respondents' felt safe to disclose these views and to have the personal self-awareness to recognise their feelings. Senior nurses took a pragmatic view, seeing this as another challenge of the environment, which faces young military nurses and they remained impartial, recognising the ethical challenges.

“I have more empathy for my British counterparts than I do my Afghan patients. You can call me awful, I don't know, but I am aware of it and I try me level hardest to be as non-prejudiced and to be as good as I can with every aspect.” (GG)

Nurses consciously detached themselves from any legal processes and treated the casualty as a vulnerable patient. This requirement is a key message in pre-deployment preparation,

resulting in care, compassion and dignity being provided for all patients, irrespective of their background, beliefs or affiliations.

Clinical leadership

Effective leadership from the administrative military chain of command can ensure that staff remain disciplined, and potentially provide a barrier against poor practice. Clinical leadership has a pivotal role in ensuring care, compassion and kindness are applied in practice (Thomas and Rowland, 2013). Clinical leadership involves influencing the troops to share a common vision and the ability to get the best from a group of individuals. This includes junior nursing personnel on their first operational tour being successfully forged into a team. Senior nurses invest in getting to know their staff; building a rapport to understand other peoples' views and aspirations and are conscious of multi-factorial operational stressors. Respondents stated they intervened and helped as required, whilst noting that in this environment many nurses thrive. This model of intimacy, and to a degree paternalism, doesn't characteristically sit well within a civilian healthcare leadership model. In this study, there were clear examples of nursing leadership being employed, and operational tours were seen as a means of developing the leaders of tomorrow. To achieve this, senior staff identified the importance of role modelling and setting the right example:

“I conduct myself in a certain way, achieve certain standards throughout that shift, and don't get sucked into bad practice. That is how I demonstrate leadership”. (EE)

If necessary, this means having the morale conviction to complain and report significant events. Mistakes may originate from the high tempo of clinical activity, and respondents highlighted the importance of using Patient Safety Incident reports to ensure this is constructed in a blame free environment.

Where clinical leadership is gained within the peacetime setting was not clear. Defence nurses do not hold senior NHS clinical positions, do not manage civilian wards or departments, and experience reduced opportunities associated with developing civilian clinical leadership skills. However, respondents reported that the clinical operational environment is so fundamentally different to civilian practice that a lack of these management and leadership opportunities was not viewed as a limitation. The necessity to manage a team of civilian nurses was questioned as being an effective way of preparing for deployments. Respondents highlighted that there was no budget to manage, no executive board to report to, a commanding officer who is easy to access, and requirements that only military appointments can provide. Opportunities for developing healthcare governance experience and clinical supervision appear in other military healthcare settings. Therefore civilian managerial positions were not seen as a pre-requisite, and respondents felt that leadership training and opportunities embedded within a military career is appropriate.

Team building

Developing a well-balanced, functional team is a key component to a successful tour of duty. The bonding process and building friendships include socialising together. This activity commences in pre-tour, and is carried forward to the claustrophobic setting of Camp Bastion, where nurses live, work, and eat together. As soon as possible, socialising involves USA and other multi-national colleagues:

“From a team dynamics perspective it is important to see each other and to be part of each other’s lives. Hopefully that has a positive aspect on our working hours. We have deliberately asked the guys to come back over and do things together, going out for a pizza, or going to visit Merlin airframe sites, just to see the bigger picture. It really builds the team up to being a much better team, but we are also keeping an eye on ourselves out of hours.” (KK)

Working in Camp Bastion motivated people to try harder, to integrate and function as a team with clearly defined roles, responsibilities, strong communication strands and peer support. Teams need to be able to trust each other whilst understanding and respecting the role of military discipline and rank. Nurses described being proud of their team’s outputs, seeing them unite and provide high quality clinical performance under the harshest of environments. Team members reported being treated as adults, and given time for rest, respite and recuperation. When personnel change over, it is important to be able integrate new members into the team. Naturally, not all troops will be compatible, and it requires leadership to successfully address this.

Military skills

The respondents were volunteers who have made a lifestyle choice to deploy in support of fighting troops and other casualties. Operational tours provide an insight into what frontline troops experience, and the role was reported as being demanding, with nurses experiencing the same stressors such as being removed from family and friends and their normal social constructs. Yet for many deploying is the reason they enlisted, and all the preparation and peacetime employment within civilian hospitals and other medical facilities is merely groundwork for this role.

The requirement is not just to be a nurse, but a soldier; being physically and mentally fit, and able to cope with austere environments. Nurses who had worked outside of Camp Bastion reported the prospect of being targeted, and being fired upon. There is a military mind-set that results in nurses undertaking non-clinical roles and getting involved in routine military chores. This willingness to get enmeshed in military life can result in far ranging benefits in relation to identification within the wider military team, potentially reducing stigma and leading to a better interface with troops.

There were isolated reports of personnel not wanting to deploy for reasons such as: having a young family; having completed multiple tours or the impact of 6 month tours, but in these cases the interviewees stated that once in Afghanistan they were fully committed to their role. However, for a significant amount of respondents, this is where they wanted to be, and they reported considerable benefits associated with this chosen occupation; sentiments aligned to recognised mental health benefits of serving within the British Armed Forces (Finnegan et al, 2011). Some described the experience being easier than peacetime roles. There is no alcohol, and the routinized lifestyle led to a contented existence.

“You wake up, go for breakfast, walk to work, you don’t have to worry about driving to work, you don’t have to worry about finding a parking space and being late. You don’t have to worry about running a car, running a house, all of these things are taken care of.” (MM)

Respondents described being lucky to be at Camp Bastion; acknowledging they were working in a unique setting, and they felt privileged to be able to contribute. The tour was described as brilliant, rewarding and leading to a sense of positive wellbeing. Even those

who had completed several previous tours reported the same outlook and enjoyed the operational experience. This collective stance promotes a positive morale within the hospital.

“It’s a rewarding job and there are a lot of people who joined up to do this. At the end of the day, the rest is doing training to do this. Having that experience, gaining that extra knowledge, and toughing it out through the tour makes people grow.” (AA)

Understanding local culture was seen as an important and something that could have been further reinforced during pre-deployment training.

Scope of practice

Respondents reported that military nurses must have the correct clinical competencies, with skill sets aligned to working within one’s own scope of practice. Certain areas of delivery were noted as high quality and responsive, for example pain management. This was predominately with adults, and defence nurses were challenged when moved from their comfort zone; for example, when caring for a child. There was also different skills sets amongst individuals, teams and nationalities.

For a number of reasons, not all care was of the highest quality. Examples included not being fully attuned to patient needs; lights inappropriately left on at night; too much noise when patients were sleeping, and lapses in care or administration such as drugs not being ready for patient transfers; leading to natural frustrations. Other areas were poor record keeping and not detailing information such as dressings having been changed. Nurses reported not feeling confident that they could address these shortfalls in others’ behaviour without inviting some personal criticism. There are instances of basic omissions in nursing care; which applied to both British nurses and our Allies. Skills that a previous generation of nurse took for granted was missing. Issues such as completing observation charts stemmed from the hospital environment being radically different to that faced in the UK NHS, which used electronic medical records.

“I had to do teaching of how to fill in an observation chart. Never expected to have to do that. I assumed that any nurse that has come through their nurse training could fill in an observation chart. And that they would be readable, but no.” (DD)

Specific areas were noted for developing nursing skills such as wound care and dressing application. Means to address this shortfall is thorough changing practice in pre-deployment training and the use of Practice Educators within the operational environment, in particular the Ward.

Ethics and futility

The military clinical environment raises acute ethical issues that have been associated with moral distress resulting in nurses leaving the profession and burnout (Fry, 2002), and in this study, a sense of futility. However, empirical ethical guidance is scarce as literature in military medical ethics is unfortunately limited (Sokol, 2011). Respondents reporting fearing that locals may die when returned to the local healthcare system.

“Some patients are probably not going to get better whilst they are with us. Afghans and CPers may not get to an airhead, and they would come to the ward, and be either palliative

care or minimal intervention. That's difficult, and people find it difficult. Certainly people who have deployed before, and seen similar things before, are a bit more hardened to it. I'm quite hardened to it now. The new nurses certainly aren't. They will say, why can't we do this, and they have to realise the limitations that we have got. We can't send them back to the UK to get fixed. "(CC)

Some nurses found these situations extremely stressful, especially when dealing with children or young adolescents. In 2007, a Canadian paramedic reported the transfer of patients to the local Afghanistan hospital being a "death sentence" (Sokol, 2011). However, there have been significant advances based on a coalition commitment to improving healthcare facilities; but concerns still exist that the local population casualties will struggle once DMS clinicians have left.

Nurses face other pressures, such as being mindful of what resources they have, and to ensure stocks are available as the war / conflict unfolds (Department of Defence, 2004). A particular concern is caring for children, with nursing anxiety often stemming from lack of clinical exposure (Finnegan et al, 2015) and previous negative operational experiences:

"I am a nurse who is happy to say that I am not happy with children. They all died on me last time. I think it is being aware of what you can do, and not necessarily clinical skills but doing more than just checking that the pumps are working. You have to give so much more, and kids just worry me." (GG)

Respondents were conscious that the effect of a child dying had a negative psychological impact on themselves and colleagues. The wider implications regarding futility and the care of children, and how defence nurses deal with the psychological implications and vicarious trauma will be published in a separate paper.

LIMITATIONS

This study was conducted in the austere environment of War Zone Afghanistan which inevitably led to research study limitations, including that the lead author's role as a DMS Senior Nursing Officer may have unduly influenced responses and so introduced bias during the data collection phase. The respondent's views refer to a particular point in time, and may not be reflective of nurses' views in different conditions or varying levels of clinical activity. Findings reflect the beliefs of deployed Secondary Healthcare military nurses and may not replicate the opinions of British military nurses employed in other areas such as PHC or other armed forces. In addition, Afghanistan is classed as an enduring operation, persisting over 13 years, and the lessons learnt may not be transferable to the future short time span contingency deployments. The cohort of British military nurses was chosen to facilitate the aim of obtaining saturation, but therefore potentially limits the transferability of the findings to other nursing populations. Finally, a number of references refer to previous research undertaken by the author/s. However, these citations reflect a significant mass of the British Armed forces operational qualitative research studies, and the direction to conducting these studies.

CONCLUSION

This paper presents findings from the first British Armed Forces qualitative nursing research study undertaken during an operational deployment. This provides an original and innovative insight into the characteristics and values that deployed defence nurses recognise as integral

to military nursing. Defence nurses face challenges not generally encountered within civilian practice although it is within these areas that military nurses' gain experience, learn and nurture the requirements for operational delivery of nursing. It is therefore likely that the findings have transferability to other Armed forces and civilian practice on an international scale.

There are numerous themes embedded within the theoretical model at Figure 1, and these categories can be polarised depending on the circumstances. Recruiters over emphasise the physical and military requirement; military nurses focus on the scope of practice, civilian colleagues are intrigued by the leadership elements whilst patients and public focus on personal attributes. However, the power of nursing as a profession is built on the amalgamation of these elements to provide the unique characteristic and value of the profession.

The theoretical model highlights challenges to nurses on an international scale, but by embedding all the themes together then the model also offers potential answers. For example, personal values such as compassion is not a measurable part of a scope of practice that can be learnt in a classroom. Such values should be intrinsic to the nurse's personality, honed by good role models, leadership and experience. The focus on nurses holding these values is understandable because during clinical emergencies, compassion becomes desirable, or even a luxury, and the crux is clinical competency. In cases of life and death, patients want the clinician who will save them. There is a cognitive recognition of this within our society, and patients' want a competent doctor, and a compassionate (whatever this might mean at whatever point in time) nurse whose care is aligned to an understanding of the local cultures. A balance is required, which necessitates that defence nurses must be employed in all forms of operational deployment as integral to providing high quality care. These attributes have transferability to military nurses in other armed forces and civilian nurses on a universal level.

In defence nursing, history has demonstrated that the essence of compassion and empathy in relation to an altruistic motivation to relieve suffering goes a step beyond compassion, with extraordinary reports of bravery where clinicians ignore their own personal safety to support strangers. In order to contextualise these occurrences and examine the theoretical model presented in this paper, further research is required. A quantitative study to determine differences due to demographic features such as gender, age, rank, and being a parent would prove insightful.

The findings can inform defence nursing on a number of levels. Respondents primarily focussed on scope of practice, and factors regarding personal characteristics and values had to be drawn out during the research interviews. The authors' are certainly not suggesting that all military nurses have the characteristics and values presented in this paper. Therefore, the findings provide selection panels with an additional tool to help the recruitment process, and present a prompt to focus on all the components of being a military nurse, and not just one area, for example physical fitness. It is this selection of the best candidates that will ensure that they have the greatest chance of future success and will manage to 'stay the course' post initial qualification. Noting the increasing global migration of nurses, it is hoped that this paper can help motivate similar helpful models.

There have been few qualitative studies undertaken in the DMS, yet they have presented novel insights into defence healthcare; providing information to inform and change

educational programmes and clinical practice. Thereby presenting an opportunity to improve operational capability and the quality of deployments for DMS personnel. The model at Figure 1 provides defence nurses with a framework for a realistic personal development plan that will allow them to build upon their strengths as well as to identify and ameliorate potential areas of weakness. Placing nurses first, with a model that focusses on the requirements of a good nurse has the potential to lead to better patient care, and improve the quality of the tour for defence nurses.

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