Title: The Role of Military Nurse Teachers: a qualitative study of the perceptions of ten military nurse teachers.

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I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other university

Signature:

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Abstract

Military Nurse Teachers from the British Defence Medical Services have provided educational support to military nurses since the 1880s. Following recent policy developments military nurse teachers have been required to evaluate their professional role.

The aim of this small scale study has been to explore the military nurse teachers' perspective of their role. The study used the approach of qualitative description to provide a voice for the military nurse teachers. Data were gathered from interviews with ten military nurse teachers – personal one-to-one interviews with eight participants and email interviews with two participants.

The major findings focus around the discrete but completely interrelating professional identities of the military nurse teacher; military, nursing and education. Military is the overarching identity whilst nursing is the underpinning professional persona. Education acts as the speciality component.

The findings demonstrate that military nurse teachers implicitly identify as military nurses, and as part of that community of practice more than with the academic environs of the university. Despite commonalities of military, nursing and education the participants displayed contrasting opinions in relation to their role. Some teachers clearly view education as their dominant role without a clinical component whilst others see clinical practice as integral to their persona as a military nurse. Clinical practice is viewed by some participants as a necessary component in order to guide their educational practice. In the wider scheme clinical currency, or competence, is an important consideration which stems from contribution to the raison d'etre of military healthcare; operational delivery.

The military nurse teachers' identity has implications for their practice and opportunities for development of educational roles. Further research is recommended to investigate the professional practice opportunities for educational provision across the peacetime and operational arenas.

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Chapter 1
Background and Introduction

1.1. Introduction

Military nurse teachers have been an integral component in the preparation of military nurses of the UK Armed Forces for over a century. During this time the nursing profession has undergone significant professional development and the changes have been embraced by the military nursing cadre. Military Nurse Teachers, like their civilian colleagues, moved into Higher Education institutes in the 1990s and following subsequent closure of military hospitals clinical practice for military personnel has been undertaken in Ministry of Defence Hospital Units (MDHUs). These moves have distanced Military Nurse Teachers from both the military and practice environments.

Military nursing operates in peace and war and the nature of conflict and medical interventions requires nurses to be prepared for practice in challenging environments. In light of the changes to the education and practice environments the complexity of the Military Nurse Teachers contribution to today's military nursing has been the primary question for this study.

1.2. Background to the study

Across the globe military nurses constitute an integral component of the medical support for their respective Armed Forces. Preparation for the specialty of military nursing comprises education and training provided by subject matter experts in nurse education and clinical practice. The aim of this study has been to explore the role of a specific group, British Army military nurse teachers, who are the subject matter experts in military nurse education.

During the past two decades there have been significant changes across nurse education necessitating major adjustments in role for nurse teachers across the civilian and military arenas. Additionally there have been recent policy changes in the delivery of military nurse education which have had a direct impact on the role of military nurse teachers. Whilst changes in role for civilian nurse teachers

have been discussed in the literature, there has been no study to date focusing on military nurse teachers or the effects of developments in nurse education and how recent changes may impact on their professional practice.

With the continuing global involvement of British Army personnel discussion of the nature of academic preparedness of the nursing contingent would appear appropriate, particularly in light of the recent changes in educational delivery. Also appropriate is that the educational providers, the military nurse teachers, be central in this important discussion. Thus this study is timely, not only in its exploration of military nurse teachers' individual perspective of their role, but also in relation to the recent changes within their educational arena and how the teachers view implications for their future practice.

To explore military nurse education requires an understanding of nursing and nurse education in the military setting; the origins and subsequent development. Therefore this initial chapter looks at the context of military nursing and its position in the wider military healthcare arena. The following sections of this chapter provide an overview of the origins of nursing in the Army; the largest nursing service in the British Armed Forces, through to the subsequent amalgamation with the Royal Navy and Royal Air Force Schools of Nursing within the current organisation – the Defence Medical Services (DMS).

1.3. History of Army Nursing

The formal recognition of British Army nursing was achieved through Royal Warrant on 1 February 1949 declaring the formation of the 'Queen Alexandra's Royal Army Nursing Corps' (QARANC). On that day Army nurses became the QARANC (known colloquially as QAs) and an integral part of the British Army as soldiers and officers, and members of the senior women's Corps in the Army. Army nursing, however, had begun long before 1949; nurses have been involved in caring for members of the Armed Forces for decades. Military field hospitals were established during the Roman Occupation AD 43 and a nursing contingent

was employed to care for injured soldiers. The 'nursing' of soldiers continued during subsequent times of conflict carried out by various religious institutions - the Order of St Augustine and the Order of the Knights of St John of Jerusalem – but organised nursing in the Army did not occur until the Crimean War under the leadership of Florence Nightingale at Scutari. Florence Nightingale's achievements during the Crimean War are well documented in the nursing and military history literature. On her return to the United Kingdom she founded the first school of nursing – the Nightingale School of Nursing in St Thomas's Hospital, London. Miss Nightingale was also instrumental in the venture to build the first British military hospital in Hampshire in 1880.

Today's military nurses are employed in caring for the soldiers, sailors and airmen of their respective Armed Forces and undergo both professional and military education and training to ensure they are fit for role. In the British Armed Forces the teachers of professional nurse education have, predominantly, been serving members of the Armed Forces themselves. Some teachers enter the military as qualified nurse teachers whilst others are military nurses who enter nurse education following extensive military and clinical experience. This mix of experience has benefits for both the nurse education and student nurse cadres.

1.4. Army Medical Services School of Nursing

The training of nurses in the QARANC commenced in 1950. Until that time Army nurses were recruited into the Corps as Officers, already qualified as nurses having undertaken nurse training in civilian hospitals. Some of the Sisters were employed as Sister Tutors and were seconded to civilian teaching hospitals for teaching practice (Hay, 1953, p.348). They returned to the Army to train Nursing Orderlies of the Royal Army Medical Corps (RAMC). The introduction of soldier ranks into the QARANC in 1950 enabled the expansion of this Sister Tutor section into a nurse training centre to train soldier nurses in addition to the orderlies (Hay, 1953, p.348).

Nurse training was conducted along the same lines as that provided in the civilian hospitals. The nurse training programme, known as the pre-registration programme, followed the same curriculum as in civilian hospitals and successful completion saw student nurses register with the UK professional regulatory body as qualified nurses. For the QARANC learners clinical practice was carried out in military hospitals in UK and Germany. Secondment to civilian hospitals was established for those specialities not catered for in the Army, such as care of the elderly patient. Sister Tutors were re-titled as nurse tutors and underwent the required national Registered Nurse Tutor (RNT) course in order to achieve a teaching qualification. During the 1980s the Certificate in Education (Cert Ed) and Post Graduate Certificate of Education (PGCE), with subsequent supervised teaching practice, were accepted as an appropriate level teaching course, and the RNT course was phased out. Nurse Tutors were now expected to gain a degree level qualification in nursing or healthcare related studies prior to a specialist Masters level qualification.

Nurse training in the Army continued thus until the 1990's and the move of nurse education throughout the UK into institutes of higher education. This move saw the amalgamation of the Army School of Nursing with its counterparts in the Royal Navy and Royal Air Force, and a geographical move from its location in Aldershot to the University of Portsmouth. Nurse tutors were now re-designated as military nurse teachers and defence nurse educators. Prior to amalgamation the term 'military' was used within the Army. Amalgamation of the three Services was termed a 'defence' force. As this study concerns Army personnel the term 'military' will be used throughout.

The military nurse teachers became part of the academic faculty and military nurse education moved from certificate level to encompass both the pre-registration diploma and degree level programmes.

During this period the majority of military hospitals within UK were closed and Ministry of Defence Hospital Units (MDHUs) were opened in NHS Hospitals around the country to provide secondary healthcare for soldiers, sailors and airmen. In 2001 the Ministry of Defence closed the last remaining military

hospital and established the Royal Centre for Defence Medicine (RCDM) in Birmingham as the major military centre for healthcare, professional practice and development of healthcare professionals. As a consequence nurse education, under a new contract, moved from the University of Portsmouth to the University of Central England, Birmingham, now known as City University.

As part of the contract with City University military nurse teachers have worked alongside their civilian counterparts in the delivery of the pre-registration programme. Unlike the contract at Portsmouth military student nurses are now educated together with civilian students on the programme. Consequently military nurse teachers had responsibility for a cohort of students which included both military and civilian individuals.

The contract required military nurse teachers to support the pre-registration programme through teaching activity, curriculum development, module leadership, and academic and personal tutor activity. Therefore there has been significant commitment to the pre-registration programme. This meets the requirement for nurse teachers to maintain currency in educational studies. However, nurse teachers who hold a clinical specialist qualification are also required to maintain clinical currency within the clinical area, particularly in a speciality which has a significant operational commitment, for example intensive care, emergency department and operating department nursing. Irrespective of speciality or activity the role of nurse teachers is as support to the nursing personnel of the Defence Medical Services (DMS).

1.5. The Military Nurse Teacher

As stated the role of the military nurse teacher has been focused on the preparation of student nurses to carry out their professional role as qualified nurses, particularly in relation to the care of soldiers. Their additional role for qualified military nurses in post registration education has been in the provision of the BSc (Hons) in Defence Nursing Studies, focusing on developing knowledge in operational nursing. The move to higher education institutes and the demise of military hospitals has resulted in a broader focus for the military

nurse teachers and student nurses in order to encompass the increasingly civilianised educational and clinical exposure during their pre-registration education. For military nurse teachers and their students the university environment brings a different perspective to the educational preparation for life as a military nurse. Student nurses became 'university students' and military nurse teachers 'university lecturers', adding an additional dimension to their professional identity.

The geographical repositioning of both groups has impacted on their professional identity as military personnel, segregated them from the influences and ethos of the military schools of nursing and exposed them to the wider world of civilian learning and practice. The integration of student nurses with their civilian peers identified that the educational preparation for a degree in nursing can be delivered by the University. This has culminated in the withdrawal of military nurse teachers from the pre-registration education programme. This is a significant change for military nurse education. For the first time since its introduction into the British Army the academic component of military nurse education will be delivered by civilian personnel in a non-military establishment. As a consequence of this policy change the military nurse teachers involved in the pre-registration programme were redeployed into other roles within the DMS.

1.6. Defence Medical Services

The role of the DMS is to provide healthcare support to the Armed Forces of the United Kingdom. The DMS comprises healthcare professionals of the three services; Royal Navy, Army and Royal Air Force, from all disciplines concerned with healthcare - medicine, nursing and the Allied Health Professions. Healthcare support is provided in a variety of settings, both in peacetime and on deployed operations. Peacetime support is afforded in military primary healthcare facilities and in collaboration with the NHS for secondary care. Operational support is through the field hospitals and medical regiments manned by healthcare professionals from fulltime DMS and Reservists and Territorial personnel. When not employed on operational duty DMS personnel carry out

their peacetime role in military primary healthcare facilities and NHS hospitals engaged in clinical duties and further and higher professional training, and in DMS managerial and leadership headquarters.

1.7. DMS Personnel

A significant number of military healthcare professionals enter the Service as qualified in their chosen profession. Others may elect to undergo their initial education within the Services as cadets or serving personnel (medical students, nurses, biomedical scientists). Length of commitment to the Services is from 3 – 34 years dependant on age, length of selected engagement and avenue of employment. Each discipline has an established career pathway which will encompass clinical, managerial and leadership elements. Student nurses enlist for a minimum of 8 years to incorporate 5 years return of service following their initial education.

Irrespective of their profession, trade or qualification military personnel sit within the hierarchical structure of the Army organisation. This hierarchical structure is signified by the rank system, with each rank signifying the expected levels of responsibility in role. Military nurses are granted the rank of Corporal (two higher than the starting rank of Private) on qualification and will undertake clinical practice, military training and military knowledge courses prior to consideration for further promotion. This rank of Corporal is awarded on successful completion of their degree and where there is demonstration of good character. The rank affords them some authority in their practice, within the Army's structure, recognising their role as professional, autonomous practitioners in their speciality of nursing.

1.8. Employment in the DMS

Over the past two decades DMS personnel have been operationally deployed in such areas as Northern Ireland, the Balkans, Sub-Saharan Africa and the Middle East, providing medical support in peace-keeping, peace-making, humanitarian and conflict operations. The current tempo of military operations requires a high

level of medical support in terms of preparing troops for deployment and providing healthcare on operations. This results in frequent deployments for DMS personnel. In order to meet the requirement for continuing prowess in clinical ability, on-going education and training to embrace developments in healthcare practice is fundamental. Clinical practice within the NHS system provides exposure to both acute and chronic medical and surgical conditions, whilst pre-deployment training involves clinical scenarios to replicate the real life conditions encountered in the course of operational duty. Both elements are essential in ensuring that DMS healthcare professionals are fit for role.

1.9. Introduction to the study

As a nurse teacher my interest lies in how people learn and the transfer of learning and maintenance of skills. Whilst this is required in all areas of nursing practice it has particular resonance in military nursing where nurses are frequently called upon to utilise skills and knowledge in varying and often austere environments. Their scope of practice involves not only transfer of theory to practice, but practice to practice, with incorporated reflective practice. Whilst it is axiomatic that nursing is a practice based profession, the practice of nursing emanates from a combination of art and science. There are elements of practice and understanding that stem from a scientific basis and undisputed truths. Notwithstanding the scientific elements of nursing the ‘art’ of nursing lies in the practice, based on experience, intuitive knowledge and professional judgment – formed through the transfer of learning and reflection in, and on, practice. For military nurses the transfer of learning from the civilianised environment of NHS practice to the operational field hospital in, at times, hostile conditions, becomes a necessary and automatic reality. As such our educational provision needs to ensure that military nurses are sufficiently prepared for their role as qualified nurses within the DMS. This would suggest that military nurse teachers need to remain abreast of the demands of professional practice for deploying nurses and developments in healthcare in the operational environment. These demands

also include military operations and nurse teachers need to remain aware of the changing nature, direction and intent of military activity.

Whilst my practice as a clinical nurse has involved periods of duty in operational areas my recent experience has been located within education and healthcare audit. As such my operational experience may be viewed as 'out of date' particularly in relation to current and emerging military medical and surgical protocols and developments, and environmental factors. Griffitts (2002) estimates the 'half-life' of nursing knowledge as between two and five years so without continuing education and application to practice nurses may be unable to remain abreast of developments in healthcare. Thus military nurse teachers may have decreased their overall awareness of military healthcare practice and ethos as a consequence of the level of commitment to the pre-registration programme in a predominantly civilian environment.

The requirement for currency in one's specialist area has been acknowledged throughout recognised professions. For example medical doctors and dentists are required to undertake relevant professional development throughout their career, and accountants have mandated continuing professional development. The Nursing and Midwifery Council (NMC), nursing's regulatory body, directs that all nurses participate in the minimum of 5 days professional development over a period of 3 years and stress that professional development activity be relevant to practice. Therefore military nurse teachers' professional development should, theoretically, encompass educational and clinical practice, across military and civilian practice arenas.

1.10. The Research Study

The aim of this study has been to explore the military nurse teachers' perspective of their role. The intention is to discover how military nurse teachers feel their role contributes to the educational preparation of military student nurses and educational support for nurses following qualification.

Military nursing has developed over the years as a distinct community of practice but the role of nurse teachers within this community has not been examined. It

could be argued that military nurse teachers could claim membership of distinct communities of practice such as university lecturers in addition to the communities of military nursing and the military organisation.

The study will commence with some broad questions which should become increasingly refined throughout data collection. This is dependent on the participants' perceptions and emerging themes. It is envisaged that their narratives will elicit perspectives on their contribution and the role of military nursing within the wider military healthcare arena.

An interpretive approach has been selected to explore the military nurse teachers' perceptions of their role. Interpretive approaches look for the meaning of individuals' actions and thought processes (Weaver and Olson, 2006) thus enabling understanding of their world.

The study design has been influenced by Grix's (2010) building blocks of research. This tool has proved useful in providing direction for the construction of the study, particularly in the early phases.

The following chapter will explore literature relating to nursing, education, military nursing and nurse teachers to gain an understanding of how the education and practice components of nursing are viewed by the profession.

Chapter 2

Literature Review

2.1. Introduction

The aim of this chapter is to explore the literature relevant to this world of military nursing nurse teachers and their professional presence within the communities in which they practice. With continuing advancements in military healthcare and its delivery it is imperative that the preparation of nurses and other healthcare professionals remains abreast of changes and developments. Nursing curricula are responsible for educating the profession at all levels so it is important that the advancement of nursing education, theoretical and clinical, is in keeping with the needs of the healthcare environment. The changes in the academic level of nurse education, in the move to an all graduate profession, have resulted in an increased focus on academic achievement. Thus the role of nurse teachers in the education of nurses is critical in relation to academic preparation for practice. The link with military nursing is particularly important as its focus of nursing practice is based, predominantly, on the provision of care on the battlefield. Military nurse teachers, like their civilian colleagues, carry out their educational practice in the university environment, distanced from clinical practice arenas. Within their practice there are personal and professional influences which interact with their overarching identity as a serving military person.

In order to explore the world of military nurse teachers one requires an understanding of the world they inhabit; military nursing, defence healthcare, nurse education, and thus the complexity of the subject under scrutiny. Their world comprises their professional identity as members of the Army, nursing and education professions.

Whilst there is a plethora of literature relating to the practice of nursing there has, traditionally, been little that pertains to the practice of British military nurses in the peacetime or operational environment, the nature of military nursing (Griffiths,

2007; Kenward and Kenward, 2015; Currie and Chipps, 2015) or military nurse education and teachers. At the time of this study there was no dedicated centre for British military nursing research and any research undertaken was generally as a component of specialist training programmes or higher education. It could be argued that British military nurses have undertaken their research in isolation, in some instances without in-house academic support and without a recognised repository for completed work. Thus publication of work was an individual's responsibility. This lack of published research is changing and there is now a focus on research in the military nurses' primary domain – the operational arena. Whilst the focus on the operational arena is sound the initial preparation of military nurses to undertake professional practice within the wider healthcare arena is unquestionably important. This is the domain of the military nurse teachers and encompasses professional socialisation, theory and practice, knowledge acquisition and related communities of practice.

2.2. What is military nursing

Military nursing is regarded as nursing care performed for and by military personnel in a variety of environments. Agazio (2010), talks about the uniqueness of the military nursing environment where military nurses require training in soldier and survival skills. Skills in weapon handling, field sanitation, aspects of navigation and communication equipment are deemed as essential as clinical ability in the performance of their role. This requirement for soldier and survival skills in the military nursing environment highlights the different components of the role, in addition to the clinical skills and experience that form the military nurse package. This combination of military and nursing skills produces the deployable nurse, able to practice in different environments in peace and war.

Scannell-Desch and Doherty (2012), viewed 'soldiers first, nurses second' as being the difference between military and civilian nurses. This suggests the dominance of the military aspect of identity and the need to demonstrate the

military values over those of the nurse. This sits well with the construction of a military identity through the activities peculiar to the soldier or 'soldiering' (Woodward and Jenkings, 2011). Activities such as those outlined in the previous paragraph, which are, generally, unnecessary skills for a nurse in civilian practice. What these skills emphasise is the military component of the role where qualities such as 'caring', although essential for a nurse, must abide alongside robust military skills which may save their own life and the lives of those in their care. The military identity of the nurse also conveys the sense of belonging, belonging in the military community as opposed to an outsider providing healthcare.

2.3. Military nursing literature

The literature around military nursing has emanated, predominantly, from the United States of America (Currie and Chipps, 2015), and focused on the operational environment and practice. Griffiths and Jasper (2008) suggest any research into British military nursing has been overlooked. The focus of published research has traditionally been the experiences of military nurses from the eras of the Vietnam and first Gulf Wars. There is now literature relating to the second Gulf and Afghanistan wars (commencing 2001and 2003 respectively), with an upsurge in clinical military nursing research papers since 2004. Currie and Chipps's (2015) review found that of the published literature pertaining to the Gulf and Afghanistan Wars (2001-2014), only one originated from the UK with the remainder from the USA. It is suggested that this is understandable due to resources available to the US Armed Forces. The increase in military conflicts since 1990 has provided military nurses from several countries with operational experience and the US Army Nurse Corps has used these opportunities to develop a repository of nursing research. Kennedy (1994) contends that military nursing research was initiated by the US Army Nursing Corps, which reflects the US Armed Forces enduring practice of research activity across their organisation. Additionally, the US Armed Forces have a well-established Tri-Service (US Navy, Army and Air Force) nursing research programme (Currie and Chipps, 2015).

There is also some literature on operational activity published by Australian military nurses. The nature of conflict since the first Gulf War has seen an increase in the amount of medical and nursing support required to support fighting troops. Due to the configuration of fighting support it is rare for a country to fight alone. Thus deploying troops may work alongside colleagues from a different country (for example USA, Denmark, Australia). Whilst there may be cultural differences practice within these countries is similar. Therefore, generally, the professional literature around operational military nursing is applicable across continents due to the comparable nature of the battlefield environment.

In addition, whilst there is professional literature relating to nurse teachers and their role, and literature pertaining to nursing students' experiences, there is no literature identifying the role of the military nurse teacher. This could be related to the absence of research into military nursing per se as stated above. This lack of knowledge around the role of the military nurse teacher provides reasoning for a study into the teachers' perspectives of their role. Knowledge of the role will be valuable in determining their contribution to military nursing and possibilities for role development in the changing environment of nursing and nurse education.

2.4. Literature relevant to the study

The published research that has informed this study has been drawn from the professional literature of, predominantly, the USA and UK. Other contributions are included from authors whose contributions focus on nurse teachers, nurse education and the relevance of nurse teachers to the overall nurse education process. Publications relevant to military nursing have been included, in particular literature around the construction of professional identity. Such literature provides insight into how individuals such as military nurse teachers, with discrete albeit multiple roles, construct their professional identities. Other issues of importance such as belonging, in relation to communities of practice and the theory practice gap are explored. Such arrangement enables the subject

under scrutiny to be explored from different perspectives whilst ensuring that the focus on the 'military' element remains.

2.5. The context of military nursing

The role of UK military nurses is to provide healthcare support to personnel of the Armed Forces wherever they may be stationed and / or deployed. Military nurses are uniformed personnel, as in they are either enlisted or commissioned into one of the three Services. All nurses in UK, military or civilian, undergo the same theory-practice programme to enter the profession of nursing. Where military nursing differs from civilian nursing is in the entrenchment of military nurses in the military organisation necessitating the dual persona of professional nurse and military person. Hale (2012) states that military culture is "a unique way of life", markedly different from the culture of civilian organisations, so it follows that with entrenchment in this culture military nursing will be different from nursing in the civilian domain. Allison (1919) wrote about the influence of war and observed:

> "In a civil hospital, with its standardised methods and equipment, the full capabilities of a graduate may not always be known, but in an active Army hospital, where the number of patients may change from a few thousand or more in a single day, the resourcefulness of nurses particularly, upon whom the responsibilities rest so largely, are often taxed to the limit".
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> (Allison, 1919, p.837)

This statement has resonance for military nurses of the twenty first century. As in civilian hospitals the predominant healthcare work force is the nursing contingent. They alone are the consistent contact for their patients and their ability to provide high quality care is paramount. The difference with nursing in a military environment lies with the nature of the environment, which may be hostile, demanding and changeable (Finnegan et al, 2015), and becomes an all-consuming existence for the duration of the deployment. Military nursing has

been referred to as more than just a job, rather as a full time commitment during peace and war (Scannell-Desch, 2005). The practice of nursing *per se* can be stressful, without the additional pressure of working in an unknown environment which may be hostile and with limited resources both professionally and personally (Bond, 1986; Faulkner, 1988). As such the importance of a firm theoretical knowledge base related to clinical practice in such environments cannot be over emphasised, along with the requirement for continuing education. The clinical areas are seen as possibly the most important arena for student learning and ongoing professional development for registered nurses (Melia, 1987; Bartle, 2000; Campbell, 2003). Military nursing, akin to other communities of nursing practice, requires rigorous and consistent education processes. With clinical areas seen as the significant area for learning the role of nurse education, in the university setting, must be to provide students and learners with the necessary knowledge and skills to embrace all learning opportunities and learn from practice.

2.6. The position of Nurse Education

Throughout the literature nurse education is viewed as a lifelong process; in common with other professions (Jarvis, 2005; Gallagher, 2007). Nurse education in the UK begins with the initial three year pre-registration education programme resulting in achievement of nationally recognised standards and thus the entitlement to practice as a nurse. Subsequent practice requires demonstrable evidence to the regulatory body of on-going education to ensure up to date practice and professional development. Usually registered nurses pursue their careers through a speciality, such as intensive care nursing, accident and emergency nursing, trauma and orthopaedic nursing as well as the area of education, each of which requires additional academic pursuit and competence. The literature reflects these stages and there is a wide range of professional books and journals available to inform nurses throughout their career. Additionally all registered nurses, irrespective of specialty, have an obligation,

stated in the NMC's Code of Professional Conduct (NMC, 2015), to provide educational support to their junior colleagues.

Developments in the profession of nursing have seen alterations in pre-registration education. The initial change came in the late 1980s with the introduction of 'Project 2000'. The Project 2000 programme moved nursing away from the traditional apprenticeship style training, a move which affected the entire system of nurse education and training (Lord, 2002). Student nurses spent less time in clinical practice with an increased concentration on theoretical knowledge. The aim was to expose students to higher education rather than continue to fuel a system that responded mainly to NHS requirements. However, the relevance of higher education was not accepted by many nurses and their rejection of academia became a major issue with the implementation of the programme (Lord, 2002). Simultaneously the reduction of student nurses in practice impacted on the service delivery in hospitals. Students had been in practice as service deliverers as opposed to the supernumerary status they enjoy today. Thus Project 2000 essentially saw their removal from the workforce whilst their time in practice required increased levels of supervision and support.

Nurse education has now moved into the echelons of higher education. The move reflects the desire to move nurses beyond levels of "mere competence" (Watson, 2006) and provide nursing with a "firm academic base" (Findlow, 2006).

The relevance of these changes for military nurse students has been two-fold. Their education moved from the military school of nursing, situated alongside the military hospital, to a local university and their practice area moved from an established military hospital to a local NHS acute Trust. It could be argued that nursing practice is similar irrespective of environment (Foley, Kee, Munick, Harvey and Jennings, 2002), but the actual setting of practice and members of the healthcare team influences their sense of the practice environment. Therefore the setting of a civilian hospital and university dilutes the military influence and ethos, whilst reducing exposure to the population they will support

on operations. Additionally the opportunities for students to work alongside military nurses has been reduced and their practice may be carried out in areas that have little relevance to military nursing on operations, for example in medicine for older people. Consequently part of the military nurse teachers' responsibility lies with infusing military values throughout the students' programme and university experience.

2.7. Military nurse teachers' identity and role

Inculcating military values within the academic programme is a critical component in developing students' self-concept as military nurses. The students' image of self as nurses promotes formation of their professional image for themselves and others. Initial experience as student nurses is within the confines of the university environment and their first impressions of nurses as professionals are learned from their nurse teachers. These initial impressions will be based around professional theory and philosophy and may differ from the reality of practice (Pilhammer, 1995), but serve as central to the students' professional socialisation (Ohlen and Segesten, 1998). It is purported that construction of professional identity is established during the pre-registration programme as a product of the students' socialisation as nurses (Ohlen and Segesten, 1998), but is reliant on role models (Adams, Hean, Sturgis and Macleod-Clark, 2006). Such modelling is provided by nurse teachers (Power, 2016). It is important to note that until recently military nurse teachers were fundamental in this process of socialisation, supporting the students' development of professional identity as nurses in the military context. The teachers' position in their organisation is central to this development; for military nurse teachers this has involved both the university (educational) and military organisations. Their role as an educator, now distanced from the military arena, could be viewed as dilution of their own identity as a uniformed nurse.

Identity is "not hereditary, inborn or natural" (Yazdannik, Yekta and Soltani, 2012) but developed through interaction with the societal environment, experiences, our

place in the world. Adams et al (2006) propose that professional identity is constructed as part of our professional socialisation, alongside the acquisition of apposite knowledge and skills. This conforms to the notion that developing professional skills enables an individual to function as a nurse thus develop their self-image as a nurse. For military nurse teachers professional identity as a nurse would have been developed during their early socialisation within the nursing profession. Identity as a military nurse is constructed through participation in military culture, through professional practice, military training and belonging to the military family. Belongingness is construed as central to human activity (Levertt-Jones, Lathlean, Maguire and McMillan, 2007); for individuals to be part of a community of people and feel valued for their contribution. Military nurse teachers, superficially at least, achieve that belongingness through their military persona – they are part of the military family. Their wearing of uniform, their military rank and qualification as a nurse provides the visible features of belongingness. However, belonging to different professions or organisations presents challenges in relation to establishing professional identity in role. In addition to 'belonging ' to different organisations; to the military, to nursing and within the university, military nurse teachers may also be seen to be disconnected from both the military and nursing. Adams (2011) comments that nurse teachers who straddle two separate professions, nursing and teaching, are unable to cement their identity with either. This is further complicated by the overarching authority of the military with its philosophy and doctrine and may present challenges in professional practice. Individuals address professional issues in accordance with professional values and within safe parameters of practice. Where professional values may be seen to conflict with the military mission dialogue is required with integrity as part of one's professional identity as a nurse. A strong professional identity facilitates greater flexibility with role changes (Cook et al, 2003), an useful attribute for military nurse teachers with multiple aspects of their professional role.

As military personnel nurse teachers, as all military nurses, are governed by military law. Nurses, as other healthcare professionals, practice within the remit of their regulatory bodies. They have professional responsibilities for practice within the parameters of their Code of Conduct (NMC, 2015). Kelly (2010) points out that where their professional responsibilities conflict with their military requirements the potential for 'dual loyalty conflict' ensues. This 'duality' corresponds with Griffiths and Jasper (2008) 'double-hat' identity for military nurses. Military personnel assume their identity as 'military' through entry into a military organisation which exists through a "strict hierarchy of power and subordination" (Atherton, 2009), which relies on obedience throughout all ranks of personnel. The diminution of individuality is integral to the hierarchical structure of the military organisation. It could be argued that the military clones its personnel through training, regulation and discipline to produce individuals who can enact the military mission. Personnel belong to the military community and become immersed in the culture and practice of the organisation. As stated the military identity is developed through common practices, teamwork and mutual engagement. Mutual engagement is a significant factor in communities of practice as described by (Wenger, 1998, p.45).

Communities of practice were initially discussed by Lave and Wenger (1991) as a means to encompass learning in a specific area of practice (Andrew et al, 2009) or mutual engagement in practice (Wenger, 1991, p.74). Duncan-Hewitt et al (2005) explain how such communities of practice share a mission, identity, knowledge base and common practices. Within the military organisation the concept of a community of practice becomes evident through shared mission and identity. Members of the military learn from established practices and such learning structures their sense of belonging to the organisation. Additionally the wearing of uniform and rank denotes a position within the organisational community, irrespective of professional identity. Within healthcare there could be a sense of 'experiential learning by another name', where healthcare professionals consolidate and develop their knowledge and skills through

interaction with others in a specific area. Areas of practice share common goals, procedures and processes where individual practitioners participate, gain experience and become proficient in the accepted ways of working. Advantageous to this community is the presence of healthcare professionals from multiple disciplines through whom practitioners, students in particular, can engage with problem solving, decision making, and professional judgement in addition to the acquisition of psychomotor skills.

Wenger (1998 p.73) specifies distinct characteristics of a community of practice as; mutual engagement, joint enterprise and shared repertoire. Mutual engagement refers to the dynamic development of relationships between members, joint enterprise is the working towards common goals and shared repertoire relates to the understood ways of working to achieve their goals (Callahan and Tomaszewski, 2007). All of these characteristics correspond with the workings of the military environment where individuals work within known parameters, codes of ethics and codes of practice. For military nurse teachers, straddling education, nursing and military communities, membership of the differing communities of practice requires commitment, enthusiasm and robustness.

2.8. Theory – Practice and education: implications for military nurse teachers

Literature relating to the role of nurse teachers has become more thought provoking following the changes to nurse education programmes and the move of nurse education into Higher Education Institutes (HEI). Issues regarding role, in particular involvement with the clinical component of nursing, have become customary along with the ubiquitous theory practice gap discussion. Following Project 2000 the move to higher education was cemented in the early 1990s and saw the demise of the traditional schools of nursing which had been situated alongside NHS hospitals. For military nurse teachers this was a time of major upheaval. The move for the individual schools of nursing in the three single Services to amalgamate and reform into one school of nursing was simultaneous

with decamping to a HEI. At the time the majority of these nurse teachers regarded the move to HEI as an opportunity to raise the profile of military nurse education (anecdotal evidence) and further their professional education. The majority of nurse teachers were undertaking higher education programmes which they viewed as essential for their practice as teachers. In retrospect the move was viewed as permanent; nursing education, along with Allied Health Professional education, became a component of HE and part of the military medical education and training piece (the then Royal Defence Medical College (RDMC)), which had previously concentrated on medicine and dentistry. This presented, for the first time, a united healthcare professions approach for the British Armed Forces. In actuality the move resulted in geographical and professional distancing of the nurse teachers from clinical practice areas, their clinical nurse colleagues and students in practice; in keeping with their civilian colleagues across the UK, as predicted by Yassin (1994). Brake (2005) understood Yassin's (1994) stance as presenting two aspects of the predicament of the theory to practice gap. Overall theoretical knowledge may be viewed as unrealistic and usually impracticable for practice. Where theory could be useful and influence practice it may be disregarded due to ignorance or inflexible ways of working in practice. Brake (2005), comments that attempts to reduce the theory practice gap had concentrated on the educational input instead of improving learning in the clinical areas. This could be interpreted as improving practitioners' critical analysis of theory and evidence, as well as developing strategies to change practice. This is an interesting perspective. It could be argued that this has always been the purpose of nurse education; to prepare students for the healthcare arena and facilitate the development of skills to implement, challenge and change practice. However, it is accepted that the apprenticeship style of nurse training, prior to undergraduate level education, tended to focus on the acquisition of psychomotor skills in clinical practice and understanding conditions rather than nursing theory and developing a body of knowledge. Theory continues to be viewed as the content of formal education (Gallagher and Ousey, 2007), with practice as the activity involved with the

delivery of nursing care. Gallagher and Ousey (2007) refer to the 'gap', the theory-practice gap, as the difference between the two. Theory and practice diverge, usually, in that they are delivered in separate locations, geographically and conceptually (Gallagher and Ousey, 2007). Practice occurs in reality with continuous evolution whilst theoretical perspectives are discussed at a distance from practice. Military nurse teachers are ideally placed and experienced to lessen the gap between theory and practice through articulation of their own experience as nurses and military nurses. It is assumed that military nurse teachers use aspects of their experience for the benefit of their students. This assumption is not exclusive to military nurse teachers as civilian nurse teachers would draw on their clinical knowledge and experience to support their teaching. Use of knowledge in conjunction with experience demonstrates to students how knowledge transfer, between the theoretical structure of education and the reality of clinical practice, may be developed. Knowing how to use theory, from formal education, in the reality of practice has connections with the development of reflective practice, tacit understanding and experiential knowledge. Eraut (2007) comments how the influence of tacit understanding affects how knowledge may be learned. This suggests there are different ways of knowing, different ways of understanding professional knowledge and thus varying ways of learning, in the professional context. The following section will explore ways of knowing and expand on the importance of experiential knowledge and tacit understanding in nurse education and practice.

2.9. The nature of knowledge in nursing

Nursing can lay claim to some seminal influences around knowledge and ways of knowing (Carper, 1978; Benner, 1984). Carper (1978) explained four ways of knowing; empirical, ethical, personal and aesthetic (Johns, 1994) for nurses. Empirical knowledge relates to the science of nursing, what is fact and we can observe and describe. Aesthetics relates to the 'art' of nursing, which is more than the artistry involved in technical skills. Personal knowledge is challenging to teach (Carper, 1978, p. 133) but represents what it is to be a nurse; how

interrelationships affect those who are being cared for. Finally ethical knowing requires nurse to understand what is good and what is right balanced with options for care. Utilising these ways of knowing enables nurses to move beyond ritualistic care, to interpret the experiences of those in their care and design appropriate interventions. Such interpretation connects with reflection and reflective practice and, I believe, with Benner's (1984) practical knowledge which is advanced through clinical experience (Benner, 1984, p.3). For Benner (1984) practical, propositional knowledge - the "know-how" may be developed without theoretical underpinnings thus stressing the involvement of experience. As nurse teachers we have promoted learning from experience as fundamental to development as a practitioner. Students are encouraged to reflect on experiences in order to improve their knowledge and understanding in practice. Links are made between practical experiences and underpinning theoretical perspectives.

Carper's (1978) ways of knowing appear to legitimise the use of knowledge other than empirical in the provision of nursing care, such as the "know-how" of practical knowledge. Practical knowledge gained through experience is a pre-requisite for expertise (Benner, 1984, p.3) and is enhanced through reflective practice. To reiterate a previous statement; practice is the foundation of the nursing profession. Practice and theory need to entwine to avoid ritualistic care based on tradition but each component must develop in light of new evidence. This alludes to evidence-based practice and it is reasonable to desire nursing to embrace reflection and evidence-based practice within experience to promote expertise in practice. Irrespective of terminology, the relevance of ways of knowing, reflection on practice, relevant experience and developing expertise is huge for the military nurse. Clinical placement in the NHS cannot prepare for battlefield conditions, the physical and emotional stress of the environment nor the polytrauma that ensues from conflict. Pre-deployment training in the form of simulated experiences is in place which raises awareness and tests military personnel's personal and professional stamina. Walder and Olson (2007)

discuss the use of simulated experiences where appropriate clinical placement is unavailable. They comment that simulation can aid skill achievement by exposing practitioners (or students as in their account), through exposure to uncommon or unusual experiences. Thus the simulated events in the military nurse's pre-deployment phase provide exposure, not to uncommon experiences but to experiences that are uncommon in NHS clinical practice. Therefore simulation and operational experience provide experiential learning opportunities for military nurses. Preparation for operational deployment is important for all military healthcare practitioners. It is crucial that sufficient training and preparation of military nurses is provided. As the primary caregivers for patients military nurses are exposed to the physical and emotional traumas of those in their care. Equally as important is the physical and emotional welfare of the nurses, to enable them to perform their duties competently and compassionately. Nurse education has a significant role in enabling military nurses to develop the knowledge and professional skills to contend with enactment of their role in differing environs. Returning to the role of the military nurse teacher, there are opportunities for teachers to share experiences, discuss approaches to maintain professionalism with compassion and how to manage experiences involving distress – physical, emotional, moral and ethical. In order to educate and support military nurses, there is the requirement for teachers to be familiar with the reality of operational experience. As previously stated the role of a military nurse is different from their civilian counterparts as they inhabit a different world. It could be argued that military nurse teachers need to inhabit the world of operational experience in order to carry out their education role. The whole context of military nursing and military nursing education is characterised by the 'art and science' of the profession. As previously stated knowledge and practice create the 'knowledgeable doer' who utilises knowledge and experience to develop their professional learning. The essential component in the acquisition of knowledge, skills and experience for nurses and nurse teachers, is their practitioner colleagues. Colleagues act as mentors, facilitators, and teachers, dependent on context but importantly they allow for the 'learner' to participate in

their learning. This notion of 'education in nursing' corresponds with the acquisition and participation metaphors discussed by Sfard (1998). Sfard's (1998) discussion details differences between acquisition and participation which reflect the demarcation between knowledge acquisition and practice – 'acquisition of something' versus 'becoming a participant'and using participatory experience. The theory practice gap fits well with these discrete metaphors although the military nurse teacher's intention is that they should merge. Education needs to be participatory, particularly where theoretical knowledge and clinical practice need to unite to make sense of practice. Benner (1984, p.36) discusses how clinical practice presents practitioners with more complicated reality than theory can prepare them for. Theory provides the foundation but it is the clinical experience which enables the practitioner or student to become more proficient, and for Benner (1984), to become an expert in practice. Benner (1984, p.184), quite rightly stresses that nurse education should provide the 'background knowledge', the 'broad base' from which the practitioner develops their practice, with guidance from expert practitioners and through experiential knowledge. This approach envelops the metaphors of learning described by Sfard (1998) and discussed by Paavola, Lipponen and Hakkarainen (2004), with 'situational knowledge', through participatory activities in the military culture, allowing practitioners to build their nursing knowledge. Military nurse teachers are pivotal here in facilitating the cognitive element of knowledge acquisition and utilising their military nursing experience to prepare students for the situational context. The military nurse teachers use their experience to encourage students to be mindful of learning opportunities to develop their professional judgement. Professional judgement comes from using experience to create a body of knowledge that cannot be explained, the intuitive aspect of practice that is developed through creation of tacit knowledge. Tacit knowledge is a fundamental of intuition (Polyani, 1966 in Billay et al, 2007), which develops through experiential learning in practice. So whilst expert clinical practitioners support students and new graduates in clinical practice the responsibility for laying the foundations lies with the nurse teachers and the educational process.

2.10. Theory – practice: credibility and competence for military nurse teachers

The development of nursing as a profession, developing a body of knowledge and autonomous practice, has been as a result of increasing the level of education. Mulhall (1998) stated that research has been used to 'legitimise' nursing, and nursing education restructured to encompass research and the production of evidence. Whilst nursing knowledge emanates from an array of related disciplines there needs to be a fundamental understanding of the biology of man and practical application in order to nurse. Thus the combination of education with training, the integration of theory with practice, and evidence with practice, are all essential for nursing. As previously mentioned the theory practice gap has been well documented in the nursing literature. Nursing is a combination of art and science and there is place for promoting both in nurse preparation. Discussion tends to emanate from determining where the responsibility lies for each element or who is in the best position to facilitate. From an educator's perspective the ideal scenario would be to enable the theoretical component and cognitive skills to link with the practice of healthcare, to provide skills for the enactment of the role of a nurse.

Over the period following the move to HEIs there had been concern that newly qualified graduate entry nurses would not be ready for clinical practice (Lofmark, Smide, Wikblad, 2006). However, Watson and Thompson (2000) claimed there was sufficient evidence to show that graduate nurses were as competent and caring as their non-graduate colleagues and importantly, from the nurse educator perspective, more accomplished in their decision making skills.

This goes some way to support the educational component of nurse preparation; facilitating the development of professional reasoning, problem solving and decision-making skills as opposed to the training element of promoting technical skills. Nurses require theoretical competencies underpinned by academic training, ethical commitment and social accountability (Finnegan et al, 2015). This is important in every aspect of nursing but is particularly salient in the

military context. The challenging nature of the military environment involving harsh conditions, continual exposure to polytrauma and high levels of patient throughput can have deleterious effects on healthcare personnel. The requirement for critical decision making and problem solving, clinical acuity and managerial skills is paramount alongside emotional resilience and self-determination. Whilst skills in all aspects may be honed through experience, their foundations are laid in the academic component of military nurse education. From this perspective the requirement for nurse teachers who are credible in all aspects of their role would be indisputable. It also raises the question of the importance, or not, of continuing clinical prowess whilst an educator's primary role is concerned with education, not training, from a location outwith the clinical practice arena, be it peacetime or operational.

The competence or credibility of nurse teachers has proved a topic for discussion. The geographical and professional distancing of nurse teachers has impacted on the perceptions of nurse teachers by their professional colleagues, in particular around their clinical role (Griscti *et al,* 2005). It is axiomatic that nursing is a practice profession and various authors have commented on the credibility of the university based nurse teachers (Gillespie and McFetridge, 2006; Adams, 2011); the ability to maintain up to date evidence based practice when not in practice is a recurring theme. According to Adams (2011) there is no comparable demand for maintaining credibility in one's teaching practice which suggests that the 'teaching' component of the nurse teacher role is viewed as less important than the 'nurse' component. This is questionable. The Nursing and Midwifery Council, as Nursing's governing body, requires all registered nurses to be fit to practise, meaning they require the necessary knowledge and skills to carry out their role (NMC, 2010). Fitness to practise is determined through personal documentation demonstrating that nurses have met the requirements. Therefore military nurse teachers declare their fitness as nurse teachers of nursing. Although nurse teachers are required to hold a teaching qualification (and have it recorded as a qualification on the NMC register), there

is, as Adams (2011) implies, no overt scrutiny of continuing ability to teach. However, this may change with impending revalidation requirements where documentation to declare fitness to practise will include practice-related feedback, reflective accounts and reflective discussion with a fellow registrant. What is currently in place for nurse teachers, as an employer's requirement, is annual peer observation and line manager appraisal which should provide an outline of educational practice and ability.

Aside from their teaching credibility there is another issue regarding nurse teachers' contribution to the preparation of nurses. Wilson and Startup (1991) carried out a study in 3 Welsh nurse education centres to assess the nurse teachers' contribution in nurse training prior to Project 2000. The major qualities of nurse teachers highlighted at that time were communication and friendliness. Interestingly the students identified that teaching should clearly relate to the reality of life in the clinical areas but observed that there was minimal contact with teachers in the clinical area. Wilson and Startup (1991) commented that "within a more unified system of professional socialisation teachers may need to possess greater clinical credibility".

2.10.1. Clinical credibility in role

Opposing viewpoints on the issue of clinical credibility are noticeable within the literature (Wilson and Startup, 1991; Ramage, 2004; Calpin-Davies, 2001; Mateo and Fahje, 1998; Mitchell, 2005; Carlisle, Kirk and Luker, 1997), with no resultant consensus except that clinical credibility remains an important issue. Wilson and Startup's (1991) study found that students felt that what was opined in the classroom did not match with what they experienced in practice and as previously stated they also experienced a lack of clinical contact with teachers. This is of concern in that students appeared to be relying on teacher contact in the clinical area despite working alongside clinical practitioners. Ramage (2004) concluded that nurse teachers were required to re-establish their role as a clinical practitioner in the practice arena. Her study found that nurse teachers did not

feel that their educational role was recognised, neither their previous role as a clinical practitioner. Thus nurse teachers felt compelled to 're-negotiate their role', which could be seen as re-establishing their identity as a nurse, through mediation with the practice areas. Carlisle et al (1997) found that nurse teachers who had been in post more than five years had diminished clinical competences. This is unsurprising given their academic responsibilities which limit the time available for clinical practice. Mitchell (2005) suggested that these teachers would be involved in clinical research. That may be the case in some scenarios but is not true of the military nurse teacher. As previously stated there has not been, until very recent years, any central direction or focus for military nursing research.

As nursing is a practice-based profession there is the general assumption that nurse teachers are clinically competent (Fawcett and McQeen, 1994). Benner's (1984) seminal work adapted the Dreyfus (1980) model of skill acquisition for exploring nursing development and practice. The Dreyfus model hypothesised that in the development of skills in practice the learners pass through five stages – novice, advanced beginner, competent, proficient and expert. Theoretical knowledge may be seen as the baseline (novice level) whilst experience provides the construction of professional judgement and enables the practitioner to travel along the continuum towards the expert level. Thus the requirement for practice to consolidate theory, promote critical reasoning and develop psychomotor skills to complement developing knowledge.

Benner (1984) stated that 'experts practice from experience' and draw upon personal, intuitive and experiential knowledge. Assuming that nurse teachers enter the educational field following a substantial period in clinical practice their experiences should provide valuable knowledge and skills to impart to students. Military nurses complete at least one tour of duty (two years) in clinical practice prior to entering education unless they hold a teaching qualification on entry to the Armed Forces. In this instance it is generally accepted that they will complete one year in clinical practice to develop an understanding of military

nursing. Returning to Benner's elucidation of 'expert'; this would appear to represent a nurse in fulltime clinical practice as opposed to a nurse teacher juggling the roles of academic and clinician. Thus the nurse teacher may be classed as 'competent' on Benner's continuum (Little and Milliken, 2007) and has significant experience and understanding to impart to student nurses.

Gillespie and McFetridge (2006) believe that clinical 'credibility' aids the educational process as it imparts quality information of use to the learner. Where a nurse teacher does not maintain his/her clinical skills the value of the information may be said to be outdated. However Adams (2011) states that "a teacher does not have to demonstrate that he or she can write poetry or a novel to teach literature". According to Brennan and Hutt (2001), clinical credibility implies scholarship in nursing and the skills to assimilate theory to practice in the classroom or practice setting. Thus the nurse teacher who maintains his/her practice through teaching, keeps up to date with the professional literature or undertakes research maintains their clinical credibility, if not currency. Without clinical activity their clinical currency, described by Brennan and Hutt (2001) as clinical competence, cannot be maintained. Worldwide, nursing students identify clinical competence as being an important quality of effective teachers (Nahas et al., 1999). Whether students differentiate between competence, credibility and clinical awareness is not explored. Nurse teachers, like their clinical colleagues need to remain up to date with emerging knowledge and practices relevant for nursing but this does not necessarily require them to be actively involved in the provision of direct care. Or does it?

These concerns have been the focus of policy recommendations. The report 'Fitness for Practice' (United Kingdom Central Council (UKCC), 1999) indicated that protected time would enable nurse teachers to undertake clinical practice in order to meet the requirements of their learners and governing body. Whilst this is encouraged for military nurse teachers it is not always possible due to teaching and other university commitments. The current professional and regulatory body for nursing and midwifery requires that nurses undertake activity in their area of

expertise, their specialism, therefore nurse teachers register as Practice Educators with the Nursing and Midwifery Council (NMC) and declare their teaching and scholarly activity as evidence of up to date practice. However, there is an extra dimension to the role for military nurse teachers; they are military personnel in addition to being nurses and teachers. As stated above there is a tension between the roles of nurse and teacher so it is unsurprising that there is discussion around the role of the military nurse teacher, particularly as they have no identified operational role. Therefore whilst the role of the military nurse teacher straddles three professional elements – military, nursing and education – there is, currently, no operational role for the military nurse teacher. This reference to the 'operational role' is important. Operational activity could be construed as the fundamental activity of all military personnel. The purpose of an uniformed nursing force is to provide nursing care and healthcare support to personnel of the British Armed Forces, an operational imperative.

The overall perception of the move of nurse educators into HEIs, has been that all nurse teachers have lost their clinical credibility. Gui et al (2009B) commented that Chinese nurse teachers' undertook clinical practice only on an occasional basis, working with their students. From this they surmised that their clinical skills could deteriorate through lack of their own practice or healthcare developments. They also commented that, as with other countries, there could be an argument for Chinese nurse teachers to maintain their clinical credibility.

Gui et al's (2009B) study addressed job satisfaction for nurse teachers in China, not the educational preparation of nurses so there was no discussion as to the relevance of continuing clinical contact for teachers. However they did include the fact that for several years nurse teachers were not nurses. One assumes this was prior to graduate level education and could have occurred through lack of qualified nurses to teach following the stoppage of nurse education during the Cultural Revolution of 1966-1975. This supports the fact that specialists in other subjects provide valuable input in nurse education. This links to military nurse education where the nurse teachers are qualified nurses, military personnel, and

as the findings will demonstrate, there is an expectation in some quarters that they will be clinically credible. The notion that teachers from other disciplines could support nurse education could affect the inclusion of military nurse teachers who are not clinically credible. Should this notion be considered, the contribution of non-clinical nurses in military nursing may need to be explored in the future. Teachers of other disciplines could be involved in nurse education programmes, particularly in relation to science, pharmacological and managerial aspects which could denude the role of the military nurse teacher.

Guy *et al* (2011) explored the perceptions of Australian nurse teachers of their competency framework. One of the themes identified was the perception that nurse teachers were viewed as experts in relation to clinical practice. Nurse teachers accepted that they needed to be 'clinically aware' in order to facilitate understanding of nursing knowledge in students but that the experts were the clinical practitioners. This makes sense in the Australian context as nurse teachers are employed in a variety of settings, which may be university led education or clinical practice. The general consensus from Guy et al (2011) is that nurse teacher competencies need to be specific to the educator's environment. Applied to the military nurse teacher environment competencies would need to relate to university led education but with a strong focus on integrating theory with practice. To that end there is the question as to whether military nurse teachers should be familiar with the Defence Operational Nursing Competencies (DONC), which have been implemented to provide standards of clinical competency for nursing positions on operational duty. There are elements within the DONC that military nurse teachers could provide educational support for such as reflective writing, self and peer assessment and construction of a portfolio of evidence (see Appendix 1).

Griscti *et al's* (2005) study of Maltese nurse educators found that the majority of participants felt their role was in preparing students to successfully complete the academic component of the programme. Although participants stated that their

clinical role was important, factors such as lack of time and educational commitments impinged on their ability to be involved in the clinical area. The Maltese scenario is noteworthy for its similarity with the structure of nurse education in the UK. Maltese nurse education was developed along the lines of the model of nurse education in the UK and moved into the HEI sector in the late 1980s. As with the UK model how the clinical role of nurse teachers was to be continued was not clearly defined. Indeed, in the UK the clinical teacher role was removed when education moved into HEIs (Grant et al, 2007). Mitchell (2005) suggests that the clinical teacher role was ineffective in addressing theory practice issues; which was the purpose of the role. The clinical teacher role was customary when the apprenticeship style of training and education was in place and provided the link between the school of nursing and clinical placement. The clinical teacher had no educational role in the school of nursing so Mitchell's (2005) comment about the lack of addressing theory practice issues may have relevance.

The recurring theme within the three studies outlined above is the notion that nurse teachers, with educational commitments as their primary role, are viewed as requiring up to date clinical prowess. This has relevance for both civilian and military nurse teachers, who need to relate their theoretical contribution to the student's reality of clinical practice. Continuing clinical exposure would assist in this endeavour. Consideration would need to be given as to whether the military nurse teacher would undertake clinical practice to maintain their clinical currency, competence and credibility or whether they should be utilised as an academic and placement link for students. With the withdrawal of military nurse teachers from the pre-registration programme student nurses have no contact with military nurse education. Therefore the presence of military nurse teachers in the practice environment could prove beneficial for military student nurses, junior military nurses and the teachers.

Little and Milliken (2007) state that whilst nurse educators are expected to be demonstrate expertise in both education and clinical practice, this is difficult to

achieve. Little and Milliken's (2007) judgement is based on Benner's (1984) interpretation of skills acquisition ranging from novice to expert. Benner's (1984) seminal work identified how moving between environments resulted in decreased levels of proficiency, competence and expertise. Whilst Benner (1984) focused on different areas of clinical practice the same comparison would apply to the differing environs of education and clinical practice. Although differing environments may affect individual practitioners' levels of confidence and initial ability it is assumed that their educational preparation for role would enable the transposition of competence. However if the gap between theory and practice abounds vital links may be overlooked and nurses may function utilising psychomotor skills developed through repetition without applying underpinning knowledge. Ideally, experienced practitioners develop their clinical expertise from practice, clinical supervision and reflection with underpinning theory as their foundation. The inclusion of evidence-based practice provides another link between theory and practice for practitioners, and supports the integration of theory, research and practice in the clinical setting. The theoretical, knowledge base forms part of the professional approach within nursing. This base provides evidence for practice and the development of the professional body of knowledge. A disconnect between theory and practice has the potential to result in inadequate care.

2.10.2. The Theory–Practice gap

The issue of the theory-practice gap features regularly in the literature, and has been mentioned in the previous section. The theory practice gap is the gap between what is theoretical knowledge; the '*science'* of nursing, and the ability to transfer that knowledge into doing; the practical '*art'* of nursing (Cook, 1991; Upton, 1998). Whilst not exclusive to nursing this gap has been a fundamental issue since the demise of the apprenticeship model of nurse education in the 1980s. Although the literature has focused on the ability of students to develop skills to overcome this gap it could apply equally to nurse teachers who do not undertake regular clinical practice, whilst for those nurse teachers who do

undertake clinical practice there are issues with identity. Kitson (2006) states that the assimilation of theory with practice continues as a major challenge to the profession, with the opinion that nurses view education and practice as distinct entities. This perspective concurs with Wood (2006) who purports that practitioners need to incorporate research with practice in the practice arena, and Roxburgh (2006), who claims that practitioners feel ill-equipped to connect theory into practice. It is disappointing that the perception of a theory practice gap continues to pervade nursing practice. It is an ongoing issue which reflects the natural remnants of an era where practice was based on traditional ways of knowing and learning through on the job experience as opposed to practising from an evidence base. Evidence-based practice was initially reviewed as evidence-based medicine and defined as the "integration of individual clinical expertise with best available external clinical evidence from systematic research" (Sacketts, 1997). Sacketts (1997) emphasised that clinical expertise is essential in patient care but insufficient on its own. This profound statement really identified the requirement for a combination of factors to be employed in the quest for quality healthcare. Sacketts' (1997) practice arena was medicine but resonated through the healthcare disciplines. Here evidence was read as clinical medical research, generally from diagnostic testing and markers of prognosis, and the combination of clinical expertise and evidence enabled tests and treatments to be updated to provide the best possible patient care. The focus for evidence was clinical research, generally assumed to be scientific research as it emanated from medicine, thus quantitative research (Rycroft et al, 2004). Rycroft et al (2004) stated that quantitative research has been viewed as the 'gold standard' in healthcare, to the detriment of other approaches. It is unsurprising that the nursing profession, as the companion to the medical profession, struggled to emulate medical research and sought other approaches to evidence their practice. Utilising elements of established research traditions from other disciplines (Hall, 2006) the profession has endeavoured to build a knowledge base.

2.11. Evidence-Based Practice in nursing

Nursing, like medicine, is a practice profession, centred on the care of people. Relationships between patients and nurses are different from relationships between medical staff and patients owing to the differing interactions. These relationships complement each other and evidence from each relationship contributes to the overall body of knowledge (Rycroft et al, 2004), a body of knowledge which should be focused on improving patient care. Mantzoukas (2007), talks about evidence-based practice as an "imperative for clinical decision making of contemporary nurses". The benefit of evidence-based practice is the ability to integrate sources of evidence other than clinical research to improve a profession's knowledge base. Research will demonstrate knowledge from specific studies and although findings may influence practice there is always an element of whether generalisation of results is sound. For good nursing practice a combination of research and clinical expertise is required alongside knowledge of the patient experience and environmental context (Rycroft et al, 2004).

2.12. Operational roles: Relevance for military nurse teachers

As stated there is currently no identified operational role for the military nurse teacher in their primary specialty as an educator. However, as registered nurses, and in many cases as clinical specialists, military nurse teachers are eligible for deployment in nursing, command and administrative posts. For clinical specialists an operational deployment meets the requirements for maintaining their clinical competence (thereby securing their specialist pay award). Other nurse teachers may be deployed in general nursing or nursing command posts.

Some nurse teachers see their role as, primarily, ensuring that military nurses have the requisite skills to enable them to perform their role; skills such as problem solving, decision making, leadership, research understanding, thus the educational underpinning for practice – none of which necessitate an operational role. Other nurse teachers are of the opinion that operational experience as a

registered nurse is essential to inform future educational practice and such experience is essential to their role. Without a clearly defined role one has to rely on the individual teacher ensuring that they possess sufficient knowledge and undertake sufficient professional development to maintain their registration as a registered nurse teacher. Nonetheless, it is the duty of the employer to determine the job specification and competence requirements of military personnel. Thus the Army Medical Services (AMS) determine their requirements of healthcare personnel which are articulated through the Operational Performance Standard (OPS). Each employment group has an OPS declaring requisite training, competence and skills. However, at the time of this study the OPS for nurses had not been completed. Consequently the military nurse teacher remains without a clearly designated role outwith their commitment to the university and education, but does remain within the community that is military nursing. Irrespective of location and role military nurse teachers remain military nurses and part of the military family.

One study exploring the nature of military nursing tells of three major categories identified in the findings (Griffiths and Jasper, 2008). One of these; 'That Double Hat', identifies the duality of role for military nurses who need to balance the professional and the military components of their role. In simple terms military nurses are employed for their nursing skills (and qualification), thus the professional side of their role is paramount. However, as serving members of the British Army the professional elements are juxtaposed with the military elements of the role and neither can be disassociated. Nursing practice is performed within the professional Code of Conduct (NMC, 2015) and personal levels of competence irrespective of environment. The military component of the role is more visible in operational theatres of conflict where healthcare arenas do not conform to the peacetime setting of the NHS environment. Frictions between military and professional responsibilities have to be resolved by individual practitioners (Hawley, 1997), through a thorough appreciation of the dual professional accountability. This applies to all military and professional

personnel and should form part of the moral and ethical component of military nursing. Military nurse teachers need to be familiar with settings and scenarios where professional accountabilities may conflict and incorporate these within their educational practice.

2.13. The role of the nurse teacher

The role of the nurse teacher addresses pre and post registration programmes for nurses, delivered in higher education institutes. This undertaking involves commitment to learners, organisation, profession and self in order to meet the demands of the teaching role. Koh (2002) acknowledged that the role of the UK nurse teacher had altered considerably over the previous decade in relation to workload and function. This resulted in a certain 'tension' between academic teaching and learning in and from clinical practice. As stated previously 'tension' between theory and practice has been a recurring issue for nursing. The move of nurse education to higher education institutes compounded the distance between theoretical learning and its implementation, or transference, into clinical practice. However, this tension alludes to the perceived difficulties of transposing theory into practice alongside the fact that theory emanates from the academics as opposed to emanating from practice. Thus there is a sense of imposition on practice. The sense of imposition relates to the perspective that the practice arena needs to conform to the theorising of theorists. This is a perspective that remains, irrespective of the educational locality. The purpose of education seems to have been obscured in that theoretical knowledge provides a framework for practice through reasoning, problem solving and decision making rather than merely imposing standards. Also, the tension may relate to the fact that those seen as the theorists, the nurse teachers, are predominantly positioned outside of the clinical practice arena, and by default, not clinically current. The disinclination to accept academia as an integral component of nursing still pervades (Andrew, Ferguson, Wilkie, Corcoran and Simpson, 2009). Risjord (2007 p.1) states that research should provide the underpinning knowledge for nursing, enabling the advancement of nursing practice. He

comments that the term ‘nursing knowledge’ is ill-defined; it should include both theoretical and experiential knowledge. Risjord (2007) ascertains that practice knowledge should be informed by research, the evidence base, and the theory practice gap arises where this does not occur. The focus of researchers and practitioners may differ but the intent remains the same (Conway and Elwin, 2007). The difficulty appears to be the relationship between research evidence and the evidence required for practice, due to differing opinions on the nature of evidence. The ongoing dialogue around reducing the theory to practice gap, implementing evidence-based practice and the value of research in practice raises the question of what knowledge is required to inform practice. What knowledge will stand as evidence? The following section will explore the nature of knowledge and ways of knowing and how this pertains to nursing and nurse education.

2.14. International perspectives of the nurse teacher role

Baker, Fitzgerald and Griffin (2011) carried out a study on nurse teachers’ levels of job satisfaction and empowerment in the USA. They stated that it is easy to understand the difficulties in attracting and retaining nurse educators when one considers that they have teaching responsibilities, students to counsel, committee work to carry out, research to undertake and publishing current scholarship. Many also carry out clinical practice to retain skills and additional classes to maintain nursing licensure. Similarly Canadian nurse teachers have a duality of role; as teachers and clinical practitioners, and strive to maintain a balance between the two roles and competence in each (Little and Milliken, 2007).

In a Norwegian study nurse teachers regarded teaching and nursing competencies as more important than other aspects of their role such as evaluation skills, teacher student interaction and teacher persona (Johnsen, Aasgaard, Wahl and Salminen, 2002).

As previously stated, in Australia there are clinical nurse educators employed to provide clinical education. However, their role overlaps with other members of the nursing team such as clinical nurse specialists, nurse consultants and practice development facilitators. This has resulted in an ill-defined role identity for the clinical educators not improved by the apparent requirement for their educational endeavours to develop 'functional rather than professional competence' and 'maintaining rather than critiquing the status quo in practice' (Conway and Elwin, 2007). It is evident from the literature that roles within the nursing profession are similar across the globe. There are issues with individuals maintaining links between education and clinical practice with no overarching view on how differing roles can encompass all aspects of practice. It is debatable whether consensus is required, although recognition of each role and clear direction on what is required of nurse teachers by their employers and their professional bodies would enable nurse teachers to focus on the essential properties of their role. It raises questions about nurse teacher identity, their values in practice and how they construct their world.

2.15. Attitudes and values

For Haigh and Johnson (2007) the literature suggests that nurse educators have an influence on the values that students develop during their pre-registration programme. Other nursing personnel affect the formation of student values, for example their fellow students, but more importantly the clinical nurses they meet along their training journey (Ramage, 2004). Haigh and Johnson (2006) focused on the values that the nurse educators possess. Their 2006 survey asked nurse teachers from nineteen countries about their attitude and values to nursing behaviours and focused on altruism, honesty and intellectualism and academic achievement as the literature suggested that these categories address a significant majority of nursing standards. Their findings showed that nurse teachers valued high levels of honesty in their work, and the major importance of kindness both professionally and personally. There was no evidence that the educational level of the nurse teachers influenced the findings in these two

categories. For the category of intellectualism and academic achievement the importance of intellectual pursuit was evident. Haigh and Johnson (2006) concluded that these values are apt for nursing today and their communication to students should be formalised within the curriculum. Although the response rate for Haigh and Johnson's survey was only 18.5%, with only nine out of nineteen countries represented, the findings should not be discounted as they provide us with some insight into the common values held by nurse teachers.

Skip (2012) states that the misconduct of nurses, resulting in disciplinary action by their regulatory bodies may be linked to a failure to learn or understand values either as a student nurse or post registration. Skip concludes that if students are to learn professional values and ethical behaviours these should be imparted by professionals with appropriate 'value laden experiences' (2012). Military nurse teachers fulfilled this component of the educator role for pre and post registration students when they were employed in the university setting. With the faculty for the pre-registration programme now entirely civilian this value added component for military students has been removed. This civilianisation of the nursing programme may impact on the attitudes and values of student nurses, devoid of military nurse teachers as their connection with the professional world of military nursing. This impact links with Skip's (2012) observations around learning professional values and ethical behaviours.

Adams (2011) asserted that combining the roles of nurse and teacher causes a tension between the two identities and may result in inability to establish a position across the professions, raising issues of professionalism (Adams, 2011) and identity. Nursing has long strived for recognition as a profession and meets the requirements in terms of theoretical base, programme of education and training, assessment of competence, self-regulation and service to the public. However, Adams (2011) highlights the fact that professional status is now afforded to public service providers who hitherto have been referred to as tradesmen or skilled labour, and refers to professionals as having autonomy in practice. The inference is that nurses and teachers do not have complete

autonomy in practice, owing to external controls. This could be seen as a necessary constraint and should, theoretically, ensure that practice in both professions is consistent in its application. As previously mentioned civilian and military nurse teachers practice straddles education and nursing, with no clear identity in either domain.

2.16. Summary

Those within the nursing hierarchy have welcomed the nursing profession's recognition of professional status. The Chief Executive Officer (CEO) of the International Council for Nurses (ICN) has described the present university based education for nurses as a 'major achievement' (Benton, 2011) and stressed the need to ally the educational content with current clinical practice. The CEO's view is that collaboration between the educational provision and service sector should result in 'a learning experience that motivates and equips the student for a dynamic and complex future' (Benton 2011). What is not clear is the nurse teachers' role in this collaboration as to whether this should involve active engagement in clinical practice or purely increased liaison with service providers. What will be involved is more than dialogue between the two providers, and close working is necessary to bring the CEO's intention to fulfilment. It is interesting that in the years that have elapsed since the move to HEI discussion around linking the university component and practical elements of nurse education continues as an on-going issue. However, the link between education and practice has raised concerns both before and since the move into HEI and is not based solely on nurse teachers' clinical credibility. Benton (2011) stresses that situated learning should become an integral component of the educational programme and, that whilst the post qualifying preceptorship period is necessary it will not rectify any discrepancies in the foundational educational experience.

Review of the literature has demonstrated that nurse teachers have a significant role in the educational preparation of nurses. It is evident that military nurse teachers belong to the military community of practice and by virtue of their

qualifications and experience hold the pre-requisites for inclusion in the communities of practice of military nursing and academia. Thus military nurse teachers straddle three professional arenas in the course of their duties – nursing, education and the military. Each arena makes its own demands and the nurse teacher has to balance his/her professional practice in accordance with each. The requirement to remain current, credible and competent in each arena is challenging and as the findings from this study will demonstrate there is no unanimity on how this is achieved or maintained. In this respect military nurse teachers are not dissimilar from their civilian colleagues in the UK and overseas.

This review of apposite literature has identified some of the complexity of role for nurse teachers. The lack of literature specific to the military nurse teacher role has necessitated discussion around civilian nurses and teachers. The significant issues arising highlight the continuing theory practice gap and clinical credibility which both connect to the overarching identity of the military nurse teacher. The noteworthy issue relating to their military role is the lack of an established operational role, which could have a significant impact on their continuance in role. In light of the literature reviewed the important questions for the researcher relate to the military nurse teachers' understanding of their role and what aspects of their role are deemed important by them. Thus the study will centre on the military teachers' narratives of their professional (military and nursing) lives and seek to answer the following questions:

1. How do military nurse teachers perceive their role?

2. How do military nurse teachers view the professional development of military nurses?

3. How do military nurse teachers reconcile the professional and military aspects of their role?

The following chapter will discuss the research design utilised to explore the questions posed.

Chapter 3

Research Methodology

3.1. Introduction

The aim of this chapter is to clarify the purpose of the study and discuss the rationale for and subsequent selection of the methodological approach. Establishing the purpose of the study sets the scene for the research design and activity. The research questions have been informed by the literature and support the researcher's original interest in how military nurse teachers view their role.

In my role as a nurse teacher I view the theoretical underpinnings; the science element, as paving the way for the artistry of nursing; the doing of nursing. The combination of art and science makes provision for a knowledgeable doer, who develops their knowledge and expertise from immersion in the reality of practice. From this viewpoint the role of the military nurse teacher is pivotal in the development of learners of military nursing. However, military nurse education, (like civilian nurse education), is not limited to the university environment and military nurse teachers have a reservoir of knowledge and skills which could be utilised across the educational and military nursing arena. To that end exploration of the teachers' role, the teachers' understanding of their role and their past, present and future contribution to nurse education would appear justified, advantageous and timely. Exploration of the role, through the unearthing of individuals perceptions requires an investigative approach which recognises the reality of the participants and how they identify themselves as military nurses. The intention is to discover, not determine, the world of military nurse teachers.

3.2. Researcher perspective

My interest in how military nurse teachers contribute to the education of the profession is of long standing. This interest stems from several years involvement with military nursing and military nursing education. The original plan for this study involved seeking perspectives from military nurse teachers,

their student nurse groups and employers. On reflection a study of this magnitude warranted engagement from all three Services (Royal Navy, Army and Royal Air Force) and multiple researchers. Ethical approval for the original study was sought and gained from the Ministry of Defence, based on the original intention. Due to delays in procuring approval and personal commitments the focus of the study was realigned to explore the professional lives of military nurse teachers. In actuality this meets the original purpose of the investigation – to explore military nurse teachers' perceptions of their role.

My working life has been spent in the nursing arena and at the time of the study I was a member of the UK Armed Forces as a Nursing Officer in the British Army. My practice was initially in primary and secondary care nursing areas and latterly in nurse education and governance. Throughout my career my interest has focused on how nurses learn and utilise their knowledge and skills within the constantly developing healthcare arena. Of particular interest has been how nurses in the British Armed Forces transfer their knowledge and skills across and between their practice arena, from National Health Service (NHS) hospital secondary care environments and peacetime primary care, to the challenging environments of deployed operations.

For my undergraduate studies I carried out a literature review of teacher effectiveness from the perspective of all stakeholders. My research at Masters Level examined the educational preparation of military nurses for the operational military nursing role. The study focused on nurses who had undertaken operational deployments and did not include the educational providers. This doctoral study has afforded the opportunity to develop on my previous research through examination of the educational preparation from a different perspective, this time centring on the contribution of the military nurse teachers. The intent is to provide some insight into their world which will contribute to the greater reality that is military nurse education today, and seek to clarify how their role can support the practice and advancement of military nursing.

As a serving member of the Army community the researcher's position in relation to military rank has to be considered as a major factor in the research process. Military rank represents ability and time in profession. The influence of rank is noticeable in the subservient behaviour of lower ranks, acknowledging the authority held by the higher ranking officer, and presumed expertise. Rank brings benefits and disadvantages to the research process. Researchers look for voluntary participation, with freedom of expression in data collection and where the researcher holds a higher rank this may impede that aspect of the process. In this study all the participants were known to the researcher as educational colleagues, over a period of years. The implications of this familiar contact were present throughout the research process particularly the interview stages. Participants may have initially volunteered to be involved with the research because the researcher had been a fellow teacher. Alternatively they may have participated because they valued the opportunity for the 'voice' of the educators to be heard. As an 'insider' - a fellow teacher, a serving military officer, a nurse – participants may have viewed the researcher as ideally placed to understand and communicate their perspective. The purpose of the research, along with confidentiality and anonymity, were reiterated throughout the study to ensure that participants felt their views, as professionals, were respected. It was imperative that participants felt they were part of a systematic, ethical process which would be distinct from the rank and military connotations which had the power to influence their interaction with the researcher. What was evident was that due to the researcher's military, nursing and educator experience, the participants expected the researcher to understand their narrative. This was expressed through their use of language, components of which only an 'insider' would appreciate, and the expectation that the researcher would understand the various scenarios they presented.

3.3. Purpose of the Study

The rationale for the study has previously been stated but it is worth re-establishing here as a means of support for the research design. Military nurse

teachers have been involved in the education of medical assistants and nurses in the British Army since the 1880s (Hay, 1953). They have supported nurse education through the years of transition from apprenticeship style training to university education. With the recent nationwide changes in the design and delivery of nurse education the nature of nurse teachers' continuing involvement is important. Nurse education is based on a graduate profession, delivered in the university and military nurse teachers are no longer involved in the pre-registration programme for student nurses. The impact of these changes on the military nurse teachers' contribution has yet to be determined. The purpose of this study is to establish military nurse teachers' perceptions of their role, taking into consideration the changes that have occurred. An understanding the nature of their involvement will enable some projection as to their further professional development and utilisation in role. Utilisation in role is important for the military nurse teachers' contribution and the continuing development of military nursing as a profession. Individual military nurse teachers will bring their unique perspective, based on their clinical and academic experiences, to the study. Thus the expected outcomes for this study are for multiple realities and interpretations of the world of military nurse education.

Whilst nursing is a practice-based profession and the reality is clinical practice, the fundamental underpinnings of practice are embedded in theory. How practitioners perform, behave and interact with their environment may be seen as a reflection on their educational preparation and, in this study, the military teachers' input. In the current climate of increasingly specialist healthcare and university contracted pre-registration education the role of the military nurse teacher appears to have undergone some erosion and what the future holds for military nurse teachers remains to be seen. The impact of their loss from the contracted pre-registration education programme is currently unknown and would be worthy of review in a separate research study.

3.4. Research Design

Exploring the nurse teachers' role required careful selection in relation to the design of the study. Whilst selection of an appropriate research design should be a decision based on the nature of the phenomena under scrutiny, it has been challenging to identify the most appropriate approach in order to reap the most benefit. The aim of any research should be to make a contribution to the specific professional arena, thus choice of mode of inquiry should emanate from the questions to be answered (Begley, 1996). An understanding of the main approaches is necessary in order to make this informed choice with which to proceed; a task in itself with more than forty methods available (Smith, Bekker and Cheater, 2011) for the healthcare researcher. Crotty (1998) sees the starting point as establishing the theoretical perspective or paradigm and moving to select the methodology that best meets your epistemological and ontological views, and will enable answers to your research questions. Grix (2010), with his framework for selection of methodology and methods in order to determine the research process, provides some useful direction for novice or developing researchers. Grix's (2010) framework consists of the following components:

- Ontology – what is out there to know
- Epistemology – what and how can we know about it
- Methodology – how can we go about acquiring that knowledge
- Methods – which precise procedures can we use to acquire it
- Sources – which data can we collect

Source: Grix J (2010) The Foundations of Research 2nd edition

The applicability of an approach to the subject phenomena is essential (Morse et al, 2002) and the frameworks of Crotty (1998) and Grix (2010) provide suitable guidance for the development of a research design for this study. Using Grix's (2010, p.68) framework of the building blocks of research listed above helped to structure the design for this research study. This framework outlines the relationship between the central elements and emphasises the logic of beginning at the beginning to ensure a cohesive question-method fit (Grix, 2010, p.69).

Similarly Welford, Murphy and Casey (2011) outline the elements of research using Crotty's (1998) framework to show interrelationships. Using these frameworks the ontological position for this study stems from my understanding of the military world, my 'worldview', what I believe constitutes the world of military nurse teachers. In Welford, Murphy and Casey's (2011) table the ontological position is about truth, in this instance from the lived experience of several realities. Personal assumptions and beliefs about what is military nursing, the context of military nurse education and that this world consists of individuals who construct their own meanings and interpretations. These notions form the foundation of an ontological position within constructivism.

Using the same frameworks for direction the epistemological position is one of subjectivity (Welford, Murphy and Casey, 2011), which conforms to Grix's (2010, p.62) anti-foundationalist stance that is focused on understanding rather than explanation. The ontological and epistemological positions stated here pertain to this specific research study but reflect the researcher's professional identity as a nurse, interested in exploring and understanding as opposed to explanation.

3.5. The nature of the research design

The selection of an interpretive or qualitative approach is appropriate to meet the purpose of this study – to explore teachers' interpretations of their role – as the intention of qualitative research is to enable the development of an understanding of the experience. In this instance the experience is that of being a military nurse teacher, being a university lecturer, being a military nurse and how these multiple aspects of the professional role are managed, developed and perceived, by the teachers. A qualitative approach to research has the benefit of enabling an exploration of these issues, permitting a holistic view overall and thus would be suitable for this study.

Smith, Bekker and Cheater (2011), in their review around the pragmatic versus theoretical debate over interpretive research approaches, claim that compliance with the philosophical origins of qualitative methods undermines the contributions that research may make and suggest that these methods stand alone, without

being underpinned by a specific epistemology. This review was influential in motivating the researcher to look outside of the traditional approaches used in nursing and nurse education for a design for this study, whilst remaining true to the ontological and epistemological position. The decision, to classify this study as qualitative description, with phenomenological overtones, has been based on the desire to seek out descriptions of the past and present role of the military nurse teacher and explore how the role may be developed, from the perspective of the teachers. There was a reluctance to be bound by the parameters of the traditional interpretive approaches, to allow natural development of the study through focus on the data, and for the reason that the research purpose failed to correspond with a distinct category. There is no overall agreement or direction on which research paradigm(s) are more appropriate for nursing research for different researchers raise different questions (Welford, Murphy and Casey, 2011). This allows researchers the freedom to determine their own approach based on their knowledge and assumptions. Grix (2010) states that some research is conducted between the established research paradigms or 'on the border', and is acceptable. This indicates that there is that freedom, fluidity of direction, given that researchers will provide rationale for their position.
For this study the military nurse teachers' perspectives of their professional lives is under exploration alongside how they explain their world and their actions. As stated the research purpose fails to sit within any discrete category postulated by the literature, therefore qualitative description as interpretive research, following the ontological and epistemological stance of the researcher, located somewhere 'on the border' would appear to be a logical position.

3.5.1. Qualitative description

Qualitative description has been described as 'a distinct method of naturalistic inquiry' (Sandelowski, 2000), seeking clear explanations of experiences (Sullivan-Bolyai, Bova and Harper, 2005) with the intention of providing rich description. This approach is not hindered by rigid adherence to underlying philosophical or theoretical underpinnings and is a 'valuable method in itself'

(Sandelowski, 2000). In this manner qualitative description enables the researcher to provide a broad account of the subject under scrutiny with accurate representation of the data.

Qualitative description is distinct from interpretive description, which was developed by Thorne et al (1997), through an adaptation of grounded theory, ethnography and phenomenology, to establish an alternative qualitative approach. Sandelowski (2000) suggested qualitative description has been an existing but undervalued approach appropriate for health sciences research. From this the supposition is that this appropriateness includes researching healthcare educators and education. However, to justify qualitative description as the framework of choice it is necessary to discuss the traditional approaches utilised within nursing and nurse education.

3.5.2. Traditional approaches

Denzin and Lincoln (2005, p.22) state that all research is interpretive in that it is directed by the researcher's own understanding about the world and how to investigate their areas of interest and concern. Denzin and Lincoln (2005, p.22) portray an interpretive framework, or a paradigm, as the collection of the ontological, epistemological and methodical suppositions of the researcher, which guide the research structure and implementation. Other paradigms have been identified as positivism, post-positivism and critical social theory (Weaver and Olson, 2006a).

Interpretive is a generic term and the nature of an interpretive paradigm is to understand the 'subjective world of experience' (Cohen and Manion, p.36). The nature of investigation is fluid and open in order to understand the world of the participants rather than the perspectives of the researcher. Particularly relevant to this study is the opinion that the participants are the experts (Morse and Field, 1995 in Welford, Murphy and Casey, 2011), despite the researcher's insider knowledge.

In nursing the more frequently used traditional methodologies within the interpretive paradigm are phenomenology, ethnography, grounded theory, action

research and case study (Weaver and Olson, 2006b). These emanate from other disciplines, namely anthropology, psychology/philosophy and sociology (Polit and Beck, 2008, p.222). Each approach has its merits dependant on the research purpose and the resources available. The merits and constraints of phenomenology, grounded theory and ethnography will be discussed in relation to appropriateness for the study of military nurse teachers.

Of the traditionally used approaches phenomenological enquiry would present as an appropriate methodology for this study based on the premise that it could facilitate in-depth exploration, and interpretation of participants' experience in relation to the role of the military nurse. The strength of phenomenology is centred on the focus on individuals' experience, which elicits their reality and truths, the elicitation their viewpoint. Phenomenology, like nursing, considers the whole person and values their experiences (Wells, 2009). Nursing involves understanding people and recognising the genuineness of their experience as pertinent (Oiler, 1982). This corresponds with interpretive research, recognising the stories of study participants. Holloway (2003) states that in phenomenological enquiry researchers' focus on narratives of the 'lived experiences' as opposed to the participants own feelings or values. Within this study the intent has been to construct a picture of how military nursing and military nurse education dovetail to promote nursing. The 'lived experiences' of the participants is paramount but it is their perspectives on experiences and events that will reflect how their role contributes to military nursing and its developments. Their feelings and values are central to understanding how their contribution may be manifested and thus the purpose of this study.

Grounded theory has established its place in nursing research (Polit and Beck, 2008, p.229). Grounded theory focuses on individuals' relationships and enactment of roles within society. Holloway and Wheeler (1996, p.99) suggest this acceptance in nursing is due to the neat, orderly manner of data collection and analysis, which corresponds with the way healthcare professionals conduct their practice. Grounded theory would be appropriate for exploring how military nurse teachers modify their practice within the community of practice of military

nurses. However the purpose of grounded theory is to generate theory, which is not the intention of this study.

Ethnography is an approach whereby the culture and behaviour of a group or culture are described and interpreted (Polit and Beck, 2008, p.224). In nursing auto-ethnography, as insider-research, has its advantages and disadvantages. There are several advantages such as knowledge of the environment and culture and access to the environment and potential participants. Additionally, and more importantly, the researcher's knowledge enables them to notice cues, verbal or non-verbal, or omissions in narratives that a researcher, unfamiliar with the setting, would not recognise (Polit and Beck, 2008, p.227). This could be particularly important in the study of military nurse teachers where the nature of their environment and setting is unique and an understanding of this uniqueness and its nuances may prove difficult for outsider-researchers to comprehend. The disadvantages arise when researchers cannot disassociate research from practice and findings become the researcher's perspective, the researcher's voice as opposed to those of other group members, and the researcher loses objectivity (Polit and Beck, 2008, p.227).

Consideration of the approaches outlined above suggested that no one single approach would meet the needs of this study. Moreover, methodological emancipation (Thorne, 2011) has meant that there are other approaches which could meet the requirements. This 'methodical emancipation' assertion (Thorne, 2011) follows from the identification that nurse researchers have become adept at borrowing research traditions from other disciplines, but generally the profession has shown reluctance to identify and label the approaches that genuinely convey nursing's location and emphasis (Thorne, Kirkham and MacDonald-Emes, 1997). This borrowing from other disciplines has resulted in nurse researchers seeking 'epistemological credibility' by declaring their research as ethnography, grounded theory or phenomenology when in reality these are descriptive studies with ethnographic, grounded theory or phenomenological overtones (Sandelowski, 2002). The 'borrowing' stems from the tradition of nursing deriving its knowledge base from disciplines such as medicine and

psychology (Hall, 2006). One of the outcomes of the affiliation with medicine and the medical model has been the acceptance of scientific approaches to research, particularly as quantitative research has been stated as the 'gold standard' (Hall, 2006).

Thus, qualitative description. Sandelowski (2000) purports that the revival of qualitative description as a "complete and valued" product is necessary owing to the complexities of qualitative methods. The usefulness of qualitative description lies in its acceptance of prevailing understanding and relevant experience of the researcher(s) (Neergaard, Oleson, Anderson and Sondergaard, 2009) and gathering data on individuals' experiences.

Thus, there is a distinct shift away from the traditionally used approaches within the nursing profession. Irrespective of this current thought, and the division of nurse researchers over theoretical versus pragmatic approaches to research, there is united opinion that the central issue for credibility of research is quality (Holloway and Todres, 2003; Braun and Clarke, 2006; Rolfe, 2006). The strategies that determine quality are probably explained by verification strategies for establishing reliability and validity in qualitative research (Morse, 2002). These include congruence between research questions, data collection and analysis, appropriate sampling and must be built into the research process to establish quality. Following consideration of the various qualitative approaches the decision to utilise qualitative description for this study reflected the researcher's position as an 'insider-outsider' in the professions of military, nursing and education. An 'insider' for military and nursing and, at the time of the study, an 'outsider' for education. Despite being an 'outsider' previous experience in military nurse education afforded sufficient awareness of my closeness to this specialist area, and personal perceptions. Qualitative description, unlike the more traditional qualitative approaches of phenomenology and grounded theory, presents findings as 'low inference' (Sandelowski, 2000), as facts without 'interpretive spin' (Sandelowski, 2000). This was particularly important in relation to the 'insider-outsider' stance and enabled the interview design to be open and unstructured avoiding leading questions.

3.5.3. Role of the Researcher

The role of researcher is viewed differently in the different research traditions. Within qualitative approaches it is beholden on researchers to explain their position (Unluer, 2012). Within qualitative research researchers may declare themselves as 'insider-researchers' when investigating groups or communities that they currently have membership of, and 'outsider-researchers' where there is no membership (Breen, 2007). My role in this study has not been dispassionate and is claimed as an insider-researcher position. However, as my practice at the time of this study was in the area of healthcare governance as opposed to nurse education, the position could be argued as 'in the middle', between insider and outsider. This middle siting fits with Breen's (2007) choice of terminology for her study and certainly fits my position as an experienced, but not in current practice, military nurse teacher. My previous experience as a military nurse teacher has left me with some strong views on nurse education in the military. These views provoked my interest in undertaking this study so, whilst my assumptions are acknowledged, these views should not be discounted. Indeed I think my consciousness of preconceived views has enabled a deeper understanding of the participants, and at the very least some caution with my interpretation.

I had been employed as a ward manager both in civilian life and in the Army before moving into education. Thus I am in a position to view the educational process from 'both sides', the practical and the theoretical; both of which I feel has been of enormous benefit in my career as an educator. Clinical teaching and ward manager roles were combined so the transition from clinical nurse to nurse teacher seemed a natural consequence of pursuing a degree in nursing and a teaching course. At that time the apprenticeship style of nursing was in place so schools of nursing were situated alongside hospitals, and interaction between clinical areas, student nurses and teachers was frequent. Nurse teachers were not geographically distanced from clinical areas, although opportunities for clinical practice were directly related to their educational commitments. My experience of clinical and educational practice within the military system has

afforded me a level of cachet as a military nurse which has been valuable during this and a previous research study. This privileged position has both advantages and disadvantages. Bonner and Tolhurst (2000) outline three major advantages as notable appreciation of the group and its principles, skill interrelating with the group and a prior collaborative relationship facilitating an acceptance and ease of study relationship. Moreover, insider-researchers have the advantage of an understanding of the nuances of the organisational structure, dogma and codes of practice. All these factors have relevance for this study where participants are entwined in an organisation based on roles within a strict hierarchical structure which conform to official policy. One of the difficulties with the insider-researcher position is the balancing of previous practitioner knowledge and experience alongside the research setting (Breen, 2007) and the purpose of the study. Participants may presume researcher knowledge and tailor their responses to reflect this knowledge and unintentionally omit certain information. Equally researchers may use information as prompts as opposed to letting participants relate their experiences. Unluer (2012) discusses how insider knowledge interferes with constructing questions where the answers are already known and such questions may offend participants' acumen. The assumption here is that researcher and participants' accounts will be the same or their understanding and interpretation of an issue will match. This assumption may be false as practitioners' views vary (Finlay, 1998 in Finlay, 2002, p.537).

I was conscious of the participants' qualifications and experience in both military nursing and military nurse education during the construction of the research design. Another significant factor was my experience in both areas and how personal perceptions could be held in abeyance to restrict any influence on the participants' contributions. On reflection this had an influence on selection of qualitative description as a vehicle for exploring their views, and the utilisation of unstructured interviews. The method of data collection was an acknowledgement of their professional acumen of the military, military nursing and their current role as teachers. Facilitating dialogue with minimal constraints

was intended to elicit strong participant narrative with the benefit of deflection from the researcher's military and professional background.

3.5.4. Purposive Sample

For this study only Army personnel were included, with the exception of one senior nurse teacher from one of the other Services. Army nurse teachers are the largest group of nurse teachers within the Defence Medical Services and have a long history of involvement with education; the Army nursing link with education dates back to the 1880s. The military nurse teachers who took part in this study are all serving Army officers (with the exception of one officer from one of the other two Services). Length of service in the Army ranged between nine and thirty years and length of service in education was not less than three years (see Table 1).

The majority of the study participants had worked as nurse teachers when military hospitals and schools of nursing were in existence and then moved across into the university environment. As such they had seen experience as military nurses which, for some, included practice on deployed operations. Six of the study participants had trained in the civilian NHS environment through an 'apprenticeship style' training programme. This style of training had involved sustained exposure to the practice setting which prepared students for their ultimate role as registered nurses. Sustained clinical experience prepared the way for the ultimate role albeit in a civilian environment. The remainder of the study participants had trained within the Army School of Nursing, again, under the 'apprenticeship style' training. However, they had the benefit of exposure to a military hospital environment.

The specific connection between the participants was their initial training programme and qualification as nurses at certificate / diploma level. All participants undertook academic study at a later stage to reach graduate status, alongside their employment as qualified nurses in clinical practice.

This may not be applicable to the wider military nurse teacher community. All three Services; the Royal Navy, Army and Royal Air Force, recruit qualified

nurses from the civilian sector and from within the individual Service. Therefore military nurse teachers in the other two Services may have entered nursing through certificate, diploma or degree level education. Whilst this is not relevant to this study it may have an impact on requirements for continuing education for military nurse teachers in the wider DMS.

Traditionally employment in the different Services has entailed separate specialist activity. Nurses in the Royal Air Force had an operational role in nursing on aircraft; Royal Navy nurses on board the hospital ship whilst Army nurses supported troops on the ground, in field hospitals and field ambulance sections. Since the formation of the Defence Medical Services that separate activity has blurred and nurses are employed in their specialist clinical role rather than by the Service they represent. For example; nurses practising in a field hospital trauma unit may be from any of the Services but the commonality will be their specialist training in emergency nursing. Thus military nurse teachers, irrespective of Service, may have diverse clinical practice experience.

Although gender has not been an important factor in the study it is accepted that nursing is, predominantly, a female populated profession. As with the civilian nursing population, the proportion of male nurses is small in relation to their female counterparts. This is applicable to all three Services. This has relevance for the study in so much as identification of male participants could be a reality, hence the adoption of gender free pseudonyms.

Table 1: Participants' length of military and educational service

Participant	Age group	Length of service (years)	Length of service (in education)
Charlie	40-45	23	3
Sam	45-50	12	7
Chris	50-55	15	10
Pat	45-50	36	15
Frankie	40-45	20	10

Bobbie	50-55	34	8
Alex	40-45	12	7
Glenn	45-50	13	8
Amal	45-50	20	14
Jordan	50-55	22	10

The proposed study was discussed at a nurse education cadre study day (see Appendix 2) on conclusion of the business of the day. The teachers were invited to leave their contact details if they wished to participate in the study. Discussing the study after the study session was complete was intentional as it meant individuals who did not wish to participate would be able to leave the room whilst the researcher was discussing other issues with her colleagues. Most of the teachers present left their contact details. Additionally the study was discussed with some Army nurse teachers currently 'out of school' and employed in staff positions. Again the teachers willing to participate were provided with the researcher's contact details if they wished to participate. The participants included the one teacher who was serving in one of the other two services. This participant was employed in the same locality as two of the Army participants and volunteered to participate on hearing about the study. Whilst the intention was to limit participation to a single Service, the Army, the involvement of this participant in the locality meant that they undertook a similar role in education and therefore their views were relevant.

3.5.5. Data collection

Data collection in qualitative research is generally performed by means of interview, focus groups and written narrative (Holloway and Wheeler, 1996). Additionally observation and telephone interviews may be incorporated. Data collection in qualitative description has been identified as one to one interviews or focus groups (Sandelowski, 2010), which adheres to the qualitative approach and intent of discussing individuals' perspectives. The use of observation for this study holds no value as this technique draws out only the researcher's

interpretation of the phenomena under scrutiny. The data required is, essentially, the participants' reflective account and perceptions, not observation of their educational practice.

Appropriate methods of data collection for this study were identified as individual interviews and focus group. This choice was primarily based on gaining access to rich data in order to identify the essence of the phenomena, the role of the military nurse teacher (Jasper, 1994). Due to the disparate geographical locations and workload of the intended participants one to one interviews were deemed a suitable instrument. There was little opportunity to gather participants for a focus group without major disruption for those involved. Moreover the importance of focus groups for this study was debatable. A group discussion could elicit strong views from some or all participants dependent on the group dynamics. However, the dynamics of the group could be affected by the military rank of the participants as in junior personnel may feel restrained by the presence of more senior colleagues. Although military rank has not been viewed as influential in professional relationships between military nurse teachers, individuals may have opinions they would not wish to share within their peer group, particularly where these opinions involve military issues. The characteristic aspect of focus groups is the dynamic within the group, their interaction with each other about the topic of discussion (Kitzinger, 1994). Reticence would impact on the ensuing data. For the reasons stated focus groups were discounted as an appropriate method of data collection. The perspective around group dynamics was reinforced when a participant requested that their colleagues should not be informed of their part in the study. This aspect had not been considered fully in the research preparation. Whilst divulging information about participants was certainly not on the researcher's agenda colleagues knew about the proposed study and had freely discussed the arrangements for interview dates and times. In a measure to protect anonymity and confidentiality the participant arranged for their interview to take place away from their normal place of work to minimise interest in the researcher's presence. This was due in part to the fact that the researcher, as a senior officer from a

different department, would be noticeable and curiosity about the visit would ensue. The other reason lay in the participant's narrative where issues around the management of educational practice were raised. In this instance researcher and participant had several factors in common; age, qualifications, rank, length of service and previous collaboration on module delivery. These factors may have enabled the participant to articulate her concerns about her involvement. These concerns did reinforce the researcher's quest that participation was voluntary and confidential. Additionally it raised awareness that despite reassurances that 'rank is not an issue' in the educational arena, the researcher must maintain consciousness of this denominator and its potential for impact. The impact of the military status of the researcher may result in participants providing the responses that they feel appropriate, as opposed to exposing their real thoughts on the educational experience. The hierarchical structure of the military system cannot be removed from this scenario but may be appeased through careful preparation as to the purpose of the research, and extensive consideration of informed consent for participation. The military connotations are discussed in greater detail in the later section around ethical considerations. Informed consent should emphasise the research purpose of the study, the researcher's position as a postgraduate student not an Army officer and the value of the participants' voluntary contribution. Anonymity and confidentiality issues form part of the consent process and these are discussed further in this chapter.

3.5.6. Data collection methods

Interviews are a highly regarded data collection method in interpretive research (Qu and Dumay, 2011), who state the three general categories as structured, semi-structured and unstructured. According to Morse (1991), interviews are the main means of data collection in qualitative research, particularly in nursing research. Structured interviews have a place where answers to specific questions are required in a specified order and findings may be assessed against other interviewee responses (Grix, 2010, p.127). As a structured interview there is little flexibility which diminishes the chances of spontaneous comment leading

to additional information. This approach has a place in conducting interviews remotely, either telephone or email although opportunities for in depth probing questions are limited. Holloway and Wheeler (1996) advocate semi-structured interviews as a means to promoting discussion. Unlike a structured interview the use of an interview guide rather than specific questions outlines the issues to be covered allowing for spontaneity and flexibility. As an alternative, particularly in qualitative description studies, unstructured interviews may be considered (Sandelowski, 2000).

Unstructured interviews allow researchers to pursue a list of 'loose questions' (Grix, 2010, p.128) which requires a less orderly progression than semi-structured interviews but allows for more freedom of expression throughout the interview. Questions may become more focused in response to interviewee comment and therefore require consummate skill on the part of the researcher. The participant somewhat determines the direction of the interview and whilst data may be plentiful, some elements may be of little relevance to the study. However, unstructured interviews do provide the opportunity for participant voices to be heard, to be listened to and may address several issues and raise other issues of note. After consideration unstructured interviews were selected as a suitable approach for this study. This was due to the researcher's background knowledge of the environment and the participants. Each of the participants had a unique story to tell which would relate to their specialist knowledge and qualification, length of service in the Army and nurse education. The researcher wished to focus on the participants as individuals as opposed to a set of questions generic to military nurse teachers. This approach was intended to facilitate a narrative without individuals feeling pressured to answer specific questions. This was felt to be important from a moral perspective. As military personnel the researcher and participants are bound by organisational laws, policies and procedures. Whilst rank has little bearing in the day to day activity of military nurse teachers it is ever-present. The use of rank can be influential so the researcher wished to avoid questions which could test the participants' loyalty to the organisation and potentially discomfort them thereby

affecting interview rapport and ease of discussion. The researcher could respond to unplanned comment or divergence from the main story whilst gathering relevant data without pursuing a response if it was not forthcoming.

Data collection took place following receipt of ethical approval by the Ministry of Defence Research Ethics Committee (MoDREC). The length of time between submission and approval resulted in changes to the interview schedule. The delay in ethical approval meant that interviews could not take place until three months later than originally planned. This presented problems as two participants had been posted to different areas and one was preparing to leave the Service. Additionally the researcher was on a period of compassionate leave. Interview times were rearranged and involved the researcher travelling to different Service locations to meet with participants. The individual interviews were arranged for no longer than 60 minutes to enable participants to arrange their work commitments.

A decision was subsequently made to carry out interviews via email for the two participants who had been posted. As the researcher was now removed from the Service environment immediate access to the nurse education cadre for additional volunteers for the study was problematic. A study of the literature identified that interview by email had been found useful (McCoyd and Kerson, 2006). As the participants had volunteered to participate the researcher wished to provide them with the opportunity to be heard. It was felt that as these participants had expressed a desire to participate there was a moral obligation for their inclusion in the study. This involved the construction of a structured interview format, accepting that spontaneous questions, and responses, were impossible and correspondence could be constrained.

McCoyd and Kerson's (2006) study of interviews via email found that their respondents included more self-reflection than the other methods they used. The original format for their study was telephone and face to face interviews. Interview via email was included at the participants' request. From their data analysis McCoyd and Kerson (2006) deduced that the 'distance' afforded by

electronic rather than face to face means of communication facilitated more openness in expression. They concluded that email interviews could have significant potential for use with groups who feel unheard or marginalised in society. This premise could apply to military nurse teachers, who may feel distanced from their military colleagues through lack of a definitive role. James and Busher (2006) explored participants' understanding of their professional experiences using email interviews as a method of data collection. They invited their participants to comment on the interview procedure to determine usefulness for future research and credibility and authenticity in the method. The responses included participants' control over their responses, the ability to construct and reconstruct responses before submitting to the researcher and thereby providing careful and considered responses. The disadvantages included participants' misunderstanding of questions thus submitting incomplete or irrelevant responses, avoidance of difficult subject matter and lack of focus on the interview process (James and Busher, 2006). The point relating to avoidance of difficult subject matter was significant; as stated the intention was to avoid questions relevant to the organisation which had the potential to discomfort the participant or enhance any threat of self-disclosure.

Despite the disadvantages interview via email was deemed preferable to telephone interviewing. Novick (2008) reported that there appeared to be some reluctance over the use of telephone interviews in qualitative research. Although used extensively in quantitative methods, such as survey, there is a lack of recognition as a viable source for qualitative methodology. However there is negligible confirmation that findings are less valuable than data collected via face to face interviews (Novick, 2008). The concern for this study was the researcher's lack of experience with telephone interviews. Face to face interviewing is perceived as the 'gold standard' (McCoyd and Kerson, 2006), and enables visual interaction between research and participant. In studies where the purpose is to explore participants' perceptions consummate expertise would be required to establish rapport without the face to face contact. Although

inflections of voice may denote emotions the lack of nonverbal cues may cause these to be overlooked or misinterpreted (Novick, 2008), and there was some concern that this could devalue the data gathered. Moreover, due to the geographical distance between researcher and participants and their unpredictable workload it was felt that email interviews, which the participants could complete in their own time, would be more beneficial to the outcomes of the study.

Eight face to face interviews were conducted during the period of September - November 2011. The interviews took place in military establishments in the participants' area of practice at a date and time specified by them. The participants each arranged for a small, windowless room where the interview could take place. Email interviews were conducted between 1.) April – June 2012 (for transcript see Appendix 8) November 2012. Transcription of all recorded interviews took place prior to analysis of data. This was intentional to obtain a sense of the individual military nurse teachers' perceptions without any preconceptions or influence from other interview data.

3.5.7. Data Analysis

Qualitative data analysis is concerned with the production of an understanding of the phenomenon whilst ensuring that individual participants' perceptions are clearly represented. Qualitative description is less interpretive than in grounded theory or phenomenology (Sandelowski, 2000), but does enable the researcher to present their data in what Sandelowski (2000) refers to as 'everyday language'. This terminology suggests that the everyday language is the qualitative, or interpretive, component of the description. This fits with the recommended use of content analysis as the method of data analysis for qualitative description (Sandelowski, 2000). Content analysis may be used in an inductive or deductive manner (Elo and Kyngas, 2008). Study findings can be 'subjectively interpreted' through classification of emergent themes (Hsieh and Shannon, 2009).

The initial choice for data analysis was thematic analysis as described by Braun and Clarke (2006), for its use across a range of methodologies. Braun and Clarke's (2006) six stage framework encompasses some stages common within all qualitative analyses; immersion in the data, coding and the writing up of the 'story', interlinking with the literature. Braun and Clarke's (2006) discussion around qualitative data analysis concludes that all analysis is principally thematic but presented as another method, including content analysis. The decision to use content analysis in preference to thematic analysis was based on Sandelowski's (2000) recommendation. Qualitative description was a new entity for the researcher and it was felt prudent to follow the recommendations.
Hsieh and Shannon (2009) describe three types of qualitative content analysis; conventional, directed and summative. Conventional content analysis was selected as most appropriate for this study. This type of analysis allows for a systematic approach to the data. Firstly interview transcripts were transcribed verbatim and returned to the participants for confirmation of accuracy (see Appendix 4). It is difficult for a participant to recall accurately the content from an interview lasting at least sixty minutes but the verbatim transcription should assure participants that, essentially, what they read is what they said.
For the analysis interview transcripts were read through, without searching for trends, but to engage with the participants' stories and for the researcher to revisit the interview, recall any moments of intensity, frustration or complacency which would not be obvious in the text. Transcripts were then reread until a sense of the whole emerged. This component of the analysis proved time consuming as qualitative data by its very nature elicits a vast array of information. Moreover it was problematic in relation to the insider view of the researcher. Words or phrases using common military parlance present a different connotation when isolated from the context of a discussion. It was important to try and note such phrases and words so that they could be referred to in everyday language for the reader. The use of military terminology, commonplace for the participants and researcher, does demonstrate some elements of belonging, identity, immersion in the world of the military. Where the insider

knowledge was an advantage was in understanding the context of the participants' world and therefore some ability to identify significant comments, ideas and concerns (Hsieh and Shannon, 2009).

From the rereading of transcripts certain phrases were highlighted which seemed to capture the core of the participants own perspective of their role in military nurse education and military nursing per se. These phrases were extracted and related to a component of their role. These initial components were, essentially, the researcher's understanding of their role (see Table 2), based on own 'insider' knowledge and classed as initial themes. The purpose of this was to search the data for recurring words or expressions which seemed important to individual participants and attempt to align with significant features of the military nurse teachers' position.

This initial simple categorisation of phrases highlighted operational experience, research and education, under the umbrella of military nursing, as significant factors in the military nurse teachers' world (see Table 2). As anticipated there were several references to the 'operational' component of the role and this linked well with understanding the soldier, being informed about military practice and being a 'soldier first, nurse second'. Of the six areas initially categorised five comment on the overwhelming relationship between the military nurse teacher role and operational experience. This is an exciting find as it reinforces the connection between education and the practice arena; the operational environment, thus theory to practice. The overwhelming impression was of the components of the military nurse teacher role which stem from their immersion in the communities of military, nursing and education.

Using the approach of conventional content analysis allows information to emerge from the participants without any prior categorisation (Hsieh and Shannon, 2009) and this worked well with this study. Due to insider knowledge, and wishing to avoid any presumption, the intention was to allow the participants' information to create categories from which ideas about the whole subject of role would ensue. However, the initial categories, as previously stated, were

established from the researcher's interpretation of the information although they derive from the participants' perspectives. The content of the categories can then be scrutinised for interrelationships and links across other categories. The relationship and links between the identified categories helped to determine the major categories that would be used to present the participants' perspectives of their role. However, the difficulty lay in analysing the data gathered without being overwhelmed by words and phrases.

Table 2: Significant phrases from participants

Theme	Comment
Military nursing: operational experience Education: research focus	'We've got a role…in research' (data collection) 'Imperative of evidence based practice' 'There's no strategy for nursing research'
Military nursing: operational experience:	'Fit to deploy' 'Warrior nurse' 'Soldier first, nurse second' 'Deploying on operations' 'Need to go out on tour' 'You can't know it if you haven't lived it' 'Deploying on ops' 'Operational experience' 'Military seasoning' 'Military focus' 'Military training' 'Credibility' 'Deploy in clinical role' 'No operational role' 'It's about getting hands on' 'How can they be informed' (no operation deployment) 'Need to go out on tour, they need to see what soldiers are doing' 'Credibility….from not being on operations' 'Can't be informed' (no operational role) 'The difference is knowing and understanding the environment of the military, know and understand the culture' 'Have enough skills to

	look after soldiers, not just nursing but to look after them as military people'
Military nursing Education	'A patient isn't the issue here' (in education) 'Nurse tutors (not) kept up with what needs to be done' 'Don't need tutors' 'It would be brilliant if we weren't at the university' 'People forget they are military nurses' 'Makes sense to move education, get it out of the school' 'No operational role'
Military nursing: operational experience Education	'Useful to have those experiences to draw from for teaching' 'I'm sitting on the fence on that one' 'No, my job is to teach problem solving'
Military nursing: operational experience Education	'Exciting …..taking education….in the operational environment'
Military nursing: operational role / clinical practice Education: clinical practice / professional development	'Defence nursing needs to make up its mind'

It seemed too simplistic to partition the participants' expressions and the fear was that the essence of their contribution would be lost. The use of a software programme, NVivo, was recommended and tried. An electronic system of organising data can be helpful with collating several documents or notes (Walsh, 2003) for scrutiny and amendment throughout a project. Walsh (2003) suggests

that the software programme functions like an electronic version of a notebook where one stores ideas, but is probably less untidy. The process of entering data was helpful as it required more reading of the data but overall it was more satisfying, and less technically demanding, to consult paper notes. The use of a software programme could have been more beneficial if the researcher was less familiar with, or more detached from the military milieu.

What emerged from the data was the complexity of the military nurse teachers' role. Within the participants' comments there appears a sense of uncertainty and need. The comments in Table 2 identify the dichotomy between educational and operational practice for the participants but overwhelmingly operational experience is noticeable on their agenda. From these comments the following categories were shaped. They represent the prominent issues that emerge – the participants' identity as military, as a military nurse and teacher, the gap between education and practice (physical and metaphorical), education versus training, professional development in role. These issues can be encompassed within military, nursing and education, the three interrelated components of the military nurse teacher role and issues that correspond with the initial research questions:

- How do military nurse teachers perceive their role?
- How do they view the professional development of military nurses?
- How do they reconcile professional and military aspects of their role?

The major categories are:

1. Identity in role: as a military nurse, as a military nurse teacher

2. Military versus civilian conceptualisations of role: as a military nurse, and as a military nurse teacher in peacetime and operational environments

3. Theory – practice gap: the value of military nurse education, military training, the influence of military nurse teachers in relation to a theory-practice gap.

4. Issues around Professional development: the conflict of roles, recognition as educationalist, military rank.

Findings of the data are presented in the following chapter using the participants own words to present the significant points.

3.6. Rigour in qualitative description

Within qualitative research studies it is essential to demonstrate rigour in approach and formulation of findings. Holloway and Wheeler (1996, p.164) suggest use of the terms credibility, transferability, dependability and confirmability as opposed to validity and reliability. These components aim to demonstrate the trustworthiness of a study. Within this study participants have been identified as military nurse teachers, although their individual identity has been withheld. The researcher is not claiming to represent a different group of military nurses. The stance of the researcher as a nurse teacher goes some way to reinforcing credibility of self and the participant group involved. This insider knowledge has been acknowledged throughout and whilst this aided contextual understanding it raised awareness of the potential for bias. Lietz and Langer (2006) discuss the requirement to present findings that are overtly representative of the participants' contribution. There is ethical reasoning for accurate representation and this forms part of the research process. A purposive sample as used in this study aids transferability within the domain of military nurse teachers. In relation to dependability the audit trail of methodology, data collection and analysis provide evidence of the research process. Audit of the information resulting in research data should provide confirmability (Holloway and Wheller, 1996, p.168).

3.7. Ethical considerations.

Ethical issues are considered in all research methods (Holloway and Wheeler, 1996). For nursing research, be it concerned with practice or education, the principles are applied in accordance with the NMC's Code of Professional Conduct (2015) and the Royal College of Nursing (RCN) research guidelines

(2004) which are designed to protect participants from harm or risk. For research as a component of an academic programme as pertains to this study, ethical approval is required from the accrediting university (see Appendix 4). Additionally, ethical clearance from the Ministry of Defence Research and Ethics Committee (MoDREC) is obligatory for any research project that involves military personnel. The MoDREC submission for this study included the detailed information provided to participants, gaining of informed consent and security of data (see Appendix 5). MoDREC approval established that the research study is appropriate and justifiable (see Appendix 5). Participants were provided with the written explanation of the study and the consent form prior to agreement to take part in the study (See Appendix 6). Example of signed consent form is at Appendix 7.

3.7.1. Responsibilities to study participants

It is incumbent on researchers to conduct their research in an ethical manner in order to do no harm. This involves securing appropriate approval prior to undertaking data collection and the consideration of additional issues which may impact on the research findings, or more specifically, on the participants. Within this study there are factors concerning participants' identification as military personnel, the rank and experience of the researcher and the participants, the consent process and use of the research findings. These will be discussed in the following sections.

3.7.2. Implications of military rank

Military Researchers who are active practitioners in the area of exploration face the dilemma of how to place themselves in the research design. For this study there are advantages for the researcher being familiar with nurse education and to being part of the military nursing community. Where this may become an ethical issue is how the study participants and researcher positon themselves; whether this denotes positions of authority and subservience. The strongest connection with authority, or a perceived power base, arises from the

researcher's military rank as opposed to her qualifications and experiences as a registered nurse and teacher. Rank cannot be disregarded in a hierarchical organisation such as the military; it is the overarching identity of its personnel. The rank versus qualifications element is interesting in that it is possible for some militarily senior personnel to be less professionally qualified and experienced than their junior, subordinate colleagues. With regards to nurse education this may be the case but the professional route is similar for all – undergraduate to post graduate degree supplemented with a teaching qualification – thus there is equal opportunity for progression regardless of rank. The transition from practitioner to teacher occurs irrespective of rank as the focus is on educational provision and who has the requisite experience for its delivery. Therefore military nurse teachers, in their day to day work, function as contemporaries, as a community of practice, utilising their expertise rather than the rank structure. Participation in the research study was voluntary and this was made explicit in the initial presentation. The stance of the researcher as a student, as opposed to a member of the Defence Medical Services, was explicit in the discussion around the study. The military nurse teacher cadre is accustomed to personnel across the rank structure conducting research for academic purposes so the researcher's position as a student was acceptable. In order to promote this further military uniform was not worn when carrying out data collection.

3.7.3. Informed Consent

Informed consent is a crucial component in ethical principles (Howe and Moses, 1999). This is reliant on the information provided to participants being sufficiently detailed to allow them to understand the rationale for and conduct of the study (Howe and Moses, 1999). As stated MoDREC approval was necessary before this study could be undertaken. A question raised on the initial submission to MoDREC was the interval between the participants' receipt of information and securing their consent. Securing consent, by means of signing a consent form, is an accepted means of a participant's agreement to take part in a study (RCN, 2011, p.8). However, a signed consent form does not prove that consent is "truly

informed" (RCN, 2011, p.8) only that explanation has been given. Nor does it prove that consent is valid (RCN, 2011, p.8). The important factor is that sufficient explanation has been provided and the participant has the mental capacity to understand the information provided. No consensus on the time lapse between the provision of information and gaining consent has been established (NPSA, 2013) and should be determined by the nature of the research proposed. To ensure participants received sufficient time for consideration the information sheets were emailed when their initial agreement to take part had been provided. This allowed for a time lapse of weeks between receiving the information and participating in an interview, thus providing sufficient opportunity for participants to raise any questions or queries. The consent forms were signed at time of interview following reiteration of the significant factors of study rationale, privacy, anonymity, confidentiality and security of data. Whilst the security of data can be assured through means of password protected documents for electronic data and lockable facilities for hard copy documentation, different measures are necessary to address anonymity and confidentiality.

3.7.4. Anonymity and Confidentiality

Howe and Moses (1999) maintain privacy as a crucial tenet in the research process. They state that privacy is assured through anonymity and confidentiality and discuss anonymity as 'not gathering identity specific data' whereas confidentiality is 'not revealing identity specific data'. For Saunders, Kitzinger and Kitzinger (2015), confidentiality pertains to the concealment of all the information except to the researcher. They view anonymity as specific to the concealment of identity. Irrespective of the terminology, the privacy afforded to participants in research studies is important in relation to protecting their identity, particularly in situations where inadvertent disclosure, referred to as deductive disclosure (Kaisner, 2009), could impact on their personal or professional roles. Therefore confidentiality, the 'not revealing identity specific data' aspect, has the intention of protecting participants from harm (Kaisner, 2009). For the study

involving military nurse teachers there are issues around gathering and revealing identity specific data. The participants are easily identifiable as military personnel and more specifically as Army personnel and military nurse teachers. Thus anonymity cannot be provided. The identifiable characteristics that may be withheld or changed are military status (their rank) and gender, which would reduce the possibility of deductive disclosure by colleagues and other personnel within the organisation. Military rank has therefore been excluded from the identity specific data provided and gender identity has been reduced through the use of gender free names as pseudonyms. These measures decrease the possibility of the participants being identified by members of their military community.

3.8. Limitations of the study

The purpose of this study has been to explore the perspectives of military nurse teachers' on their professional role. However, the focus has been limited, almost exclusively, to a cohort of Army nurse teachers. There were a few reasons for this selection. The Army is the largest of the three Services that comprise the UK Armed Forces and the largest group of military nurse teachers are to be found in the Army. As a former Army nurse teacher it was less problematic to access this group as potential participants. It was felt that involving members of the other two Services could dilute the data for this small scale study. Exploration of the perspectives across the entire nurse teacher cadre would warrant an appreciably larger study with multiple researchers, although this study could, feasibly, act as a precursor and identify significant points for investigation.

There are advantages and disadvantages to being closely involved with the phenomena under scrutiny. As a previous member of the military nursing community of practice the researcher understands the military environment, the academic and military language and ways of working. Whilst this insider knowledge could be advantageous during data collection and analysis there is the potential for bias where personal assumptions about the military environment impact on interpretation of participants' narrative. Holloway and Biley (2011)

state that the self is always present in qualitative research, and like their study participants, researchers hold their own preconceptions, based on their experiences. Cultural perspectives are included with preconceptions and particularly so where the researcher has an insider role, thus insider knowledge. The insider role may permit ready acceptance by potential participants (Corbin Dwyer and Buckle, 2009) and they may be more open about their views as they assume the researcher will understand both context and content of their discussion. Asselin (2003 in Corbin Dwyer and Buckle, 2009), is of the opinion that being an insider has pitfalls where the researcher has had contact with the participants, not as a researcher but in a different role. There is the potential for role confusion with the researcher evaluating data as an insider rather than a researcher. Conversely this may provoke some reticence about their contribution. In focus groups there is the possibility of reticence to proffer opinions due to fear of ridicule, or to please another member of the group (Wilkinson and Birmingham, 2003, p.108). It could be argued that similar situations could arise in the interview setting where the researcher has similar experience to the interviewee. Interviewees may be reluctant to stray from established stances for the reasons stated above or for fear of repercussion. This may reflect the organisational, religious or cultural structures that interviewees interact with. Within this study the military structure is a constant throughout, providing an overarching umbrella of identity through hierarchical structure and dogma. Military personnel are bound by the Official Secrets Act (1989) and policies and procedures relevant to their employment and position within the organisation. The visible artefact of identity and position within the organisation is rank, assigned to each individual.

The wearing of rank and its structure is an additional factor to be taken into consideration. Rank represents the hierarchical structure of the Armed Forces and is a visible artefact of one's positioning in the organisation. Rank denotes levels of authority, power and ability. More importantly rank, like uniform, is a visible indicator of identity and belonging to and in the organisation and thus within the culture of the military family. Within this study the researcher was

senior to some participants, held equal rank with three and was of junior rank to one participant. As stated previously rank was not considered to be a deterring or restricting factor in relation to voluntary participation in the study. This may be due to the fact that the researcher was known to all participants in the role of military nurse and nurse teacher over a period of sixteen years. Another reason may be that the researcher was, at the time of the study, involved in healthcare governance within clinical practice areas so not in direct communication with the educational setting. In relation to rank and seniority the fact that the researcher was outside of the participants' chain of command, line management structure, diluted any potential issues around researcher bias or over familiarity with current projects. Thus the researcher 'belonged' but was not actively involved in participants current activity. This 'belonging' of the researcher within the community of nurse teachers enabled open, discursive narrative, which links to the previous discussion around insider knowledge and role.

3.8.1. Gender

There has been no inclusion of gender perspectives in this study. As stated the purpose has been to elicit military nurse teachers' perceptions of their role. The military nurse teacher role is gender free, as is the role of military nurses irrespective of area of practice. It is acknowledged that the UK Armed Forces is predominantly a male dominated organisation, although there is an increasing presence of females (Hale, 2008). Whilst this is indicative of the overall military organisation, the nursing profession has always been, and continues to comprise a predominantly female population. Interestingly Hale (2008) comments that militarisation has enabled females to "develop masculine identities that they would have struggled to develop in civilian life". It is not the purpose of this study to elaborate on gender specific identities as it plays no part in military nursing but Hale's (2008) work is significant in identifying the importance of masculinity in military organisations (as well as other organisations) where females have equal status and recognition. Aspects of masculinity present in the findings through military terminology, where personnel use gender free 'Army speak' as a method

of communication. The use of terminology is another representation of belonging within the military family, again irrespective of gender.

3.9. Critique of research design

The value of this study lies in enabling the voices of military nurse teachers to be heard through articulation of their thoughts and ideas. This is the first study to attempt to explore the world of the military nurse teacher. The findings demonstrate the passion of these teachers for their professional role and their commitment to military nursing. Articulation of their perspectives has been achieved through means of qualitative description involving description and subjective interpretation. A conventional content analysis approach has been used to enable the data to emerge from the participants contributions devoid of predetermined classification. The insider knowledge of the researcher has enabled context to be understood and thus facilitate identification of significant categories.

The use of qualitative description as a framework for this study was a risk for the researcher. As stated this approach was an unknown entity but provided an opportunity to explore an area of interest without 'the tyranny of method" (Sandelowski, 2000). The claim that this study was based on qualitative description, with phenomenological overtones, may be false.

Chapter 4
Findings

4.1. Introduction

The role of the military nurse teacher is multifaceted and the individual nurse teachers bring different skills from their nursing experience to the military educational environment. The purpose of investigating the gathered data has been to elicit these individuals' perception of their role and the issues that they deem important in their world of military nursing education. Interpretation of the data does facilitate some understanding of the differing perceptions, which lead to the varying enactments of the role, although it has been challenging to separate the role into discrete entities. This is due to interrelated components of each role; across the professions of nursing and education entwined with their role as military personnel, as depicted in Diagram 1, p.88. In actuality the military nurse teacher needs to be seen as a 'whole' rather than components in order to gain insight into their role. The aim of this chapter is to present the findings to demonstrate how military nurse teachers' view their role.

Using conventional content analysis in the manner discussed by Hsieh and Shannon (2005), the interlinking topics outlined above of military, nursing and education were identified. Related issues pertinent to the role of the military nurse teacher were drawn from the significant phrases depicted in Table 2 and represented here:

1. Military: identity, knowledge and training, culture, development, hierarchy, educator versus practitioner, competence, credibility, role conflict, professional status

2. Nursing: identity, professional, community of practice, purpose of military nursing, competence, credibility, status, role conflict

3. Education: identity, professional, purpose of military nursing education, ownership of the educational process

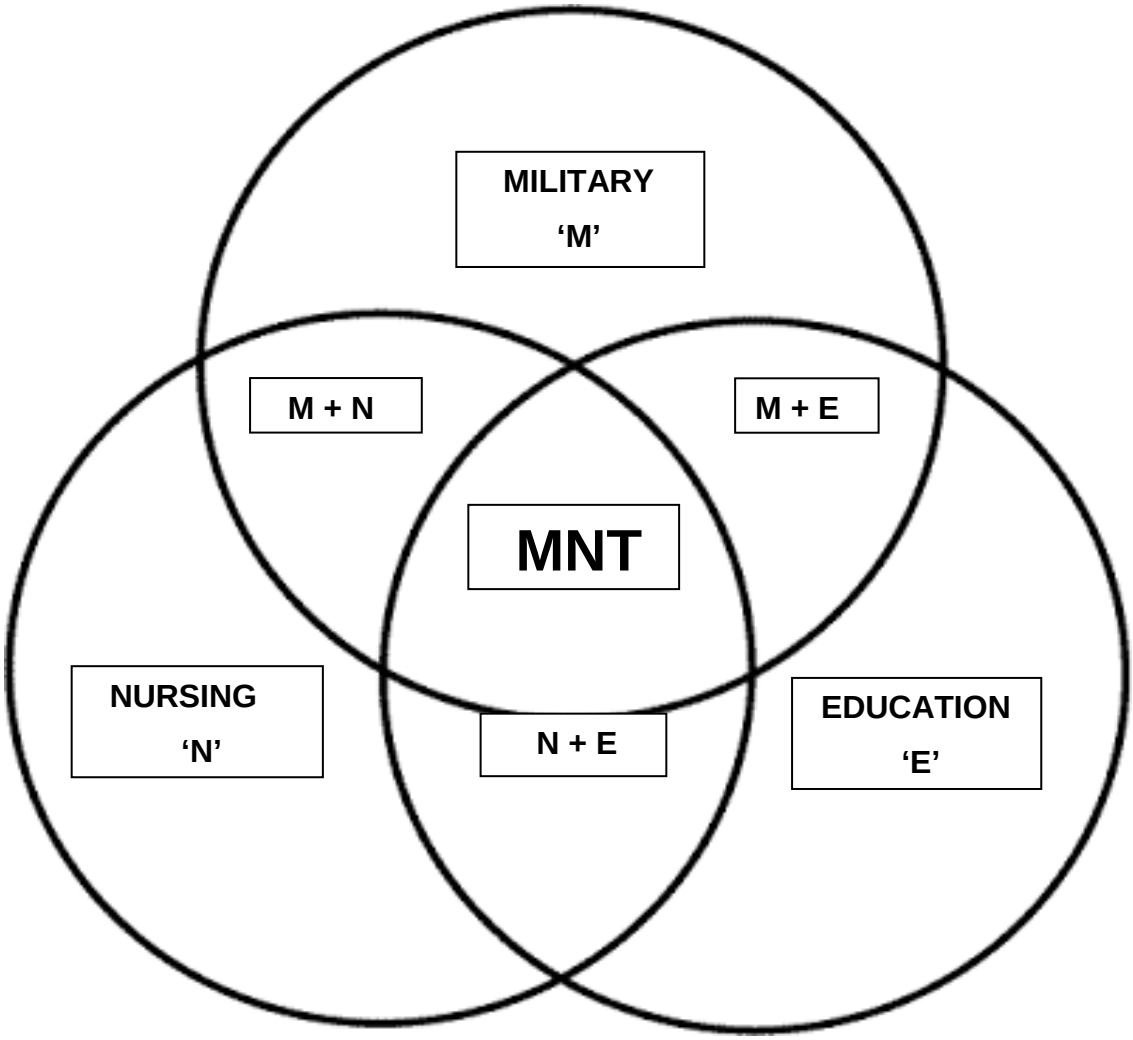

Diagram 1: Interrelated components of the Military Nurse Teacher role

The term 'professional' is used here to denote the nursing profession and several issues were linked across the military and nursing components of the military nurse teacher's role.

Due to the inter relationship between the components detailed above discrete separation for discussion has been problematic. Each component conjoins and thus there are sections of the findings which relate to more than one section. For the overall perspective of the military nurse teacher it was felt that identity would provide a logical starting point for discussion as this is the integral component across all aspects of the military nurse teacher role.

4.2. Identity and the military nurse teacher

Military nurse teachers have 'come through the system'. Their identity is as military personnel and they have practised as military nurses. These important factors engender the sense of 'belonging' within the military system. Some of the study participants viewed this belonging, as a member of the military, as essential to the military nurses' role:

> "Our nurses should be first soldiers and second as nurses to help the medical facilitation of fit for role because that's what *we* are supposed to be, fit for role".
>
> Glenn

This perception of 'we' as 'nurses as soldiers' or 'soldier nurses' shows that military nurses are part of the military community, they belong to the community, as opposed to civilian nurses who may support the military community; a crucial distinction. Glenn comments on the primary component of the nurse's role as 'military', and this includes military nurse teachers who are military nurses.

> "Military nurses understand soldiers because *they* are soldiers, soldier nurses"
>
> Jordan (interview)

> "The military nurse is supposed to have enough skills to look after soldiers not just the nursing but to look after them as military people, understand how, where, why they get injured and that culture"

Chris (interview)

Being ‘soldiers first’ enables military nurses to become immersed in the military environment gaining knowledge and understanding of the military, its people, values and culture. This immersion contributes to the difference between military and civilian nursing and is as important for military nurse teachers as for military nurses in clinical practice.

> “Nurse tutors’ need to understand these soldiers’ mentality, we’ve got to understand what they want, what it is we want as an organisation and then to understand what nursing wants from that”.

Glenn (interview)

> “The difference is knowing and understanding the environment of the military, know and understand the culture and why some soldiers will go and rescue another soldier and what these injuries are like when you’re standing, munitions and stuff”

Chris (interview)

Military nurse teachers need to understand the military mission, its values and standards in order to provide pertinent education. The military nurse teachers are articulating the need for military immersion in order to understand the military patient, the soldier, the ‘one of us’.

> “The military nurse is supposed to have enough skills to look after soldiers not just the nursing but to look after them as military people, understand how, where, why they get injured and that culture”.

Chris (interview)

Thus, the military nurse teachers are able to use their military knowledge and experience to promote the acquisition of skills in military nurses. Therefore, by inference, the military nurse teachers require first-hand experience as military

nurses in clinical practice to inform their educational practice. Their practice is an important part of their military nurse identity.

This focus on military and nursing addresses those aspects of the military nurse teacher role. Their role as a teacher, an educator, they do not see as a separate identity but an extension of their role in military nursing. However, their location in the university environment has an impact on the sense of belonging within the military community:

> "I think in this civilian environment where we're let down is people forget they are military nurses and its simple things like non uniform wearing, not participating in exercises, failing to promote the military ethos yourself as a nurse tutor that lets the system down and really invalidates the need to have anybody military in the civilian environment"
>
> Amal (interview)

The geographic location of the educational setting in the university dilutes the military culture and civilianises military personnel. This erosion of the military persona, as alluded to by Amal, has the potential to infiltrate culture, ethos and behaviour:

> "Our military ethos changed dramatically when X took over because X was very much embedded into the university and so we weren't allowed on tour, so the whole thing stopped and that's why I got out as soon as I could but the people who stayed wanted to be paid by the military but the military ethos wasn't there anymore"
>
> Glenn (interview)

The reduction in opportunities to enact their military role, such as deploying on operations i.e. 'on tour' caused Glenn to apply for a position outside of nurse education. However the university were keen for the military contingent to be part of the educational setting:

> “so the university were really glad at some times because we were all, because of the military background you always delivered on time, you know, your targets were set, were delivered, we worked hard so they liked it when we became adult branch managers and module leaders and so on. They knew things would get done so when the QAA were coming in they knew that they’d have the lesson plans and that bit they really loved because they knew that our management, whatever we said we’d do, which they couldn’t guarantee with their own staff”
>
> Glenn (interview)

The military component is viewed as important in forming the persona of a military nurse teacher. Military nurse teachers view themselves as military nurses, as soldiers and as educators – all part of a package with each component complementing the other. Where these components complement each other and benefit their students has been articulated by some of the participants:

> “Comparing previous military experience and discussing this with students keeps the focus on becoming a military nurse, not just a nurse. We have to be careful that the product is not a civilian nurse with some military knowledge but a well-rounded military staff nurse who can encompass the difficulty of being a warrior nurse and the conflict of providing care in a war environment in the future”
>
> Sam (email interview)

Sharing the military experience helps military nurse teachers’ act as role models for their students be they undergraduate or post graduate nurses:

> “years of experience can be brought to new graduates and the role for an educator is an exciting one. This relates to military nursing but where preparing nurses to meet the challenges of operations is central to the education piece”

Charlie (email interview)

Military nursing experience can influence students' perception of military nurses and impact their understanding of military nursing. Whilst the identity of the nurse teacher as military is crucial in this context their clinical currency or credibility as a military nurse is another topic for discussion.

4.3. Military nursing and the military nurse teacher

Nursing is a practice profession and the issue of 'clinical' credibility for nurse teachers has resonated through the professional literature since the move of nurse education into Higher Education in the mid 1990's (Cahill, 1997; Griscti, Jacono and Jacono, 2005; Gillespie and McFetridge, 2006). The military nurse teachers have military clinical experience which, depending on speciality, may or may not be current or operational. The comments around operational experience presented in Table 2 (p.76-77) are numerous. Some participants felt a need for operational experience, in order to inform their role:

> "I think what's missing from the uniformed nurse tutor in order to fulfil that role is operational experience. There is no operational role for them at the moment. I think they should be deploying on operations otherwise how can they be informed"

Bobbie (interview)

The purpose of military nursing is to support the troops, irrespective of environment. Bobbie's perspective is that the military nurse teachers need that experience, that exposure, to inform their teaching of student military nurses. This perspective is shared by other participants:

> "There is no operational role for them (military nurse teachers) at the moment. They should be deploying on operations, how can they be informed, and our credibility from not being on operations. That's the difficulty and that's what we are wrestling with now, trying to define an operational role"

Jordan (interview)

> "The difference is knowing and understanding the environment of the military, know and understand the culture and why some soldiers will go and rescue another soldier and what these injuries are like when you're standing, munitions and stuff".

Chris (interview)

> "I think what we also don't do well, again, it's not, we don't keep our clinical level or our specialist area interest at the same level. I think if we're going to go down this route to be credible you are going to have at least to be competent in an area of clinical practice which for a lot of people is quite scary but I don't think it's anyone's fault I think it's a fault of the system for example myself came into post in March applied for an honorary contract with [redacted] and I'm still waiting"

Frankie (interview)

Frankie is referring to general clinical practice in a MDHU as part of military nursing credibility, not necessarily operational credibility

One participant is adamant that military nurse teachers need the exposure of the operational arena:

> "I would like them to come into primary healthcare because that's where your basic nursing skills are used on tour, they (military nurse teachers) need to go out on tour, they need to be out there, they need to see what the soldiers are doing and what the nurses are doing. Very much so, out of the office and on the shop floor, it's about getting hands on"

Glenn (interview)

Being on the 'shop floor' helps military nurse teachers maintain the link with military culture and promotes teaching that is based on current healthcare developments and soldiers' experiences. Primary healthcare is a significant

component of peacetime and operational medical and nursing practice. Glenn's desire for military nurse teachers to acquaint themselves with current practice would provide up to date knowledge. This belief is not universal amongst the participants:

> "I was brought into the school to teach leadership and management and variations thereof. I don't have to be able to. No, my job is to teach problem solving, it's about developing leadership and management skills, developing a toolkit of skills, skills for them to do their job that's my job but for a nurse teacher a patient isn't the issue here"
>
> Chris (interview)

Management skills are essential components of the military nurse role; in the clinical setting, in the military hierarchy and into positions of authority.

> "I don't know, I'm a bit undecided about this really because if you are doing management type roles, governance and so on then you're dealing with the practice arena, you're dealing with practice all the time, I think for a teacher again if you're doing clinical research then you're doing clinical research in the clinical area so I'm not sure you need to go and work a shift a week to keep yourself credible. There are two sides to that, you know the camp that says you should and the camp that says you shouldn't"
>
> Alex (interview)

Similarly for Frankie there is no clear answer:

> "there's a very strong school of thought says you can't know it less you've lived it and a part of me agrees with that……However I do think when we're teaching the defence nursing degree, good example, when we are standing at the front teaching our colleagues it is useful to have those experiences to draw from for that teaching but again part of me says it's kind of like saying you have to have your tonsils out to look after someone

who's had a tonsillectomy, you don't, you can have an understanding. I'm sitting on the fence on that one".

Frankie (interview)

Military nurse teachers will have some experience of military nursing as a junior on entry to the Army. What cannot be determined is whether experience should be maintained throughout their career in education. Without an operational role they cannot be deployed although some teachers have a specialist clinical role which they maintain. These teachers deploy in their clinical role:

"their primary role will not be as a teacher, it can't be because of the restrictions on headroom, so it would have to be in another role, teaching would be a secondary role"

Bobbie (interview)

However it was noted that their educational skills were usually utilised in the operational arena:

"they would have deployed in their clinical role. Although without exception when they came back they would describe how the moment they stepped out onto the ground and someone found out they were a teacher, bingo, all sorts of stuff, they were doing academic support, they were doing teaching delivery, they were doing all sorts of things"

Pat (interview)

"speaking to the guys when they came back, on every single deployment there were people doing some kind of study, but also for other people, particularly if they're out there for six months, they want to do something"

Pat (interview)

These comments show that the military nursing and educational components of the role can be utilised in the operational context, albeit where the military nurse teacher has sufficient clinical currency to undertake an operational tour.

The value of an operational tour, as professional development or maintenance of clinical currency does not always have a positive impact on educational delivery:

> "I've got a member of staff who's deployed who I know does not use her previous experience in teaching at all, you have to question why it hasn't actually assisted her teaching in any way"
>
> Frankie (interview)

4.4. Education and the military nurse teacher

Nurse education has an independent role; it prepares the student for their role as a registered nurse. Military nurse teachers have, until recently, been involved with the preparation of student nurses delivered through the university curriculum. Their role has been to support the pre-registration programme and according to Bobbie:

> "What we want from the military tutors is to give the military seasoning, if you like, which is more difficult for them to do as they have to fit it around the university programme. What we want at the end of this programme is a nurse we can then, with a little extra training, deploy on operations as a military nurse"
>
> Bobbie (interview)

Thus within the civilian academic environment the military nurse teacher functions within each of the facets of their role – nurse, teacher and military person. Each aspect is important in relation to their professional identity although but the nurse and teacher components may be viewed as more significant in the academic environment, primarily because the academic

environment is a civilian university. Identity as a military nurse does impact in this arena, in relation to previous experience:

> "Comparing previous military experience and discussing this with students keeps the focus on becoming a military nurse, not just a nurse. We have to be careful that the product is not a civilian nurse with some military knowledge but a well-rounded military staff nurse who can encompass the difficulty of being a warrior nurse and the conflict of providing care in a war environment in the future".
>
> Sam (email interview)

Bobbie is aware that the pre-registration programme is the vehicle for qualification. For Sam the value of involving military nurse teachers and providing the 'military seasoning' is the difference between a military and civilian nurse.

However, some aspects of the nurse teacher role are viewed as generic:

> "The role of a military nurse teacher is the same for any nurse teacher in terms of demonstrating leadership in nursing and being in a position to help shape the profession"
>
> Charlie (interview)

Charlie views leadership as essential in nursing practice and not exclusive to the military organisation or environment. Thus experience and knowledge of nursing principles are more pertinent than military perspectives in the university environment:

> "Nurse teachers' often come with a vast variety of experience, theoretical and practical, all of which can impact on teaching practice and can be utilised in the dissemination of knowledge and skills"
>
> Charlie (interview)

The important factor is seen as professional experience and the ability to educate, develop the learner.

> "That's an educator's job isn't it, to take learning outside of the book or classroom, the educator will help them think, remember nursing is all about problem solving, all about what you can do in your head"
>
> Chris (interview)

Professional skills encompass management and leadership aspects in addition to the pure clinical application of nursing. Skills which will enable military nurses to function in different environments, in peacetime and operationally.

> "To enable them [the students] to consider laterally the learning they make in a civilian environment and to translate that into the role they have as a military nurse"
>
> Sam (interview)

Sam has identified a fundamental aspect of the military nurse teacher's role. Chris explains the necessity to support students to prepare for the rigours of life as a military nurse:

> "We were chucked out into an environment of which we would have understood. These haven't, they've been chucked out into an environment which is foreign to what they've had so we were taught in a NHS hospital and then into a NHS hospital job – essentially business was the same. They are being chucked into an environment where a corporal challenges a major, and she doesn't like it then they'll just have your head off and she'll go what, what. They have to prepare themselves and the culture of the military and other officers and others"
>
> Chris (interview)

Sam, like Chris, views education as facilitating the development of a nurse who can transfer knowledge and skills between practice environments. To enable this

to occur the military nurse teacher, as the facilitator, needs contextual understanding. The incorporation of learning into practice is supported by the acceptance that evidence-based practice has become a motivating force in healthcare (Mantzoukas, 2007), requiring practitioners to seek for multiple sources of evidence to guide their practice and hence the requirement for critical thinking and problem-solving skills:

> "With the imperative of evidence based practice, nurses need to be developed in their critical thinking and this may be best placed out in the units and MDHUs where they work"
>
> Charlie (interview)

Charlie proposes the delivery of some aspects of professional development in areas of practice, rather than in the university. This is post qualification and will be higher education modules for professional development. One participant felt that education should be delivered wherever military nurses are serving, including the operational environment:

> "The idea of taking education out is just brilliant and for me the great thing would be that they would be able to do that in the operational environment. Prepared to trial it but we were poopoohed. Yeah we actually managed to get agreement from here ([redacted] but then it was on a proviso, this is why it was never going to work, that the unit would have to use one of their nursing lines, lose a nursing line. Well you know straight away that's not going to happen, rather than just going well send someone as a pilot to see how that might work. We couldn't do that because they didn't want to increase the head count on tour. So that fell flat on its face which is a shame because in principle people agreed that we should try it and see if we could have some value there. You've got to prove it and you can't prove it until you get the chance to demonstrate that"
>
> Frankie (interview)

Opportunity lost for nurse education to be piloted on operations, taking education to the front line.

> "until you try it you won't know a) has it utility, I believe it has, but even, b) well you have to try it, you don't know what the job is, the thought of being able to make a new job like that, you're there to support people who have trouble doing drug calculations in that environment, that you can help the people who are on tour for the first time and are just really struggling with the pace of things, you can be there to look after the guys when the paediatric dies and whatever because you can provide that support which is education in a loose sense, you could also do education in a more formal sense, I said we could deliver a Supporting Learning and Assessment in Practice update, we could run one of the modules, and people just look at you……"
>
> Frankie (interview)

> "it kind of makes sense to move education, get it out of the school, we still need that but get it out of the school and make it more accessible to people"
>
> Frankie (interview)

Taking education out to the units involves the military nurse teachers with the nurses on the ground. Here theory to practice, discussion of practice to practice related issues could be discussed in the real time environment of the military. An additional advantage would be the visibility of the military nurse teachers in the military domain. Such provision of education has potential as an area for military nurse teachers to develop. There is some reticence about taking education to the operational arena:

> "If it is possible or practicable that education may be shaped and supported on operational tours then this is to be welcomed. The reality is that this may not be prioritised according to the nature and demand of the

> particular tour. It is essential therefore that the education piece is provided at the pre-deployment phase and post the tour in line with all training requirements.
>
> Charlie (email interview)

Charlie is correct in the presumption that educational delivery on operations may not always been timely or appropriate. However, Pat's experience is that military nurse teachers who have deployed in clinical posts have always been requested to utilise their educational skills. This demonstrates the need for educational support beyond the pre-registration programme for military nurses pursing specialist education and training.

Not all military nurse teachers see any value in remaining in the university environment:

> "We don't need the tutors anymore because the university are doing all that…..but what we have to safeguard against is losing the military training which I think is essential"
>
> Amal (interview)

> "One of the biggest issues as the department head that we have is that it would be brilliant if we weren't at the university. We can run, I think most of what we do probably from the barracks"
>
> Jordan (interview)

The university facilitate the pre-registration programme. Amal feels the removal of the military nurse teachers from the programme will not affect the outcome. Here the concern is the military training – the training that enables a military nurse to be fit for their operational role. Jordan would prefer a return to a course delivered by the military for the military within a military organisation. Whilst this may be an option for the delivery of post-registration courses a return to the military schools of nursing, however desirable, is not a viable option.

Sam and Pat offer a view on outcome:

> "I think the experience and knowledge that the military tutors have is lost to the programme. I think the students will view their nurse training purely as a civilian course and the civilian providers may not understand the military ethos and drive our students have. I guess it's hard to quantify the lack as the actual training will remain predominantly the same….it's more the value added factor that is missing"
>
> Sam (interview)

> "I guess it depends whether you are or are not interested in the value added stuff……because……..we'll go back to a situation where like the military nurse is qualifying, been salaried for 3 years and in those 3 years they'll never have worn an uniform other than their civilian uniform and even then they don't always wear them and never speak to another military person in 3 years so I would be concerned about the product that we get at the end of that"
>
> Pat (interview)

The withdrawal of the military nurse teachers from the pre-registration programme was a high level decision**:**

> "the perspective was that we were overtraining because we were achieving such high results because we'd got such a good rate of military teachers to trainee (student nurses)"
>
> Bobbie (interview)

Bobbie had some thoughts on the impact of the withdrawal:

> "I think the outcome of that downstream is that we are not going to get that same beast at the end. We tend to get better standard of student at the very beginning so that almost sets the path for a higher achievement at the end providing that the support network is there and the withdrawal"

Bobbie (interview)

The military training previously referred to by Amal does not appear to be considered as part of the educational programme. Thus education and training, at least in the military context, are different and discrete. The 'value added' component mentioned by Pat and Sam is centred on the military nursing component – the belonging to the military family and becoming the 'product' (the military nurse) that the military requires.

The withdrawal of military nurse teachers from the pre-registration programme has generated discussion around future roles.

> "With years of experience different perspectives can be brought to new graduates and the role for an educator is an exciting one. This relates to military nursing but where preparing nurses to meet the challenges of operations is central to the education piece"

Charlie (interview)

For Charlie experience and expertise can be utilised with new graduate military nurses, with a specific focus on preparation for operational deployment. There is also a short course which all military nurses from the three Services attend following qualification prior to entering graduate clinical practice. The 'Transition to Military Practice' is trainer led:

> "I don't think it's an educators job to do the TtMP but I think you will have to have a nurse tutor involved in it as part of the team because they will be able to help explain the context so, the nurses, she'll say yes but your job as a nurse is in the military on operations and will set the context which they won't understand (the trainers) they won't have been in that environment"

Chris (interview)

The trainers provide the military training but the military nurse teacher has a role in aiding the newly qualified military nurses to understand the professional as well as the military context. This is an important part of the junior nurses' familiarisation with the military environment and where they can learn about conflict in role.

Research is developing as part of the operational remit and there is a role there for military nurse teachers:

> "Our role could be preparing people or undertaking research, I mean yeah sure we've got a role, we've got a role, we've got a role for data collection, we've got a role for answering really important clinical questions"
>
> Alex (interview)

Alex sees the involvement of military nurse teachers as critical in the research arena:

> "We're not really going to have much of a reputation, all the research is going to be done by civilian counterparts, I mean goodness me it's ripe for research at the moment and it's going to be known as a job you put your boots on and you work, there's not really an awful lot else goes on"
>
> Alex (interview)

Involvement in research could engender the sense of belonging in the military family, re-establish military nurse teachers in the military environment and provide opportunities for professional development. For Sam there is a need for that professional development:

> "military nurse teachers need experience in specialist area and experience of research. Ideally an MSc that would demonstrate their understanding of all aspects of research and the ability to be 'reader of research' to put it into practice and to carry it out"
>
> Sam (interview)

For Sam military nurses teachers need specialist experience, outwith the educational field. This infers 'specialist' clinical practice experience and is related to the discussion around credibility and competence in role. For Frankie achievement of higher level qualifications is related to educational delivery:

> "Nine in my department and there are four with Masters degrees so everyone else is BSc with PG Cert or Dip and of course they won't have done any research at Masters level which is key. You can't hold somebody up as a SME (subject matter expert); someone who can support someone's education if they are educationally not there themselves so yes it clearly could have a knock on effect"
>
> Frankie (interview)

Funding is provided for a post graduate certificate or diploma in education in order to teach:

> "we will fund PG Cert and PG Dips and if they want to do the full Masters they can come back round but of course no one bothered so there's a group of people sat there and I'm ….'could you possibly complete your Masters?"
>
> Frankie (interview)

Irrespective of higher academic achievement Frankie sees the recent trial implementation of Practice Educators as a positive move towards increasing the accessibility of educational provision:

> "I think a lot of us would be very keen to fill that role because we can see that there's a need for it – quite exciting. The idea of taking education out is just brilliant and for me the great thing would be that they would be able to do that in the operational environment particularly for enduring operations like we have at the moment"
>
> Frankie (interview)

The Practice Educator role would develop in the MDHUs initially to support military nurses in their peacetime role:

> "It was actually more looking at post reg and particularly the newly qualified nurses, your nurses going through a new clinical area, you're not necessarily the one working alongside them but for the people who are working alongside them and it kind of makes sense to move education, get it out of the school, we still need that but get it out of the school and make it more accessible to people"
>
> Frankie (interview)

An alternative option is proposed for the allocation of newly qualified nurses to a military nurse teacher:

> "I think every military nurse when they finish their preceptorship should be allocated a named military tutor, educator to facilitate their professional education for the next three to four years. A Nurse Education Advisor is great but they can't do it for everybody so there should be a group of these people, twenty I suppose, minimum, and you're just going to be Capt B. You're an educator and you'll be with her and she will interview you and just facilitate your professional development, absolutely try and get much more development, all this friction between the Officer Commanding Nursing and having somebody there who's a mediator, doesn't have to be an officer could be a Warrant Officer"
>
> Chris (interview)

The teacher would be responsible for facilitating professional development for junior military nurses. Potentially this could benefit the individual nurse and the Army as the teacher could ensure that the professional development pathway meets Army requirements. The notion of a military nurse teacher as a professional development officer has been attempted previously:

> “Way back in the days of 1996 the MDHUs had a clinical educator set up role. Y was one of them and was absolutely invaluable because not only did Y help with the military students in the hospital Y helped all the students who were on post reg courses, not just competencies, skill mix ones, the ones doing study courses and modules, Y was around and advised them about assignments, negotiate a bit of time for experience, additional practice elements to be added together with what they were studying”
>
> Chris (interview)

The military nurse teacher as a professional development officer was viewed as an opportunity for improving access to education:

> “I think we missed a bit there I think we could have been trailblazing, we could have been ahead of the game, you know we could have built on that. There are many more advantages to having nurse teachers in a military hospital unit and I think we could have got away with, if that’s the right term, having a smaller pre-registration element in Birmingham because we wouldn’t have had to work so hard going out, outreach all the time”
>
> Pat (interview)

Practice educators or professional development officer posts in the military hospital units could have provided the educational input close to clinical practice, but the post did not remain:

> “it was done as a trial because at that time they had been looking at, obviously, seen as a first time in the water for that, give it a trial of this continuing education officer post at the MDHU. The then head of school was XX, he was very pro this idea of lecturer practitioners so he was the sort of driver behind this and whoever was our director at the time was on side and set up it as a trial and it was really successful. The role grew.

> Initially Y was sent across there to just look at supporting our post reg nurses, qualified nurses in post reg learning and whatever higher education they were doing but ended up expanding the role to other areas and it was successful. Towards the end of that post they had a school head change…….And the post didn't continue, it was completely scrapped. And everybody was drawn into the centre and that kind of post never really saw the light of day again"
>
> Pat (interview)

Whilst practice educator, continuing education officer or professional development opportunities are recognised as possible opportunities post registration nurse education (BSc (Hons) in Defence Nursing Studies), remains currently, in the university setting:

> "I think it's very much running courses and yes we have just started in the last couple of weeks looking at the modules and seeing about developing them further because clearly they need updating. Lots of work to do and clearly we need to look at blended learning as well which I do believe has been, not really attacked at all. There are aspirations for us to move to Lichfield and deliver from Lichfield, I'm not sure though but one would imagine there is so the role is very much you come into the school and you do a teaching qualification and then you teach on the defence degree or SLAiP or whatever it is you're teaching on and whatever scholarly activity you may do is very much down to you really".
>
> "I think there is an aspiration for us to develop the MSc again that's still in an embryonic stage, there's an aspiration for us to develop other modules like clinical governance and clinical supervision that'll be kick started in a couple of weeks. There is no discussion surrounding careers within like what you're doing, aspirations to do PhDs, there's no actual structure to support anyone who might be interested in doing a PhD so for me I see

being a defence tutor at the moment is simply delivering education. If I choose to embark on scholarly activity that's very much an independent activity, that's how I see it at the moment. So it's teaching, it's teaching focused, there's nothing wrong with it being teaching focused but it's not a developing centre, so it's not a centre of academia"

Alex (interview)

Alex is conscious that education does not appear to be progressing and professional development opportunities for military nurse teachers are limited. Alex, Frankie and Sam feel research, the training in and doing of, is an important component of their role and would constitute academic activity as opposed to being solely 'teaching focused'. Alex is concerned for the future:

"I think it's kind of reached crunch point for serious, for people who might be serious in pursuing a sort of academic career, I'm not as sure that the way we're running it here would really support that because in my view, and this is utopia really, but I think defence nursing or defence needs to make up its mind. Are we going to have a school which simply delivers a module which brings a lot of non-graduates in the Army up to graduate status? However if you want to be serious about promoting and developing a body of knowledge in defence nursing then there needs to be some kind of parallel scholarship model as well and there's no strategy for nursing research"

Alex (interview)

"In five years, one of two ways, either going to not exist, the role of the nurse educator in the armed forces or it will swing completely the other way and we will have been able to move education out into the more accessible regions and the post reg piece running up at Lichfield"

Frankie (interview)

The feeling is quite strong that without intervention the role of military nurse teachers could wither away. Their passion for their specialty is evident and the findings demonstrate their commitment to finding different approaches to the delivery of educational support to military nurses.

Chapter 5
Discussion

5.1. Introduction

The findings from this study highlight the passion that military nurse teachers feel for military nursing. This passion is represented through their perception of what they can offer to military nursing. The major findings that have emerged from the data in this study centre around several differing components; relationship of theory to practice, clinical credibility, professional development and contribution to the wider military healthcare field. All of these components culminate in the major areas of professional identity, and education and training in relation to professional education, experience in the field. These areas will be discussed in turn although it is acknowledged that they are inter related within the military nurse teacher role.

5.2. Identity

The professional identity of the military nurse teacher is complex, comprising the roles of nurse and educator within that of a serving member of the Armed Forces. As a professional one's practitioner identity is based on the personal qualities of the individual entwined with 'role-based identity' (Barrie et al, 2010). Role-based identity should demonstrate the core values of the role. For military nurse teachers they need to demonstrate the values of both the nursing and teaching professions. In order to make sense of this professional identity the distinct but interrelated components of the role, that of nurse and teacher, have been explored separately. The identities of nurse and teacher are juxtaposed with the military identity, the principal component of the military nurse teacher. This point is arguable as, in reality, it is difficult to determine which component is the principal, or needs to be. Whilst the 'military' is the employer, it is, arguably, merely an organisation providing a service. Another organisation, the National Health Service (NHS), similarly employs nurses as part of its workforce whilst

nurse teachers in the United Kingdom are employed within the Higher Education Institution sector. However, identity as a 'military nurse' is formed through an individual's service in the military organisation and the nursing profession.

As members of the Armed Forces military nurse teachers hold military rank, based on professional experience and qualification as a registered nurse. Military rank functions as the 'backbone of the Army's structure' (The British Army, 2015) and denotes role and responsibility in a formidably hierarchical organisation. Thus both 'military' and 'nurse' are fundamental components for this role incorporating role-based and person-based identity traits. This duality of role becomes a balancing act where identity straddles both professional areas and both components produce the 'military nurse'; each reliant on the knowledge and skills of the other component. As a military nurse neither identity functions independently. This is borne out in the findings where participants' have focused on the knowledge and skills their learners, the military nurses, need to perform their role.

Participants have referred to themselves and military nurses in general as 'soldiers' and 'soldiers first, nurses second'. This identity as soldiers demonstrates their membership within the military community and is not exclusive to military nurses. Each member of every trade and profession in the British Army would refer to him or herself as a soldier.

It is interesting that this terminology of 'soldier first' has also been used by an US Army nursing officer (Scannell-Desch and Doherty, 2012, p.184), in Scannell-Desch and Doherty's (2012) accounts with US military nurses on their experiences of the Iraq and Afghanistan wars. Their use of the same terminology highlights how the military nurse has a 'dual role' and acknowledges that the military persona is integral, not just a façade. The 'dual role' of soldier with nurse requires military nurses to possess the fortitude to perform their role in the military environment; in UK and overseas, in peace and in war. Griffiths and Jasper (2008) talked about this duality of role as 'that double hat' effect; military

nurses belonging to the nursing profession and the military organisation. Professional parameters dictate that nursing practice is performed within the bounds of the profession whilst balancing the needs and demands of the military situation. Balancing the needs and requirements of nursing and military may give rise to conflict of professional responsibilities which all military healthcare professionals need to consider (Hawley, 1997). Overall, the function of military nursing practice is to help soldiers maintain their fitness for role through the provision of nursing care, in extremes of environment in some situations.

The 'soldiers first, nurses second' connotation shows how the participants view the military nurse as an integral component of the military, part of the community rather than an outsider who provides care. This is supported by their perception that military nurses need to be 'fit for role' in the same manner as soldiers are 'fit for role' – in terms of physical fitness, emotional resilience and military skills, in addition to professional or trade 'fitness to practice'. Being 'fit' in the professional and military context is concerned with possessing the necessary attributes for the role. This sits well with the construction of a military identity through the activities peculiar to the soldier or 'soldiering' (Woodward and Jenkings, 2011). Activities such as weapon handling, field sanitation, navigation and communication systems, which are, generally, unnecessary skills for a nurse in civilian practice. What these skills emphasise is the military component of the role where qualities such as 'caring', although essential for a nurse, must abide alongside robust military skills which may save their own life and the lives of those in their care. The military identity of the nurse also conveys the sense of belonging, belonging in the military community as opposed to an outsider providing healthcare.

Professional fitness to practice relates to the provision of nursing care covering areas such as primary healthcare, secondary healthcare, trauma care, health education and health promotion, indeed any healthcare interaction that contributes to the health of the soldier. All these factors contribute to professional identity as a military nurse. What is evident from the findings is that

military nurse teachers make no distinction between themselves and military nurses in military clinical practice.

Military nursing requires a deep understanding of the military patient, bearing in mind that the 'military patient', a soldier, could be from a range of trades and disciplines such as infantry, engineer, signals, intelligence or police. Military knowledge and understanding is viewed as a component of the military nurses' expertise, essential for enactment of their role. As military nurses the teachers need the same knowledge and understanding as outlined above and the same immersion in the military environment. Military nursing practice helps the military nurse teachers participate in the military community, and through participation they claim membership of this community.

To borrow Griffiths and Jasper's (2008) term of 'double hat', it is proposed that military nurse teachers wear a 'triple hat', combining their roles of nurse with teacher with service in the military. As such their multifaceted identity is constructed through membership of the military community entwined with their professional nursing position and educator role.

Although 'military' is the foundation for military nurse teacher identity the reason for the 'triple hat' marker is the underlying foundation of nurse and educator. As stated these are combined to produce the 'military nurse teacher' but in reality each of these descriptors may function independently.

In the wider context military organisations have been recognised as representing a specific 'occupational culture', secluded from civilian society (Soeters, Winslow and Weibull, 2006) and, representing an exclusive way of life (Hale, 2012). Hale's (2012) research identified the importance of a sense of belonging and teamship, and illustrated how moving from one environment to another is often a challenging task. Thus integrating elements of the military community into a civilian higher educational institution may result in more than the geographic removal of military nurse teachers.

Two participants, Amal and Jordan, indicated that military nurse teachers are no longer required in the civilian university environment. The concern expressed was that military nurse teachers in the civilian environment are losing their sense of military identity. The loss of military identity is a result of immersion in the civilian environment of the university; working alongside civilian lecturers and teaching groups of civilian and military students. As students identify with their civilian counterparts from exposure in their education and practice environments it should be unsurprising that military nurse teachers absorb the environmental effects. Jordan's comment that education could be delivered from the military setting, the barracks, is centred on post registration education as a means of professional development. Frankie supported this notion of moving post registration education out of the university. The suggestion was that education could be delivered in military units for healthcare professionals, thereby providing more flexible delivery and increased accessibility. Delivery within military settings highlights the presence of military nurse teachers and, in delivering appropriate, relevant education in a 'real' setting, increases the importance of uniformed nurse education.

The perception that military nurse teachers are not required in the university setting, i.e. the pre-registration programme, was not found to be a factor for other participants. Participants felt that removal of the teachers would impact on the students and that the 'value added factor' could be lost. Sam and Pat felt that whilst the programme would, predominantly, remain the same, the 'end product' (the military nurse) may not. Amal was adamant that the military training component should continue as a means of inculcating military knowledge and skills into the student's programme. The essential ingredient missing from this scenario is the experience and expertise of the military nurse teacher. As previously mentioned military knowledge and skills are generic to military personnel, they do not include aspects of military healthcare requirements or provision. The effects on the teachers and the students, of the withdrawal of military nurse teachers from the pre-registration programme is not yet known.

5.2.1 Military nurse teachers and clinical practice

Irrespective of the military involvement the complex nature of any nurse educator role arises from their position in two professions, that of nursing and teaching. Nurse teachers now reside professionally and geographically in the realms of higher education, and away from the clinical arena which is the traditional nursing workstation. The role of clinical currency in the nurse educator skill set has been discussed since the move to higher education (Gillespie and McFetridge, 2006) and is an important discussion. It is axiomatic that nursing is a practice based profession so it would seem desirable, if not essential, for nurse educators to promote the assimilation of theory into practice. Therefore a professional background of clinical experience and expertise would need to form part of the nurse teacher skill set.

The assumption is that nurse teachers will be experienced nurses, although in the findings Charlie does state 'often' not 'always'. However, previous clinical experience is expected as this is where nursing practice takes place and general nursing experience is encouraged prior to specialisation. Clinical nursing practice is the pathway following qualification for nurses to consolidate learning and provide opportunities for knowledge development and skill acquisition. So, whilst there is the expectation of established clinical skills in the military nurse teacher competence set, there is no acknowledged expectation as to their prowess as a teacher. Nursing students view clinical competence as an important attribute of good teachers so recruiting experienced nurses into the educational arena could be advantageous. Another assumption is that experienced clinical nurses will be able to convey their knowledge to students (Zungolo, 2004). These assumptions suggest that experienced clinical nurses will be able to teach others. Whilst teaching others is a requirement within nursing's professional standards of practice (NMC, 2015), including patients and colleagues, the inferred environment is the clinical arena. However, clinical experience and teaching will assist the military nurse teacher to understand the theory practice gap.

First and foremost military nurse teachers are employed as military nurses. They belong to the cadre of Army nurses and professionally they maintain their right to practice through registration with the professional body, the Nursing and Midwifery Council (NMC). The NMC requires nurse teachers to be active in their specialist area i.e. education in order to maintain their registration as a nurse. Thus from the professional nurse perspective military nurse teachers are fulfilling their professional obligations. Under discussion here is how they meet the 'military' obligations of their role. They are employed, firstly, as military nurses and require competence in that role to continue with employment. Their specialist field is education. As civilian nurse teachers educational practice as in teaching, research, scholarly activity would be sufficient. The issue of time in clinical practice is an individual's decision and the literature has stated how difficult this may be to achieve. The issue of 'clinical' credibility for nurse teachers has resonated through the professional literature since the move of nurse education into Higher Education in the mid 1990's (Cahill, 1997; Griscti, Jacono and Jacono, 2005; Gillespie and McFetridge, 2006). According to Cave (1994), without maintenance of their clinical ability nurse teachers would be unable to address the theory to practice gap and subsequently "find it difficult to justify their existence". There has been some move to encourage nurse teachers to focus on developing sustainable links between the academic and service areas rather than pursuing their own clinical credibility (Bentley and Pegram, 2003; Ousey and Gallagher, 2010). This would be beneficial to both the academic and clinical practice areas but would not necessarily equate to 'hands on' experience for nurse teachers. However, as practitioners are required to maintain competence in their own specialist area of practice, 'hands on' clinical practice is not required. Nonetheless, as demonstrated by the literature, the issue of clinical credibility has continued to cause tension within the nursing profession and remains a topic for discussion in both civilian and military environments. Competence is different from credibility and is related to specific areas of practice thus the relevance of credibility, be it clinical, educational or managerial, for practice should remain with the individual practitioner, civilian or

military. However, the issue of clinical credibility and the role of the military nurse teacher contains an additional perspective; the relationship with the operational aspect of the military nurse role. The issue of credibility generated differing opinions between the study participants as to its relevance or necessity. For some of the participants the need for clinical credibility appeared unclear. This preoccupation with clinical credibility links with the establishment of nursing academia in Higher Education. Prior to the move to Higher Education nurse teachers' responsibilities included the deliverance of 'high educational standards in practice and supporting students on placement (UKCC, 1986). Following the move the English National Board (ENB) stated that nurse teachers should be involved in clinical practice for the equivalent of one day a week Thus nurse teachers were expected to maintain clinical credibility through 'currency with the clinical environment'.

Whilst this is no longer a requirement the perception that the role of nurses is to nurse remains. Alex has linked clinical credibility, the 'hands on' practice with a research role seemingly to compensate for the lack of clinical practice in role. Professionally this lack of practice may not require justification but may be as a result of perceived tension surrounding the role of the military nurse teacher. What is apparent is the lack of clinical research which military nurses and teachers may become involved with which could contribute to the body of military nursing knowledge.

Whilst it is axiomatic that nursing is a practice profession many groups of nurses, other than nurse teachers, work in areas which do not do involve a direct clinical role. As stated by Alex management and governance roles involve participation in the clinical area albeit not in a clinical capacity. The proximity of nurse managers and governance leads to the clinical practice areas enables 'clinical awareness' whilst their competence is held in their specialist roles. University led nurse education has distanced nurse teachers from the clinical arena so whilst their competence is developed in their specialty of education their 'clinical awareness' may be lost. The difficulty for nurse teachers is maintaining oversight

of the clinical arena in order to inform their practice as educators. It is really important to reiterate that educating nurses involves university led education as the underpinning knowledge to influence practice. The acquisition of practice competence for students becomes the domain of clinical practitioners, more specifically the students' mentors, who have the clinical credibility and competence to instruct and guide development. Therefore the requirement for nurse teachers to be 'credible' and 'competent' in theory and practice would appear redundant. Previous relevant experience, and current 'awareness' of healthcare delivery, may be the necessary tools for the nurse teacher to provide relevant input. Chris viewed the role as a facilitator, outwith the clinical environment, teaching skills in leadership and management; skills which would expedite professional practice. For Chris the acquisition of suitable leadership and management skills for nurses to carry out their role, which would involve patient care, was paramount.

.Bobbie's perception is that university based nurse teachers are removed from the military environment, with no clinical practice involvement, and require operational experience to enable them to provide their primary role. Therefore, they need to be employed alongside all other military nurses, in clinical practice, in order to be informed about the military nursing environment. Or this view could be interpreted as meaning that all military nurses should deploy on operational duty. What has not been acknowledged here is the relevance of previous clinical experience, either on operations or in the peacetime environment. There is a balance between action and reflection and the important factor is whether military nurse teachers, as practitioners reflect on their experiences to inform their practice. I think the important issue here is the relevance of previous experience. Benner (1984) talks about the relevance of practice. For her practice is so much more than a compendium of procedures and techniques (Benner, 1984, p.viii) and practitioners must learn how to connect the science and art of nursing for practice to be effective. Clinical, professional judgment is learned in practice. Therefore clinical experience that promotes

reflection on action to promote the development of professional judgment holds relevance. Benner (1984) also points out the importance of a comprehensive educational grounding on which to develop skills from experience.

The other issue that has not been identified is whether the military nurse teachers require clinical practice in order to become credible, competent or clinically aware as military nurse teachers. If, as Bobbie states, the military nurse teacher requires operational experience in order to 'be informed' the emphasis should be on awareness and credibility rather than competence. Should operational competence be required it is presumed that military nurse teachers would require attainment of the Defence Operational Nursing Competencies (DONC) prior to deployment. Achievement of the DONC requires time in clinical practice. From a logistical perspective clinical practice and operational deployment may prove difficult to achieve. The military nurse teacher would be away from their primary role as an educator for the six month operational tour of duty in addition to pre-deployment training and clinical practice to achieve the DONC. On return from deployment there would be a period of post tour leave. Potentially the military nurse teacher could be away from their primary role for a period of nine to twelve months.

The emphasis on awareness is supported by Frankie who views the relevance of operational experience in the military educational arena as important for utilising the experience in teaching practice.

However, there is no consensus on the position of clinical practice in the military nurse teacher's skill set nor in the literature. As participants have stated there are nursing positions, both military and civilian, which do not require up to date clinical prowess or the ability to function as Benner's (1984) 'expert' nurse. The role of the nurse teacher is to 'educate' and that may occur in a variety of settings. However, from a military perspective, continuation of a uniformed nurse education cadre may not be a viable option without a robust role.

In some respect it is unfortunate that military nursing does not yet have a unique, bespoke military nursing academic course, the Masters programme they are developing. The current focus is on demonstrating whether military nurse teachers are credible nurses with no discussion as to whether they are credible teachers or educators. The development of higher academic programmes would show their educational prowess and pave the way for provision of internal quality education.

5.3. Education and training

As previously stated nursing is a practice profession. Over the past few decades traditional methods of nurse training in the UK have moved to a combination of theory and practice underpinned by university led education programmes. Prior to the changes brought about by the national move of nurse education in higher education in the 1990s Army schools of nursing were situated alongside military hospitals. Military nurse teachers were in frequent interaction with the clinical areas and healthcare practitioners and functioned as part of the military community. There was a close relationship between educators and practitioners to maximise the learning opportunities afforded the students. This approach to nurse education addressed both the education and training elements of the profession. In the clinical areas students developed their practical skills and undertook military skills training alongside their military colleagues. All personnel wore their Army uniform and rank insignia which denoted their belonging in the military community. This type of localised 'community' environment has some connection with Wenger's (1998) concept of a community of practice where people have defined membership and create practices to achieve the required performance, objectives or outcomes (p.6). The close proximity of the school of nursing and interaction with military nurse teachers engendered community membership and the sense of belonging for the students. This played a significant part in their professional socialisation as military nurses.

Within this military community military nurse teachers served as integral members of the Army Medical Services by virtue of shared history, shared morals, standards and values alongside provision of education and training for a specific group. As university lecturers military nurse teachers have now integrated with the civilian environment. Whilst their focus has been on military nurses one participant felt that such integration had diluted the military component of nurse education provision. Jordan's comments that nurse education could be delivered from barracks concerns identity (as mentioned in a previous section) and the perception of education being 'non military'. Jordan's concerns emanate from the fact that military nurse education is delivered from the university whilst other healthcare specific course delivery is from the Defence Medical Services military education and training establishment in the adjoining county (the barracks). Without close proximity to other military healthcare professionals nurse education appears to be isolated in the civilian sector, with the ensuing issues of loss of military identity and belonging to the military community. This isolation supports the premise that immersion in the civilian environment leads to dilution or even absence of the military component. Isolating nurse education in the university has the potential to increase not only the theory practice gap but reduce the bonding between the military family, that sense of belonging and identity, for the students. This is particularly relevant following the withdrawal of military nurse teachers from the pre-registration nursing programme, leaving a small cadre of teachers to support the post-registration provision. The effects of this isolation on future groups of military student nurses is worthy of a separate study to determine how these students should be exposed to their future role as military nurses. Aside from the comments about the demilitarisation of nurse education there are consequences for the outcomes of the pre-registration programme. Some participants have commented that the 'end product' could be a civilian nurse, which will require significant military training to become a military nurse (Sam), whilst Bobbie refers to the 'beast at the end'. The registered nurse becomes a product to meet the needs of the service. The expectation has been that the product will be a fully

formed military nurse but without the military nursing aspect from military nurse teachers the premise that the end product could be a civilian nurse is significant. The military nurse needs the ‘soldier nurse’ foundation inculcated throughout their pre-registration programme to maintain military identity, culture and ethos. This includes both educational and clinical settings.

There is tension between what is viewed as delivery of education versus utilising military nurse experiences to develop a body of professional knowledge. Alex and Frankie display a sense of urgency in relation to seeking a viable route for progression of the military nurse teacher role and position. What this appears to uncover is how the participants feel about the position of nursing education. On one side is the delivery of pre-registration education, designed to produce registered nurses that met the standards required by the regulating body. Bobbie alluded to this in the statement regarding the university delivering the pre-registration programme. The other aspect is post registration education that consists of the BSc (Hons) Defence Nursing Studies which, as Alex states, delivers modules to bring non-graduates to graduate status in keeping with the move of nursing to an all graduate profession. Somewhere in this mix is the cry for developing a body of military nursing knowledge, through research and evidence-based practice and the desire of some military nurse teachers to be involved in this direction. There relates to the fact that, despite their location in a university setting, there is no strategic direction for professional development. As Alex states any undertaking is driven by the individual.

The military nurse teachers are bound by convention to deliver the military nursing studies degree modules which ensure that military nurses undertake mentorship education and supporting learning in practice. It is evident that there is the drive to enhance the educational provision and to develop appropriate strategies for development, although lack of strategic direction.

In relation to operational and other military experience military nurse teachers may act as role models in their sharing of experience and knowledge. Charlie

expressed how military nurse teachers can influence the preparation for military life, from their previous experience. This perspective clearly highlights the purpose of educating military nurses - for their role on operational deployment. Operational deployment, whilst the primary role for military healthcare professionals, requires training. Military training takes many forms and for student nurses the main effort is to ensure they will be fit for role on qualification as a registered nurse. Becoming fit for role is based around fitness for operational deployment, focusing on areas such as physical fitness, field craft skills, weapon and chemical warfare training which are all essential components of the military role, irrespective of the nature of employment. Military nurses need a level of competency in military skills in order to fulfil their role, a role which takes them out of the civilian NHS environment into the military setting.

Amal's perception that military nurse teachers are not required, but military training is, is interesting in that the perception is that the university curriculum meets the needs of the military student nurse. This is at variance with some of the other participants, such as Bobbie and Sam, who regard the military nurse teacher's input as necessary for student nurse development as military nurses. The university curriculum uses the NHS environment as its training arena; enabling student and qualified nurses to develop and improve clinical skills and integrate theory with practice. It is acknowledged that there is 'tension' between training and education (Andrew and Robb, 2011) but for the profession of nursing education is now the remit of the university. It is accepted that, as a practice profession, 'a great deal is learned on the job' (Watson, 2006). This acceptance of on the job training and experience contributes to the perception that theory does not relate to practice.

Education is not training. Nurse education moved away from the traditional training method into higher education in order to 'educate' nurses and develop critical thinking and further their knowledge and understanding. Training focuses on acquiring specific skills which may be applied in certain contexts and settings. Thus, military training is required to enable nurses to acquire specific skills

required for deployment on operations. However, the pre-deployment training is specific to the nature of the operation and its environment; a certain level of military acumen is expected from personnel selected to deploy. As the largest workforce in military healthcare military nurses expect to undertake operational tours as part of their duties. As military personnel they are required to undertake specific military training on an annual basis to ensure their 'fitness for role'. Fitness for role includes their education as a nurse but from a military perspective it is the military skills and aptitude which is required for their military role. This fits well with the participants perspective that the 'product' at the end of a civilianised educational programme will require substantial military input to requaint them with the organisational requirements.

Another area for consideration is the notion that siting nurse education in a higher education institution sets it apart from the remainder of military training courses. It is acknowledged that the diploma for operating department practitioners is delivered from the university but only student nurses and operating department practitioner students undertake their educational programme as a military group. Other healthcare professionals such as doctors, dentists and physiotherapists enter the Army following qualification in their chosen specialty. Non registered healthcare professions such as medical technicians undergo their training in barracks whilst biomedical scientist students are supported as individuals through university education. One area for further discussion could be the necessity to educate groups of military nurses centrally rather than providing cadetships, currently used for recruitment of doctors and dentists. The difference may be as simple as the numbers required to meet the operational requirement.

The findings and discussion show the depth of feeling around professional development of military nurses and the military nursing cadre. It is shown that there is little impetus to support and guide junior teachers in their academic pursuits. There is a sense of frustration over the lack of strategic direction for nurse education and the possibility that it will become a delivery model of

education as opposed to a vehicle for developing military nursing knowledge through research and evidence-based practice.

5.4. Theory to practice

One of the major findings has been the relationship between theory and practice, a relationship central to nursing. As a practice profession nursing 'cares' for people. The RCN (2003) stressed that nursing is more than care; it is the clinical judgment involved in each step of the care process. To that end nurse education and training are geared towards the acquisition of cognitive and psychomotor skills, to provide care through an underpinning foundation of relevant biopsychosocial knowledge and understanding. These components promote competence in the science and art of nursing and produce the 'nurse'. The nurse consolidates their learning, and develops their expertise, through clinical practice. Thus clinical practice and experience become synonymous with competence, credibility and expertise. For some of the study participants 'clinical practice' denotes competence in role. Thus current or continuing clinical practice is viewed as an essential component of the military nurses' repertoire, including military nurse teachers. Military nurse teachers are in a position to influence learners and junior qualified nurses. Their credibility, in terms of their military clinical practice, is paramount. For other participants previous experience is important but it is the teachers ability to 'make them think', enable students to develop their professional reasoning, that is of overriding importance. All aspects are required for nursing; it is a question of deciding who provides what, when and where. Watson (2006) highlights that the university environment is about education rather than training and this is an important distinction. However, it is important to consider that there needs to be dialogue between the practice and education sectors in order to maximise learning opportunities, potential and experiential. The dilemma facing military nurse teachers is there dislocation from the practice areas and, in some areas, a lack of appropriately experienced military nurses to support students in practice. As previously stated, the outcome of the withdrawal of military nurse teachers from the pre registration programme

has yet to be realised. A lack of interaction with military nurses in practice may compound the lack of military nurse teachers in the university. This corresponds with some of the participants concern around the production of a 'civilian' nurse who will require re-integration in to the military as opposed to the 'beast at the end' or 'product' that the military expect. Bobbie alludes to the presence of military nurse teachers as providing a support network. The substance of this support is not specified but the inference is that the military nurse teachers provide the link between the military and civilian environments and can thus help to prepare military nursing students for their future role. Sam refers to this as the 'value added factor' - the military focus.

The end product is the military nurse, albeit a nurse educated in the civilian education system with clinical experience in the NHS environment. Three participants viewed the absence of military nurse teachers in the pre-registration programme as having a direct effect on the 'end product' suggesting that this product would not be militarily aware or focused. This perception may be a remnant of the traditional ways of educating nurses, for example the apprenticeship style where student nurses were part of the healthcare workforce, learning and practising alongside colleagues of nursing and other healthcare disciplines, fully immersed in practice. Additionally this perception may be the legacy of military hospitals, staffed by military healthcare staff, caring for military patients thus militarily focused. It is interesting to note that medical officers (medical doctors) enter the Army following medical school education and undergone a nine month preparation programme to prepare them for practice as an Army doctor. One accepts that the role of medicine is different from the role of nursing in healthcare but there may be aspects of the doctors' military preparation which would prove useful for military nurses.

The option of deploying military nurse teachers on operations could be a potential for the future. Frankie discussed how the proposal was accepted but logistics precluded a pilot study taking place. That scenario may change in the future. The operational environment is the core of military nursing and it is

understandable that military nurse teachers would wish to be involved in that area. Sufficient education and preparation is required for the core to function effectively and Charlie's point around pre and post deployment education is unquestionable as all peacetime practice is preparation for the operational environment.

The potential for 'taking education out of the school' into military has been discussed and is worthy of pursuit. The 'units' mentioned are field units where personnel prepare for deployments through a combination of military, physical and clinical training. MDHUs, the Ministry of Defence Hospital Units, are clinical areas within NHS Trust hospitals which provide the environment for peacetime clinical practice. Educational delivery in these areas promotes the inclusion of military nurse teachers as part of the military community but more importantly takes education into the practitioners' environment. This is significant in raising the profile of the military nurse teacher and the relationship between theory and practice. As nurses, and other healthcare professionals, draw on several sources for their knowledge base (Rycroft-Malone et al, 2004), critical thinking, as Charlie states, is fundamental for the assessment and evaluation of said sources.

Taking education out of the university to the field units reinforces the commitment to military nursing, the requirement for military nurse teachers to be involved in the military family and to facilitate the military component into education. This is an important contribution as clinical practice in the UK takes place within the NHS. Taking education out to the units, linking education with military practice fulfils, to some extent, what Bobbie sees as a requirement from military nurse teachers, albeit it is not operational experience.

5.4. Strengths and weaknesses of the study

This study has explored a group of Army military nurse teachers who form part of a nursing cadre in the Army and a larger cadre within the Defence Medical Services, which includes military nurse teachers from the Royal Navy and Royal

Air Force. Findings from this limited selection cannot be generalised across the Defence Medical Services cadre and exist only in the time frame in which they were recorded. To determine the perceptions of military nurse teachers in the three Services would require a larger research study involving researchers from each Service. Other aspects to be considered would be how individual teachers' perceptions may alter with job promotion thus occupying different positions in the hierarchical structure of the Army, and in different employment situations such lecturer-practitioner or practice-educator.

The greatest strengths of the study may also be its weaknesses. The insider knowledge of the researcher was beneficial in accessing participants and the logistics involved in carrying out the study. The impetus for the study arose from the researcher's personal experience as a military nurse teacher. However, a significant disadvantage of this personal knowledge and experience became evident in the early stages of data analysis where salient points were overlooked. The use of content analysis as the tool for analysis allowed for the data to determine issues worthy of discussion but required the researcher to look below the surface and beyond the obvious. My closeness to the world of military nursing meant that certain behaviours, language and expectations were considered acceptable and in some instances 'normal'. This stems from the structure in which military nurses and military nurse teachers reside. Their organisation, the military, functions for a purpose, to defend the realm. Each individual within the military organisation has a role to play to ensure that the purpose is upheld. Military nurses and military nurse teachers play their role in the provision of quality healthcare to serving military personnel. It could be argued that the military and sub sections of the military, for example the Defence Medical Services, function as 'role organisations' (Handy, 1990, p.148). Within role organisations policy and procedure directives ensure consistency of action and individuals assume the role based identity of the position they occupy. According to Handy (1990, p.149) individuals are less important and "can be trained to fit the role". It became apparent that despite being removed from the

bonds of the organisation, effectively now a veteran, elements of my role-based identity remained. I had been trained to fit a role. I remained inured to the terminology, practices and beliefs of military nursing and organisational practice. Thus my insider knowledge could be viewed as a hindrance in seeking information from the data and may have limited my awareness, in some instances, of issues voiced by the study participants.

This potential for insider knowledge as a weakness in design was a factor in the selection of qualitative description. Qualitative description, like other qualitative approaches, aims to describe individuals' perspectives of their world. Unlike other approaches qualitative description is steeped in existing knowledge and recounts data in language similar to the participants (Neergaard et al, 2009) without in-depth interpretation. However this approach does require subject matter knowledge in order to determine which data is meaningful for the study. The presence of a subject matter expert has the potential to affect participant responses. For this study the presence of the researcher as a subject matter expert and a senior officer could prejudice participant responses in relation to divulging personal views on the military, the university, their colleagues. Conversely, the researcher's own perspective may influence the discussion. Thus the researcher's background and experience constitutes a weakness.

Qualitative description lacks a theory base, which in some studies may be a disadvantage. For this study, a starting point for exploration of the military nurse teacher, gathering data on participants' perceptions was viewed as paramount as opposed to theory development.

The delays in MoD ethical clearance and subsequent intervention of personal circumstances presented hurdles to overcome and changes to the planned accomplishment of the study. Interview via email would not have been selected as a method of choice for data collection in the first instance. Whilst this necessary alteration has improved my awareness of using open-ended questions in the written form it has decreased the richness of data which could be gathered

through face to face interview. The benefits of engaging with an individual on a one to one basis include encouraging a free flow of dialogue and opportunity for divergence of thought. These opportunities do not occur with written responses to written questions, particularly when completing online and at a geographical distance. The emotion of the context appears lost.

Anonymity and confidentiality have been of concern throughout the study. In the small community that is military nursing there is the potential for a reader to identify participants by the nature of their responses or location of employment. Thus every effort has been made to anonymise participant information, but it cannot be assured. This may be perceived as a weakness.

The strengths of the study; insider knowledge and the employ of qualitative description, may be seen as inherent weaknesses. Despite the weaknesses I feel that this small scale study does provide some comprehension of the professional perspectives of military nurse teachers. There is an important role for the findings to serve as a starting point for a discussion on the future direction of nurse education in the Defence Medical Services.

Chapter 6
Conclusion

6.1. Summary of findings

This small scale study has explored the world of military nurse teachers through their perceptions of military nursing and their role. The findings have elicited their passion for military nursing and how they, as specialists in education, visualise their support in the nurture and advancement of the actuality of military nursing. The study has endeavoured to move beyond descriptive representation of the participants' views of their positioning as military nurse teachers to incorporate the entity that is military nursing. This has been essential in order to understand the importance of the military nurse teachers' contribution to this specialist area.

The major findings of the study reflect the military nurses' contribution to healthcare delivery. In an increasingly specialist arena of medicine, healthcare and operational imperative professional contributions need to be easily transferable to practice, particularly clinical operational practice.

The major findings focus around the discrete but completely interrelating professional identities of the military nurse teacher; military, nursing and education. Military is the overarching identity whilst nursing is the underpinning professional persona. Education acts as the speciality component.

Throughout the findings it is evident that military nurse teachers implicitly identify as military nurses, and as part of that community of practice more than with the academic environs of the university. Despite their commonalities, military, nursing and education, the participants displayed contrasting opinions in relation to their role. Some clearly view education as their dominant role without a clinical component whilst others see clinical practice as integral to their persona as a military nurse. Clinical practice is viewed by some participants as a necessary component in order to guide their educational practice. In the wider scheme

clinical currency, or competence, as some participants state, is an important consideration which stems from contribution to the raison d'etre of military healthcare; operational delivery. Without a significant contribution in this arena the purpose and function of military nurse teachers could be called to account. With the demise of military nurse teachers in the pre-registration arena any future role may need to incorporate the primary business of the military nurse; providing healthcare support. Delivery and utilisation of education extends beyond the boundaries of a higher education institution and the participants recognise the need for change to reflect this.

The policy decision to withdraw military nurse teachers from the pre-registration arena could be viewed as the opportunity to develop future roles in academia, research, both in peacetime and operational environments to fully integrate with other members of the Defence Medical Services. It is acknowledged that military educators in other disciplines, in the main, maintain their teaching and academic role alongside clinical activity. Disciplines such as medicine and dentistry. It is acknowledged that undergraduate education, professional development and higher specialist training are sourced externally for these disciplines, which, apart from specialist training is different from nurse education. Consultants in hospital based specialities and General Practice trainers provide specialist education in practice. Their areas of practice are common to nurses so there may be opportunities for the military nurse teachers with a specialist qualification to develop the lecturer practitioner role. There is the potential for military nurse teachers to develop roles as practice educators for the MDHUs and some medical units such as the field hospitals where there is a need for academic support, guidance and strategic planning of professional development.

There are opportunities for the promotion of practitioner research across the spectrum of military nursing and collaboration with other disciplines through the integration of evidence-based practice. These contributions should be the major factors influencing clinical practice, and foremost in the requirements of the Defence Medical Services and Army nursing in particular.

The development of future roles requires strategic planning which involves determination of the Army's requirement of its nursing workforce. The findings from this study may be instrumental in focusing the strategic leads on the knowledge, skills and abilities that are available within the military nurse teacher cadre, and open the discussion on how to utilise these educators across the spectrum of nursing and other healthcare disciplines. As one participant stated 'it is an exciting time to be an educator'; the opportunity to develop new roles is in the hands of the educators themselves.

6.2. Recommendations

It is proposed that military nursing has a decision to make. The production of the Army Nurses OPS should provide clear guidance on the qualities, attributes and competencies required by Army military nurses. From the OPS the nursing cadre can decide how delivery of their contribution to military healthcare may be achieved and the important stakeholders in that delivery. As an important stakeholder military nurse education requires direction and clarification of role. The necessity for some specialist nurses to deliver operational care is not disputed and military nurses must be supported to achieve specialist status. With the implementation of graduate level education for qualification as a registered nurse the role of military nurse teachers lies in developing post qualification professional knowledge and competence and higher level academic programmes. There are the additional implications of professional revalidation which is effective from 2016 and applicable to each nurse registered for practice with the NMC. Military nurse teachers could provide a valuable resource for continuing professional development with academic support to enable registered nurses to address the demands of revalidation. The role for military nursing education is significant and essential in a world of continually evolving healthcare technology, expectations and professional accountability. This requires teachers across the healthcare arena so there are opportunities to develop the roles of practice educators as well as university lecturers. This is dependent on the requirements of the Defence Medical Services. As already stated this study has

provided a voice for the cadre which, it is anticipated, serves as a useful basis from which to initiate the discussion about military nurse education, its direction of travel and how this may be advanced. There is no clear pathway and the findings demonstrate the tensions that exist concerning the role. Further research into the requirements of the Defence Medical Services nursing contingent would be timely.

6.3. Personal reflections

The impetus for this study arose from professional experience as a military nurse teacher. Promotion and subsequent employment in other areas of Army nursing practice allowed for periods of reflection on my practice as a teacher and the importance of the military nurse teacher cadre in the professional education of military nurses. Despite the small scale approach and limitations it has been hugely satisfying to discover how passionately military nurse teachers feel about their contribution to the profession and to the wider military healthcare arena and the personnel that it supports. The research process has exposed my assumptions and preconceptions about the actions of individuals within an organisation, particularly one with a rigid hierarchical structure. As a current 'outsider' to the organisation with 'insider' knowledge my understanding of the limitations to autonomous practice for the military nurse teachers has aided my objectivity in data analysis. The downside of insider knowledge and practice is the desire to participate, particularly during the data collection stage and a more structured approach would be considered for future research studies. However, this study has permitted military nurse teachers to communicate their aspirations for the future of military nursing and their cadre. This alone has made the study worthwhile.

6.4. Final comment

Nurse education is an important strand of military nursing in the British Armed Forces. In the current climate of operational necessity, changing healthcare needs and expectations and technological advancement it is vital that military

nurses, alongside healthcare professionals from other disciplines, are provided with the education and training to meet these demands. This study has shown that military nurse teachers are capable and motivated to support them in this endeavour.

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APPENDICES

Appendix 1

British Association of Critical Care Nurses – Military Region

Defence Operational Nursing Competencies Explained

Nursing Competencies

Nursing competencies are not a new concept, the former UK nursing regulator the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (1999) used the term competency to 'describe the skills and ability to practice safely and effectively without the need for direct supervision'. This reference is still used today by the current Nursing and Midwifery Council (NMC) (2010); however they have further identified a nurse's competence as 'considering the nurse's levels of competence as a whole. It combines the skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions'. The recent Francis Inquiry (2013) has identified there is a requirement to recognise the importance of professional competencies, by recommending nurses must demonstrate in their annual learning portfolio an up to date knowledge of nursing practice and its implementation. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being accurate and countersigned by their appraising manager.

The Defence Operational Nursing Competencies

The Defence Operational Nursing Competencies (DONC) was introduced for all Nursing Services in 2009, using Bloom's Taxonomy Model (DGPL, 2009).

Bloom's Taxonomy

Bloom's taxonomy model was first published in 1949 and since then it has evolved (Bouchard, 2011). The 1956 model consists of three domains of educational activities:

- Cognitive
- Affective
- Psychomotor

The DONC specifically uses the cognitive levels from this model; the following table outlines the level, domain and explanation of each level and taxonomy (Bloom et al, 1956).

Level Taxonomy Explanation

1 Knowledge Recall from previously learned information

2 Comprehension Demonstrates an understanding of the meaning or purpose of previously learned information

3 Application Use of previously learned information in novel and concrete situations

4 Analysis Examines the underlying components of learned information and gain an understanding of their organizational structure

5 Synthesis Integrate previously learned information and its components into new concepts

6 Evaluation Uses definite criteria (either provided or self-created) to judge the value of other material and information

DONC Competencies are written between levels 2-4. Core competencies outline essential skills for military nurses from all nursing Services (Core & Specialist Competencies) then Service specific annexes are completed as necessary.

Assessing Competency

In order to assess competence a range of assessments can be used including:

- Direct observation of the individuals performance
- Working alongside the individual
- Reflective discussion
- Oral presentation
- Clinical simulation
- Reflective writing
- Self and peer assessment
- Portfolio of evidence
- Feedback from mentors and others

(National Education for Scotland, 2007)

Evaluation of the DONC

Currently no formal evaluation of the DONC has been conducted, however, anecdotally it is recognised these competencies provide a framework for professional development within the military nursing environment. The US military also uses competencies and recognises the patient population for military nurses is broad and subject to change, making it necessary to have a wide range of skills, which differs from civilian practice (Ross, 2010). Agazio (2010) further identifies the importance of using military specific competencies not only to prepare military nurses for their deployed nursing role but also to assist in limiting occupational stress by not being adequately prepared.

Supporting Validation

To support military nurses develop their professional portfolio and validation, the British Association of Critical Care Nurses Military Region has provided the following learning resources:

- Training courses with generic DONC cross referenced training
- Training courses with practical elements
- Self and peer assessments

These resources have been peer reviewed by both military critical care nurses and the BACCN National Professional Advisors. The self-assessments are free and can be downloaded at www.baccn.org.uk

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Defence Operational Nursing Competencies Core

Defence Operational Nursing Competencies – Land Annex

Defence Operational Nursing Competencies – Air Annex

DGAMS Policy Letter 05/09 Defence Operational Nursing Competencies (Land Environment)

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Appendix 2

File Ref 20110311/DPMD

09 Mar 11

AGENDA FOR A MEETING OF THE NURSE EDUCATION CADRE TO BE HELD IN THE LIBRARY, DMS WHITTINGTON, AT 1100 ON 10 MAR 11

	ITEM	LEAD
1.	Introduction	NEA
2.	Opening remarks	The Dean
3.	Library Update	Mike Rowe
4.	OF4 Update	OF4 Small Cadres
5.	Challenges for Nurse Educators a. Career Pathway for Nurse Educators b. Practice Educators within MDHUs or Regional c. Deployment of Nurse Educators d. Defence Degree and MSc – where now? e. Future changes to Nurse Education nationally f. All degree profession? What about Certificate nurses?	NEA
6.	Group Work	All
7.	Lt Col Holman – Research Questions	MH
8.	Any other business	All
9.	Date of next meeting	All

K M DALBY-WELSH
Maj
NEA

Identifiers removed

- 01/31/12 at 4:42 PM

To

- MAUREEN HOLMAN

Message body

Hi Mo,

Happy New Year! - hope you are OK.

Had a look at the transcript. It is always a bit weird reading these things back - you then realise how much you ramble in conversation! Doesn't help when punctuation is a bit thin on the ground, but it's always difficult to properly transcribe that. It looks pretty much a true record of our conversation to me. Hope it makes sense to you.

Very happy for you to use the content for your analysis.

Keep well.

Cheers,

STUDENT HIGHER-LEVEL RESEARCH

UNIVERSITY OF EXETER

Graduate School of Education

Certificate of ethical research approval

STUDENT RESEARCH/FIELDWORK/CASEWORK AND DISSERTATION/THESIS
You will need to complete this certificate when you undertake a piece of higher-level research (e.g. Masters, PhD, EdD level).

To activate this certificate you need to first sign it yourself, then have it signed by your supervisor and by the Chair of the School's Ethics Committee.

For further information on ethical educational research access the guidelines on the BERA web site: http://www.bera.ac.uk/publications/guides.php and view the School's statement in your handbooks.

Your name: Maureen Holman
Your student no: 570031213

Degree/Programme of Study: Doctorate in Education

Project Supervisor(s): Cheryl Hunt, Martin Levinson

Your email address: mlh206@ex.ac.uk mholman2@btopenworld.com

Tel: 07809742506

Title of your project:

Educational Preparation for role: the Role of the Defence Nurse Teacher

Brief description of your research project:
The history of nursing is intrinsically linked with war. Nurse education in the Armed Forces has its beginnings with the work of Florence Nightingale who instigated the formation of the Army School of Nursing following her experiences in the Crimean War 1854 – 56. Ultimately this led to the formation of nursing schools within the Royal Navy and Royal Air Force. Nurses were educated along the same lines as their civilian colleagues but the focus was on providing care to members of the Armed Forces with emphasis on the nature of conflict and the ensuing physical and psychological conditions requiring care. As such 'military nursing', more recently termed 'defence nursing', developed as a speciality in its own right with nurse education and practice carried out in military hospitals in the UK and overseas. Defence nurse teachers worked alongside defence clinical nurses to provide the link between education and practice in the military setting. With the demise of military hospitals and the move of nurse education into the HE sector in the 1990s defence nurse teachers were, essentially, removed from the practice setting into the university setting and simultaneously clinical practice moved into NHS provided clinical areas.

Currently nurse education in the Armed Forces of UK is provided through the Defence School of Healthcare Studies, in conjunction and co-located with a UK university based in the Midlands. Defence nurse teachers have worked alongside their civilian contemporaries within the university to provide the pre-registration nursing education programme. Defence Nurse Teachers also provide the Defence Nursing studies degree level programme which is accessible to regular and reserve forces nurses. This educational provision takes place in the university setting. The impact of this is the lack of a definitive clinical or operational component which supports their educational role. With the increasing tempo of operational nursing for defence nurses, and the focus of the nursing profession moving towards specialist qualification and practice the current role of the defence nurse teacher in the university setting would appear to have a diminishing role for the educational preparation of the defence nurses of today.

The aim of this study is to examine the role of the Defence Nurse Teacher in relation to a) ensuring that defence nurses are fit for their role in the Defence Medical Services through provision of pre and post registration education and b) defining their contribution to the defence nursing arena.

Give details of the participants in this research (giving ages of any children and/or young people involved):

Participants:

Participants will be from the following groups:
Defence Nurse Teachers
Past student nurse cohorts – 21 + years of age
Current student nurse cohorts – 19-21 years of age
Employers
Clinical service providers

Ministry of Defence Research Ethics Committee (MoDREC) authority for the research study is required and stipulates information on the research study to be made available to all participants.

Give details regarding the ethical issues of informed consent, anonymity and confidentiality (with special reference to any children or those with special needs) a blank consent form can be downloaded from the GSE student access on-line documents:

The BERA Code of Ethics (2004) and the Royal College of Nursing (RCN) Research Ethics Guidance for Nurses (2009) will be followed.
Participation will be voluntary. All participants will be provided with detailed information on participation in and withdrawal from the study, respect and dignity, anonymity, confidentiality and data protection issues prior to participation. Written consent for participation will be undertaken. All data collected will be secured and available only to the researcher. Data no longer required following the study will be disposed of safely and effectively.

Give details of the methods to be used for data collection and analysis and how you would ensure they do not cause any harm, detriment or unreasonable stress:

Data Collection

Data collection will be carried out by means of questionnaire, semi-structured interviews and focus groups.

- Quantitative: A questionnaire will be used to gather information from the nurse teachers identifying time in role, length and type of previous military and civilian professional educational and clinical experience. This information will supplement the qualitative data gathered.

- Qualitative: Information to determine the current views and perceptions on the role of the defence nurse teacher in relation to fitness for role will be obtained through semi-structured interviews and focus groups. This will involve data collection from all the different groups; the teachers, employers, service providers and current and past student nurses. With the consent of participants, interviews will be recorded and transcribed. These will then be coded thematically to identify the issues significant to the participants. The researcher will be cognisant of issues surrounding the facilitation of interviews and focus groups.

All participation will be voluntary and participants will be assured of the right to withdraw from the study at any stage. Issues relating to stress induced through reflection on experience will be discussed with participants and they will be able to halt their participation in focus group and /or interview at their request. The researcher will ensure that all participants are able to access their clinical supervisor in the event of any concerns relating to their contribution to the study.

Give details of any other ethical issues which may arise from this project (e.g. secure storage of videos/recorded interviews/photos/completed questionnaires or special arrangements made for participants with special needs etc.):

During the data collection, data analysis and write up, all data (questionnaires, audio recordings, interview and focus group data) will be securely stored in a locked cabinet in a secure building. All electronic information will only be accessible to the researcher through password protection on a system with appropriate virus protection. All information will be secured in a locked area. It will be destroyed when it is no longer required.

Give details of any exceptional factors, which may raise ethical issues (e.g. potential political or ideological conflicts which may pose danger or harm to participants):

This research study explores individuals' perceptions of educational experiences and as such involves reflection on experience. Therefore these areas should be considered as potentially sensitive. Thus the detail on consent to participate and right to withdraw is paramount to ensure informed consent. It is also beholden on the researcher to ensure that potential participants understand they do not have to volunteer to participate in this study. Additionally the researcher must consider her actions on discovering any information that may cause harm to other participants or interested parties.

This form should now be printed out, *signed by you below and sent to your supervisor to sign. Your supervisor will forward this document to the School's* ***Research Support Office*** *for the Chair of the*

School's Ethics Committee to countersign. A unique approval reference will be added and this certificate will be returned to you to be included at the back of your dissertation/thesis.

I hereby certify that I will abide by the details given above and that I undertake in my dissertation / thesis (delete whichever is inappropriate) **to respect the dignity and privacy of those participating in this research.**

I confirm that if my research should change radically, I will complete a further form.

Signed:.....**date:**...01 Apr 11.....

N.B. You should not start the fieldwork part of the project until you have the signature of your supervisor

---

This project has been approved for the period: now **until:** oct 2013 (or end of registration period)

By (above mentioned supervisor's signature): .....**date:**.....

N.B. To Supervisor: Please ensure that ethical issues are addressed annually in your report and if any changes in the research occurs a further form is completed.

GSE unique approval reference:.....

Signed:.....**date:**.....
Chair of the School's Ethics Committee

Chair of the School's Ethics Committee
last updated: September 2007

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MOD Research Ethics Committee (General)

Corporate Secretariat
Bldg 5, G01-614
Dstl Porton Down
Salisbury, Wiltshire
SP4 0JQ

Secretary [redacted]
telephone: [redacted]
e-mail: [redacted]
fax: [redacted]

Lt Col M Holman
Army Medical Directorate
HQ Land Forces
Monxton Road
Andover
Hampshire
SP11 8HT

Ref: 215/Gen/11

25th August 2011

Dear Lt Col Holman,

Re: Fitness for role: the Role of the Defence Nurse Teacher

Thank you for submitting this protocol for ethical review and making minor amendments.

I am happy to give ethical approval for this research on behalf of the MOD Research Ethics Committee (General) and should be grateful if you would send me a copy of your final report on completion of the study. Please would you also send me a brief interim report in one year's time if the study is still ongoing.

This approval is conditional upon adherence to the protocol – please let me know if any amendment becomes necessary.

Yours sincerely,

Dr Robert Linton
Chairman MOD Research Ethics Committee (General)

telephone: 020 8877 9329
e-mail: robert@foxlinton.org
mobile: 07764616756

Appendix 6

PARTICPANT INFORMATION SHEET

My name is Mo Holman and I am a QARANC Nursing Officer employed in the Army Medical Directorate. As part of my continuing professional development I am currently completing a professional doctorate in Education at Exeter University.

In part fulfilment of my doctoral studies I am undertaking a research study on educational provision. As a nurse teacher who has been involved in both Army and Defence Medical Services' nurse education, and an avid interest in lifelong education, I have elected to explore the role of uniformed nurse teachers in pre and post registration education. The study will explore educational provision from the perspective of uniformed nurse teachers, student nurses completing their studies and the Directors of Nursing Services. The aim is to produce a detailed exploration of how the roles that nurse teachers and education contribute to defence nursing.

I am writing to ask if you would consider participation in this study. Your support in this endeavour is invaluable to the understanding of the uniformed nurse teacher role and its contribution to the field of defence nursing. Participation is voluntary and you are free to withdraw from the study at any time.

Your participation would involve being part of a focus group and / or individual interview lasting 40-60 minutes. With your permission the focus group and interviews will be audiotaped.

Confidentiality of your name, position, area of employment is assured and resulting transcripts will be securely held, available only to the researcher and destroyed on completion of the study. Transcripts of your participation will be confirmed by you prior to inclusion in the study.

Written consent to participate will be sought at time of focus group and interview but you will be able to withdraw from the study at any time should you so wish.

If you are willing to participate or would like to discuss the study further please contact me at mlh206@ex.ac.uk or contact me on 07809 742506

M HOLMAN ARRC OStJ

MA BSc (Hons) RGN ONC Cert Ed

Appendix 7

CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES

Title of Study: Fitness for Role: Changing Perceptions of the Role of the Defence Nurse Teacher

Ministry of Defence Research Ethics Committee Reference:

- The nature, aims and risks of the research study have been explained to me. I have read and understood the Participant Information Sheet and understand what is expected of me. All my questions have been answered fully to my satisfaction.
- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researcher and be withdrawn from it immediately without having to give a reason for my withdrawal. I also understand that I may be withdrawn from it at any time, and that in neither case will this be held against me in subsequent dealings with the Ministry of Defence.
- I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.
- I agree to volunteer as a subject for the study described in the Participant Information Sheet and I give full consent to my participation in this study.
- This consent is specific to the study described in the Participant Information Sheet attached and shall not be taken to imply my consent to participate in any subsequent study or deviation from that detailed here.

Participant's Statement:

I [redacted]

agree that the research study named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Participant Information Sheet about the project, and understand what the research study involves

Signed [redacted] Date 3rd Nov 2011

WitnessName M HOLMAN

Signature [signature]

Investigator's Statement:

I MAUREEN HOLMAN

confirm that I have carefully explained the nature, demands and any foreseeable risks (where applicable) of the proposed research to the Participant.

Signed [signature] Date 3 Nov 11

Perceptions of the Role of the Military Nurse Teacher

Interview questions

1. *How long have you been involved in the military nurse education arena?*

   7 years

2. *What influenced your decision to move into nurse education?*
   I was approached and asked to consider it. I have had a background in teaching prior to nursing and always enjoyed it. I also felt that I had something to contribute from a [redacted] practitioner's point of view – this however, didn't happen.

   Could you explain what did happen?
   I did try to sort this out but it was at my own volition. I did one session early on with one of the civilian practitioners and we discussed the division of work. When I got there she had covered all the areas I was to have presented as well as her own. Further difficulties arose because the opportunities offered clashed with my PGCE course (mons/tues). Later I again offered the [redacted] input and taught one of their sessions on Diabetes. On arrival of new [redacted] staff this was taken back for their team. I felt no one was interested. I became more involved in the Evidence Based Practice module and my role as Hd of Pre-Reg and the [redacted] team didn't access any of the Mil theatre nurses to any great extent (there were 2 other Mil [redacted] nurses at DSHCS at time)

3. *What military nurse experience did you bring to the educational arena?*

   Deployment on op in Kosovo, working with the US military medical facility. Tri-service back ground having worked at RH Haslar and TPMH Cyprus. Felt this was useful in the Tri service environment of the DSHSC

4. *What do you think is the role of the military nurse teacher?*

I believe the role to the military nurse teacher is enable the learner (either as a qualified RN furthering their education or as a student) to maximise their potential and to enjoy all aspects of their working lives. I feel that I am very much a facilitator and advisor hopefully helping to open doors. It's also important as a Military nurse teacher to perhaps provide alternatives that the learner may not have considered

5. *What do you think the role of the military nurse teacher could / should be in the future?*

I think this role should be where ever there are nurses – we should have a role on operations to support learning in that arena. Each specialist area could have a link nurse – (the old lecturer practitioner role). I also think that they should have strong links with DSPMS and be utilised on the delivery of courses not only for nurses but where there is cross over for all APHs. This fosters collaborative working in all areas
Could you explain what the role on operations would be?

6. *What nursing experience do you think a military nurse teacher should have?*

Although operational experience is extremely valuable I do not think it should preclude those who have an aptitude and enthusiasm for teaching. If deployment became part of the Military Nurse Teacher development plan this could be factored in. Experience in their specialist area and knowledge and experience of research. Ideally an MSc that would demonstrate their understanding of all aspects of research and the ability to be 'reader of research' to put it into practice and to carry it out.

Do you think nurse teachers should undertake roles / other jobs outside of education to keep them up to date with what is happening in the military setting, not necessarily operational?

Question not answered

7. *How often should military nurse teachers undertake clinical practice?*
   Please explain your rationale. If the role of the military nurse teacher is focused on ward based nurses then specialist practitioners (ie theatres) should be allowed to remain with their clinical speciality. If their role is academic based and they teach within a university setting then they should maintain their clinical practice as per the NMC guidelines. I do not believe that they should be expected to return to a ward area which they may not have practiced in since qualifying and this can be 20 years +. Their specialist experience should be utilised appropriately.

   Accepting that nurse education is going to remain in the university setting do you see military nurse teachers splitting into 2 camps – those focusing on ward based practice and those remaining in the university? Do you see the specialist practitioner teachers leading with clinical teaching etc?

   Question not answered

8. *How often should military nurses undertake operational tours?*
   In line with all other nurses.

   What role would they undertake? Question not answered

9. *To what extent do you feel you have influence over the educational input for military nurse learners (qualified nurses and students)? If not in your current role please comment on your previous post.*

   The influence can be from having an overall expectation of the output of the product at the end of training (the qualified nurse). I feel that

supporting the enthusiasm that students arrive with and to keep it fresh throughout their 3 year nurse training is important. To enable them to consider laterally the learning they make in a civilian environment and to translate that into the role they have as a military nurse. Now that the DSHCS has given the role of the personal tutor to the civilian staff I believe this is a vital link that has been lost. Comparing previous military experience and discussing this with students keeps the focus on becoming a Military nurse – not just a nurse. The focus on military training is important but we have to be careful that the product is not a civilian nurse with some military knowledge but a well rounded military staff nurse who can encompass the difficulty of being a 'warrior nurse' and the conflict of providing care in a war environment in the future.
Aside from the loss of the personal tutor role what 'academically', do you feel has been lost by removing military nurse teachers from the pre-registration programme?

I think the experience and knowledge that the military tutors have is lost to the programme. I think the students will view their nurse training purely as a civilian course and the civilian providers may not understand the military ethos and drive our students have. The military tutors were able to support the civilian lecturers and provide a sense of belonging to our students. However, academically I don't think there will be any drop in the standard as the majority of the lectures were delivered by the civilian lecturers. I just think the liaison and interface between the civilian and military lecturers was good. Admin staff may not understand the university issues the same and as the civilian pers tutors have a heavy work load they may miss out on help and advice that was previously provided by the military cohort leaders/lecturers. I've waffled a bit here and I guess its hard to quantify the lack as the actual training will remain predominantly the same – its more the value added factor that is missing.

Q10. Could you tell me how long you had been in the Army before entering education.

5 years as a theatre nurse. My previous background: I left school and taught [redacted] – age ranges from 3 to adult – for approximately 12 years. Then I did my nurse training and early on specialised as a [redacted] practitioner. One of my last jobs involved teaching and supporting Dental student nurses on their clinical practice placement which I very much enjoyed and I've always taken the opportunity to mentor and teach during my career, so the move to Education was good.