New Zealand Defence Force Nursing Officers' Navigation of Professional Accountabilities and Role Expectations: An Exploration Informed by Foucauldian Concepts

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Abstract

Nurses in armed forces are responsible to their defence employers for meeting the expectations of their roles but they also are accountable to nursing regulatory authorities for maintaining the standards expected of members of the nursing profession. Inherent dichotomies exist for those delivering healthcare in defence forces which are known to create challenges for nurses. This research examines the previously unexplored ways in which nurses serving in the New Zealand Army navigate their dual responsibilities. A qualitative approach was employed in the study using information provided by 11 experienced serving and immediate past members of the Royal New Zealand Nursing Corps. Foucauldian theoretical concepts underpinned a thematic analysis to reveal patterns in the techniques used by this group of military nurses to maintain professional standards whilst performing their roles.

Complex interactions between a range of New Zealand Defence Force policies and nursing practice behaviours were found to impact upon the decisions that military nurses make and the degree of autonomy they possess. Institutional governmentalities drive a focus on combat ideologies and competition which for nurses, compels the suppression of interprofessional collaboration and affects the maintenance of nursing competence. Efforts by nurses to prioritise patient wellbeing and to comply with international humanitarian law are factors in the marginalisation of nurses. Ways in which nurses work to counteract the subordinating effects of an historic but enduring discourse of nurses not being needed has a consequence in that when nurses are needed, they may not be clinically prepared to deliver the care required. Paradoxically, the importance of nurses being operationally deployable positions those who work in

clinical practice as holding higher status than more senior ranking nurses who work in management and leadership.

This study found that nurses monitor practice environments to ensure that leadership in care delivery follows a congruent model and not the organisationally endorsed transformational leadership style. Consequently military nurses vociferously resist any perceived interference by general military personnel into professional nursing domains. Problematisation of nursing in the Army can delay nurses' transition into the organisation but ultimately serves to motivate the construction of a strong military nurse identity.

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Glossary

AFDA: Armed Forces Discipline Act 1971

Captain: A commissioned officer in the Army above the rank of lieutenant but below major

Command: An organisational unit under the control of a commander

Commander: An officer of field rank who is in charge of a formation

CO: Commanding officer

CPD: Continuing professional development

DFO: Defence Force Order

DHD: Defence Health Directorate

DMTP: Defence medical treatment protocols

DNS: Director of Nursing Services

Field rank: A senior commissioned officer of the rank of major, lieutenant colonel or colonel

Formation: An arrangement of personnel and/or logistics[1] that generally comprises a group of units

G List officers: Officers on the Army's General List. Non-specialists whose role it is to command soldiers and to plan and execute operations[2]

IC: Officer in command

Lieutenant: A commissioned officer in the Army below the rank of captain

[1] The acquisition, storage, inspection, distribution, transport, maintenance and disposal of materiel.
[2] https://www.defencecareers.mil.nz/army/careers/browse-roles/army-officer/

Lieutenant colonel: A commissioned officer in the Army above the rank of major but below colonel

LOAC: Law of armed conflict

Log: Logistics, or Royal New Zealand Army Logistic Regiment

Major: A commissioned officer in the Army above the rank of captain but below lieutenant colonel

MTC: Medical treatment centre

NCO: Non-commissioned officer who has assumed a leadership role in the enlisted ranks[3]

OC: Officer commanding. Subordinate to commanding officer

OCS: Officer Cadet School

O Group: Orders group. A meeting conducted by a commander where orders are promulgated

Officer: A commissioned officer whose authority is derived from the head of state and who is required to lead and manage others

OSB: Officer Selection Board

PDR: Performance and development report

RAP: Regimental aid post

RFL: Required fitness level

RNZAF: Royal New Zealand Air Force

[3] Enlisted members of an armed force are those who affirm an oath of allegiance to their country and who collectively comprise the bulk of personnel in a defence force.

RNZN: Royal New Zealand Navy

RNZNC: Royal New Zealand Nursing Corps

Role 2: Mobile, forward-positioned military treatment facility

SAS: Special Air Service

SIGs: Members of the Royal New Zealand Corps of Signals

SOIC: Specialist Officers' Induction Course

Unit: A department or group within a military formation

3CI: Values of the New Zealand Defence Force. Courage, commitment, comradeship and integrity

Chapter 1: Background to the study

The Battle of Baghak was an engagement between New Zealand Defence Force (NZDF) personnel, soldiers of the Afghani National Directorate of Security and enemy insurgents in Afghanistan in 2012. During the action two New Zealand soldiers were killed and six more were wounded. While the battle has been the source of much media attention, the presence at the scene of a New Zealand military nurse and the care delivered by that nurse to the dead and wounded has remained largely out of view. A subsequent military court of inquiry found that without the treatment provided by the nursing officer, two of the New Zealand casualties would not have survived (New Zealand Defence Force, 2012a). The nursing officer had been instrumental in training medics who also tended the dead and wounded during the battle. At an earlier International Nurses' Day event, I had been asked by the then Minister of Health Tony Ryall, why the Army needs nurses. It is my hope that this research will begin an illumination of the unnoticed work of military nurses, the challenges they face and the solutions they devise so that justification for what New Zealand military nurses do will no longer be necessary.

Positioning myself in the research

My academic interest in military nursing has come about because I am a lieutenant colonel nursing officer in the New Zealand Army Reserve where I transferred after the completion of a 22 year career in the full-time Regular Force. During that career I served in a range of nursing roles including deploying to East Timor as a flight nurse, and to Afghanistan as a primary healthcare and emergency nurse. My Regular Force career culminated in my appointment as the Director of Nursing Services (DNS) which at the time was the senior Royal New Zealand Nursing Corps (RNZNC) role in the

NZDF. My work as DNS was at times hampered by a lack of availability of evidence based material upon which sound decision-making could be made. In addition and on a personal level, I have always had a commitment to advancing my nursing practice but when I was in the Army I found it extremely challenging navigating my way around Defence Force processes and protocols while at the same time meeting the competencies and ethical standards of the nursing profession. In my later years of full-time military service I came to see significant incongruities between the dual responsibilities inherent in my role. That deficiencies existed in knowledge to draw upon to assist me in my work, and the lack of understanding both within and beyond the Defence Force of what military nurses do and the value they add, was decidedly frustrating.

All military nurses in New Zealand are commissioned officers in the Army. Being a commissioned officer means that nurses must like all other military officers, meet the organisation's expectations for leadership and prioritise the achievement of organisational goals above other workplace or professional demands (New Zealand Defence Force, 2017a). Nursing officers work in a range of specialty areas of practice, in management and health intelligence roles, and they deploy on operational missions and support Government interventions locally which means there is a great deal of variety in the work of a nursing officer. More detail on the employment context of military nurses in this country is provided in subsequent chapters of this thesis.

Being a nursing officer in the Army in New Zealand is an exciting career choice. There are opportunities for advancement that have no parallels in the civilian sector. Attractive salary and professional development packages are available while prospects for travel and regular social and sporting activities are not only on offer, they are a routine and expected part of service life. In return nurses must commit their time and energy to the

Defence Force in ways that can involve significant personal sacrifice. When reflecting upon my own experiences in the Army, it seemed important to me to address the real dearth of research into what that sacrifice might look like or indeed what any aspect of the New Zealand military nurse experience might involve let alone how professional spaces might be navigated.

Study aims and approach

An initial scoping inquiry into what is known of New Zealand military nurses inspired this research undertaking. The overall lack of information on military nursing in New Zealand led to a broad research aim which was to explore how nurses serving in the NZDF navigate professional accountabilities and role expectations.

A qualitative approach underpinned by Foucauldian theoretical concepts that include power, knowledge and governmentality has been employed. Information obtained in interviews with 11 serving and immediately past NZDF nursing officers has been analysed using the thematic technique described by Braun and Clarke (2006).

Contribution to the body of nursing knowledge

Addressing the gap in knowledge of how military nurses in New Zealand balance the at times competing demands of nursing professional responsibilities and those of their Defence employer, is not the only outcome of this study. Important and previously lacking information on nurses' everyday experiences of life in the Army is also presented. The findings of this study will contribute to the international body of military nursing research and provide guidance to the NZDF on the safe and effective utilisation of its nursing personnel. Nurses form the largest group of health practitioners in the NZDF so this study may provide insight into the experiences of other New Zealand military health professionals and also those of other specialist officer groups who, as

will become apparent in the body of the thesis, share some of the challenges that nurses face.

Military nursing has significance for civilian nurses because ways that nurses in the Army have found to be effective when working with different groups may help to improve the quality of care that civilian nurses deliver (Currie & Chipps, 2015). Sharing information, particularly information about how less than optimal environmental and employment conditions can be managed in order for nursing care to continue, adds to the body of knowledge that can be called upon by civilian nurses whose work is becoming increasingly unsafe and where resource constraints are adding to nurses' stress (Hughes, 2015; International Council of Nurses, 2009; Marshall et al., 2017; Willis et al., 2017). In addition, sharing knowledge of the context of what is learnt of war and conflict is an important professional responsibility (Tschudin & Schmitz, 2003).

While military nursing is a discrete world within another world, elements of the research will provide useful information for nurses who work in New Zealand organisations where healthcare is not the organisation's primary purpose such as the Department of Corrections or private industry. Overarching priorities of such organisations may impact upon nurses and therefore healthcare in ways that may not be well understood and which may therefore unknowingly affect productivity or effectiveness (Gerber, 2012; Palmer, 2003). Having knowledge available about how NZDF nurses navigate their widely divergent role responsibilities may help inform the practice of civilian nurses by offering new approaches to working.

It is also anticipated that findings of my research will be useful to non-governmental organisations that employ nurses; particularly those organisations that hold expeditionary mandates or where physical or psychological risk to nursing employees is

a recognised feature of the nursing role. Parallels exist between operational deployments in military settings and off-shore deployments for humanitarian workers (Drifmeyer & Llewellyn, 2004) so the strategies used by Defence Force nurses to meet the expectations of their roles may be similar to those employed by nurses who work for humanitarian organisations. The recommendations presented at the conclusion of this thesis may therefore be relevant to humanitarian organisations.

Structuring the thesis

Presented immediately following this introductory chapter is an in-depth review of what is known in the literature of military nurses. Such an examination is necessary to reveal the experiences, the characteristics and the challenges of military nurses so that an analysis can be undertaken of global issues that may have significance for NZDF nurses. Identifying recurring themes also helps to locate this study of New Zealand military nurses within the wider frame of overall academic work so that the contribution that this research makes to knowledge is clear. Themes covered in the literature review are those that present information on the types of services that military nurses provide and issues of a professional nature that may have an effect on the quality of care that nurses deliver and on nurses' recruitment and retention in defence forces.

What is evident in the review of existing knowledge is that the sub-visibility of military nurses is not an exclusively New Zealand phenomenon. Unless there is a war on, military nurses in many countries feel largely ignored and in some places openly resented. Nursing researchers have made the observation that being viewed as outsiders drives military nurses closer together as a group (Chargualaf, 2017; Zägenhagen & van Rensburg, 2019). This closeness combined with the unique nature of their employment and despite their positioning as outsiders, their very real sense of being part of a military family.

Challenges presented by what is referred to repeatedly in the literature as dual loyalty conflict, will be seen to form a major theme. The literature review will describe how military nurses around the globe appear to prioritise nursing care over military responsibilities, sometimes in extremely harsh environments, yet there exists an expectation by defence forces that military imperatives will take precedence over care delivery. Consequently nurses suffer ethical conflict and the corollary of ethical conflict, moral distress. Although guidance is available on military medical ethics, there is a conspicuous absence of guidance on military nursing ethics. The idea exists that what is appropriate for physicians is also appropriate for nurses; a seriously erroneous assumption if the ethical conflicts that nurses report are not able to be managed within the guidance provided to military physicians.

It is also not helpful for the promotion of ethical nursing practice that nurses rarely resist the assignation of a prevailing 'soldier first' military mentality. Complicating the domain of military nursing ethics lies the vexed issue of nurses possessing military rank. Despite the unusual and problematic assignations of rank in some countries, information is presented that supports the notion that military rank is necessary to enable nurses to be effective in their environments.

Chapter three introduces information about the role expectations and professional accountabilities of New Zealand military nurses. The employment context of New Zealand nurses is presented but I use the term 'employment' loosely because as will become clear, employment for military nurses is not something that is restricted to the hours in which they are physically at work. How institutional structures operate that facilitate this are explained firstly through the provision of a general overview of governing systems and legislative frameworks, and then by an introduction to key concepts and philosophies that underpin the way in which the NZDF operates.

International humanitarian law is introduced in this chapter because humanitarian law is positioned later in the thesis as representing a problematic binary to the soldier first mentality.

Personnel configurations are presented so that an understanding can be gained of the official conduits used by command to expedite management functions. Although a glossary has been provided in the frontispiece of this thesis, important military terms and acronyms are elaborated on in chapter three because in order for the research to achieve its aims, both the overt and covert significance of the specialist language employed by military personnel must be understood. Discipline as a tool to support the powers of command and the achievement of military objectives is described in chapter three so the reader will be able to differentiate between discipline as a rationale for the governmentality of military authority, and discipline as a Foucauldian theoretical construct. Rank and corps are discussed as instruments of authority and to posit their purpose early so that when the instruments are interrogated later in the thesis, that their effects might be fully understood.

Arrangements for healthcare in the NZDF are presented in the final sections of chapter three. How nursing fits within those arrangements is explained as is the way in which nurses are recruited and prepared for military service. Chapter three also contains an overview of nursing governance in New Zealand so that the reader is fully contextualised to the professional accountabilities of all nurses in this country.

Despite defence forces representing some of the most undisguised manifestations of institutional power and authority in the contemporary world, and Foucault's theories presenting some of the most internationally renowned ideas on power, there is a remarkable dearth of Foucauldian inspired military research in the public arena. I have

sought to address this deficiency by underpinning my research with an epistemology founded upon Foucauldian ways of knowing. Chapter four provides a description of the key Foucauldian theoretical concepts that I have used to deconstruct information gathered in this research. Little of Foucault's work is explainable in simple definitions so the chapter is divided into sections with each section focusing upon one main theoretical concept.

Chapter four begins by presenting Foucault's position in philosophy and the relationship between my selection of Foucault and the purpose of this research. The work then moves on to discuss the notion of truth and the challenge that the constitution of the truth presents to subjects residing within different systems. Explanation is given of Foucault's problematisation of the individual and his use of the term 'subject' to represent the individual, not as a free agent as that individual may think of him or herself, but as an instrument of power operating within the systems within which subjects live and work.

The connections between power and knowledge are presented together with the actions and reactions that those connections provoke. Collateral effects of the action of power on groups is investigated followed by a discussion on resistance and why the authority of power is eroded when resistance is absent. Governmentality as a mentality of governance is examined as a product of power with implications for society and institutions and therefore for subjects. How the apparatus of the state usurps the authority of other institutions and groups is discussed. A critical analysis of the illusion that is the truth and the role that judges, subjects and advisors play in perpetuating that illusion is presented. The chapter concludes with a return to the call for a modern pedagogy in military knowledge that is not based on traditional ways of knowing.

Chapter five provides a description of the methodology employed to bound the study. The design of the research is explained as are the processes that were followed to ensure that ethical standards were being met throughout the research process. This includes the ways in which conflicts of interest have been managed and how the confidentiality of participants was and continues to be protected. The procedures followed to gain approval for the research through the ethics committees of both Massey University and the NZDF are explained. Also explained are the thinking processes undertaken to identify and select participants who were most likely to contribute the information needed for the research question to be answered.

The process that led to the decision to employ unstructured interviews as the sole information-gathering technique for the study are presented as are the participant invitation processes, access arrangements and the practical challenges of recording and transcribing participant information. Thematic analysis using the method conceived by Braun and Clarke (2006) is examined to enable the reader to follow the at times complex process employed to manage the study data. Chapter five concludes with a review of how thematic analysis was combined with the selected Foucauldian theoretical concepts to create the final themes that appear in the analysis and discussion chapters.

Chapters six, seven and eight constitute the analysis sections of this thesis. A decision was made to follow Foucault's archaeological principles of thought by presenting the analysis of information as a genealogy of the military nurse's maturing professional identity. An exploration of nurses' inculcation into the Army is conducted in chapter six by drawing upon institutional governmentalities and power relations that create a state of otherness that novice nurses experience in an acute and public way. Notions of competition and status which are important to the professional choices that nurses make

are introduced. Traditional hegemonies in terms of the nurse's place in the healthcare team are uncovered.

Chapter seven extends the revelation of nurses' cultural inculcation by examining within their growing confidence, the strategies nurses employ to reduce their otherness so they can begin to navigate the complexities of their roles. Also revealed are factors that influence the decisions that nurses make to either assimilate into the culture or to offer resistance. What that resistance looks like is examined and the implications of resistance or compliance on both the nurses and on the military institution are discussed.

The final analysis chapter presents the ways in which mature military nurses deliberately or otherwise, exploit their difference to advance military nursing and to protect patients. The notion of dual agency that appears repeatedly in the literature becomes particularly apparent in chapter eight where more experienced military nurses come to recognise that they are serving two masters. Recognition is accompanied by problematisation but also by choice. Those choices are important to the research for here lie valuable clues to answering the research question.

Chapter nine draws upon each of the themes raised in the preceding analysis chapters to speak directly to the research aim. The issue of culture within the military governmentality is presented as an impediment to nurse transition and an obstruction that frustrates the optimisation of nurse potential and presents risks to the NZDF. Why this is so is teased out in the discussion where tactics of domination and multiple forms of othering that serve to legitimise the centrality of combat corps and problematise those that support them, are explored in terms of their effects on nurses. How otherness contributes to the development of a unique military nurse identity that paradoxically mirrors many of the cultural characteristics that nurses vehemently resist is investigated.

In addition to identifying how the New Zealand military nurse navigates professional accountabilities and role expectations, chapter nine compares and contrasts the findings of this research with the literature to enable an informed revelation of the similarities and differences between New Zealand military nurses and their colleagues serving in the armed forces of other countries. Limitations of the study are presented at the conclusion of chapter nine.

The thesis is completed with a summary that draws together the overarching themes of the research to connect the findings with my initial motivations for the study and to demonstrate how the research closes the gap in knowledge that was identified in the literature review. Recommendations for the NZDF based on what has been found in this research are made. Recommendations for further research inquiry concludes the thesis.

Final provisos

Due to the lack of information about the NZDF in the public arena, I have found it necessary to draw on personal communications. These communications can be seen throughout the thesis. In addition, valuable information that had been available on the NZDF website and upon which I relied to inform my research, has subsequently been removed. As the information was originally presented in a portable document format, I have referred to it in this thesis as published material.

Conclusion

This chapter began by introducing military nursing in New Zealand as a largely sub-visible domain. My interest in conducting research that examines military nursing has been explained and the challenges faced by nursing officers that motivated the scoping for this research presented. The study aim and question have been provided along with the approach taken for the conduct of the research.

The gap in knowledge that was identified at the outset of the research has been shown and the contribution that this study will make to the body of international military nursing presented. An overview of the structure of this thesis has been explained to give an indication of the order in which information will unfold and to provide coherence and continuity to connect the chapters together as a complete work.

Unless an understanding can be gained of the ways in which New Zealand military nurses balance the contradictions inherent in the professional discourses of caring and those of the NZDF, it will not be known whether NZDF nurses are working safely. In a country where nursing care is regulated and the primary function of the regulator is to protect the safety of the public, not knowing how nurses work may impede the efforts of the Nursing Council of New Zealand (NCNZ) to carry out its functions in a comprehensive way. Likewise, the NZDF is a Government entity with accountabilities to the public, so the organisation has a vested interest in ensuring that the work performed by its employees meets professional standards. Thus the question of how military nurses in New Zealand navigate professional accountabilities and role expectations needs to be answered.

Chapter 2: Locating military nursing in the literature

Introduction

In the previous chapter I introduced the topic of military nursing as an unheralded service provided to New Zealanders within an organisation known for its combat not its caring capabilities. Presented was information about my motivations to begin examining the nature of military nursing in New Zealand. An indication was provided of the contribution that this work will make to the international body of knowledge, and to the agencies and nurses that will benefit from the research findings.

My aim to explore how military nurses balance the dual responsibilities of belonging to a health profession whilst being employed in the NZDF was provided. This was followed by an overview of the structure of this thesis which begins in this chapter with a review of the literature.

Gathering information about existing knowledge will help to reveal the nature and extent of academic inquiry into military nurses. This knowledge will help to connect what is known about New Zealand military nurses with what is known internationally so that comparisons can be made and conditions for nurses in this country delineated. Reviewing the literature will also provide information on what is not known in the domain so that attention can be focused on gaps in the knowledge. Identifying gaps is necessary to provide the justification for this study into how New Zealand military nurses work.

This literature review begins with a description of the strategy employed to search for information. How the strategy was refined is recounted and then the categorisation of material is presented. A description is provided of that material which is then followed by an analysis of key recurring themes appearing in the literature. Opposing findings are

examined to identify what underlying factors may have been responsible for different outcomes. A declaration on the limitations of the literature review is provided so that what has been found in the review will not be taken as a complete representation of all military nurses. The literature reveals the gap in what is known about military nursing in New Zealand which is reflected in the final section of the chapter by the rearticulation of the research aim and the relevance of this study to nursing in New Zealand.

The military is not a common career choice for a nurse. In New Zealand less than two percent of nurses work for Government agencies with less than one hundred registered nurses working at any given time for the NZDF (Defence Health Directorate Workforce Advisor, personal communication, December 13, 2017; Nursing Council of New Zealand, 2019b). Although it is known that the health sector struggles to meet nursing demand (Nursing Council of New Zealand, 2013), the NZDF tends not to experience difficulty recruiting nor retaining nurses (Defence Health Directorate Workforce Advisor, personal communication, December 13, 2019). That nurses would choose a career in the military when other employers are competing for their services indicates the NZDF is offering an experience that has a distinctive appeal to some nurses. Eliciting why when around the globe the nursing profession seeks to improve health outcomes and enhance lives, would nurses wish to work for institutions where life is not a force to be safeguarded but one which can if necessary be sacrificed, is an aim of this literature review. It is also a fundamental issue of ethics and motivation that underpins my inquiry into New Zealand military nurses.

Search strategy

Determining what is already known about the way in which contemporary New Zealand military nurses work and therefore what gaps in knowledge exist, began with the interrogation of conventional sources of information as well as specialist libraries.

Knowledge gathering began with a search of the ScienceDirect, Scopus, and Web of Science, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), CINAHL Complete, Journals@OVID, Academic Search Premier, EBSCOhost, and Google Scholar databases. The initial search involved seeking articles relating to military nursing in Australia and New Zealand so employed the search terms “military”, “defence”, “defense”, “Army”, Navy”, and “Air Force” together with “nurs*”, “Australia*” and “New Zealand”. ProQuest was also searched to identify dissertations and theses that may have contained information relevant to the review. No limitations were placed on publication dates.

An examination of information returned in the initial search revealed the bulk of articles and texts to be related to military nursing in past conflicts, not to the experiences of nurses in the present period. The search was then expanded to include articles reporting on the experiences of military nurses from all countries however again a significant number of studies were found to be unrelated to contemporary military nursing practice. At this point the search was limited to articles published after the year 2000 and to those published in English. To ensure that newly released material could be assessed for possible inclusion in the research, regular interrogations were made of the DISCOVER and Google Scholar search engines and search alerts registered with Scopus, Ovid and ScienceDirect. DISCOVER was also employed to assist with the identification of specific articles of interest that had been referred to in other publications.

Examination of the reference lists of articles led to the New Zealand Defence Library being consulted so that access could be gained to specific military medicine journals that are not available without subscription. These included the Journal of Military and Veterans’ Health (the Journal of the Australasian Military Medicine Association), Military Medicine (the Journal of the Association of Military Surgeons of the United

States), and the Journal of the Royal Army Medical Corps. Searches of these publications returned not only reports of research studies but also commentaries and practice literature. Through reference lists in these journals, textbooks on military medicine which included sections on military nursing, were identified. No textbooks nor journals were found that related exclusively to the practice of military nursing.

The internet became a source for material relating to nursing policy and for information about the NZDF. The official NZDF website provided documents published by that organisation as well as documents produced by the New Zealand Army, the Royal New Zealand Air Force (RNZAF) and the Royal New Zealand Navy (RNZN). The website also contained Single Service and NZDF newspapers and magazines including the NZDF Force4NZ and the Army News. Throughout the course of this research, the NZDF website was continually monitored for the latest versions of strategic documents and for commentary and information on the provision of New Zealand military health services and military nursing. The official websites for the NCNZ, the College of Nurses Aotearoa (New Zealand) and the New Zealand Nurses Organisation became important sources of information relating to the strategic direction, governance and guidance of nurses.

One hundred and seventy four articles were shortlisted using the search terms and limiters described above however, because the purpose of this research is concentrated on professional matters, articles with a focus on clinical interventions were excluded. Once the exclusion criterion was applied, eighty seven articles remained. A small number of articles not relating specifically to military nurses has been referred to in this literature review to allow for the explanation of certain militarily unique phenomena. The X9 version of the EndNote bibliographic and citation computer software

programme by Clarivate Analytics has been employed to assist with the management of references.

Military nursing as a select identity

The literature advises that defence nursing is a form of occupational healthcare that contains multiple, mobile domains (Currie & Chipps, 2015). Military nurses work across a range of specialty areas of practice that have been tailored to meet the specific needs of the employing defence organisation (Sheard et al., 2016). In general nurses provide emergency and primary healthcare, and depending upon the size and requirements of a service, secondary and tertiary care (Berry-Cabán et al., 2018; Finnegan et al., 2015). Whilst patient populations in the civilian sector are similar to those in many defence forces, where categories of civilian patients depart from military patients is during times of crisis. This is because the casualty rates and the nature of injuries sustained during disasters and combat are rarely seen in civilian practice so military nurses must be prepared to respond to an unstable demand (Beaumont & Allan, 2014; Rivers, 2016; Tyler et al., 2012).

Nurses are not always valued in armed services yet they claim full membership of the military (Bassett, 1992; Scannell-Desch & Doherty, 2010). Southby (2003) asserts that unless there is a war on, nurses receive little attention, a sentiment expanded on by Bassett (1992) and Rogers (2003) who believe that any attention military nurses do receive is because they are conspicuous outsiders who are thought to be unnecessary and expensive tack-ons to combat forces; thinking that is vociferously contested by the nurses themselves (Bassett, 1992; Griffiths & Jasper, 2008; Rogers, 2003). Yet despite marginalisation, defence nurses feel a strong sense of belonging to a military family (Cox, 2005; Embrey et al., 2019). Factors that contribute to this connection include the requirement for nurses to wear the uniform of their service and to hold military rank,

and the need for nurses to not only work but to live alongside other service personnel (Bassett, 1992; Elliott et al., 2017). Due to the nature of defence forces, nurses are not always located near their families and friends so those with whom nurses live and socialise take on the guise of a family (Foley et al., 2000; Scannell-Desch & Doherty, 2010). Living and working together increases camaraderie and nurses' sense of a shared identity (Elliott et al., 2017).

An important factor underpinning the military nurse identity is the existence of a common overarching ideology that defence nurses have answered a calling to provide a service to their country (Elliott et al., 2017; Rushton et al., 2008). This philosophy is a powerful motivator that encourages nurses to support one another and to engage in wider military activities which in turn contribute to the success of nurses in their roles (Finnegan et al., 2016; Griffiths & Jasper, 2008). Support and engagement also serve to reinforce nurses' sense of their military selves and to promote the notion that their group's identity is unique to them (Chargualaf, 2017; Currie & Chipps, 2015; Finnegan et al., 2016; Griffiths & Jasper, 2008). It is thus unsurprising that many nurses find their military careers extremely rewarding (Hagerty et al., 2011; House, 2007; Pierce et al., 2018).

There exists however a negative corollary to a rewarding career. Military nurses suffer a significant sense of loss when the time comes for them to retire from service (Elliott et al., 2017; Thompson et al., 2014). The lack of recognition that nurses have as full members of the armed forces may have an influence on the success of their transition out of the services as evidenced in reports that nurses are often not aware of retirement support programmes that are routinely available to other military personnel (Elliott et al., 2017). If military nurses' reintegration into the civilian sector is not optimised, the contribution they make in subsequent civilian nursing roles may be reduced.

The assignation of dual roles

There is wide agreement that a career in military nursing means subscribing to two coexisting professions; that of healthcare and that of soldiering (Chargualaf, 2017; Griffiths & Jasper, 2008; Ruff & Roper, 2013). Whilst nurses take for granted their professional requirement to maintain nursing competence, working for defence forces also involves acquiring and maintaining military skills so that the regimental responsibilities that are a requisite of military service can be performed (Clifford, 2007; Kenward et al., 2017). Working for defence forces, whether as commissioned officers or as enlisted nurses,[4] requires individuals to be deployable which for nurses means being physically fit and possessing the skills to protect themselves and their patients from harm (Clifford, 2007; Cuellar, 2009; International Committee of the Red Cross, 1949; Kenward et al., 2017).

Military competence necessitates the acquisition of proficiency in non-nursing skills. Defence health personnel are required to learn how to use personal weapons and protective equipment, to gain the skills to survive and work in adverse climatic conditions and in combat, to understand military strategic and operational decision making, and to be able to contribute to the effectiveness of any military force to which they may be attached (Agazio, 2010; Lindblad & Sjöström, 2005). To meet these requirements nurses must attend courses, participate in military exercises and at times, perform non-nursing roles (Clifford, 2007; Kenward et al., 2017).

Whilst military health professionals are governed and supported by the same professional, educational and regulatory arrangements as those of their civilian counterparts, the contexts within which military health professionals operate are quite

[4] In some countries such as Great Britain, nurses may be recruited as enlisted personnel or as officers. Most countries recruit nurses exclusively into the corps of commissioned officers.

different to those of their civilian colleagues. Constantly changing places of work, patient dependencies, and conditions on operational deployments add unique layers of complexity to the work of defence health professionals (Collen et al., 2013).

At times military imperatives can conflict with the principles that underpin healthcare so ethical dilemmas are a concern for military health personnel (Thomasma, 2003). Ethical dilemmas have attracted considerable attention in military medical literature where it is commonly presumed that a dichotomy exists that positions physicians at odds with the profession of arms (see for example Gross, 2006; Neuhaus et al., 2001; Sparacino & Beam, 2003).

Southby (2003) makes the claim that although nursing ethics differ from the ethics of physicians, ethical challenges that military nurses face are not substantially different to those of doctors. Southby advises nurses to apply the same ethical decision-making principles that have been recommended to the medical fraternity (Southby, 2003). This is a position that would be contested by Johnstone (2017) who asserts that ethics for nurses is based on "*actual experiences* [italics author's] as opposed to hypothetical examples or the experiences of members from other disciplines, which are not always relevant to nursing" (p. 144). That the medical profession is the focus of ethical arguments in military healthcare certainly suggests that in defence forces, what applies to medicine also applies to nursing however, it may also suggest that medicine holds a hegemonic place in the thinking of military ethicists and that military nursing ethics may in fact be a very real concern for nurses but one that is not visible.

Ethical controversies are largely absent in military nursing literature but only if what is sought are the same types of dilemmas that physicians face. As will become apparent in the next section of this chapter, nurses face nursing ethical challenges, not medical ones,

and it is clear that the advice proffered to preserve the moral position of military doctors, is either not being observed by nurses or it is not fit for nurses' purpose.

What also seems largely absent in the literature is the part that non-health commanders play in assisting health professionals to maintain a safe and ethical balance between their dual roles. Multiple studies describe nurses struggling on a daily basis alone to reconcile their nursing responsibilities with their officer and soldiering obligations (Clifford, 2007; Jenkins et al., 2006; Van Rensburg & Zagenhagen, 2017). Many commanders do not appear to understand the professional accountabilities of military nurses and routinely expect them to prioritise regimental functions ahead of clinical work (Ekfeldt et al., 2015; Hodgetts & Findlay, 2012). Holding the opposing position are many nurses who, whilst understanding the need for flexibility, focus their efforts primarily on delivering care to patients (Hodgetts & Findlay, 2012). This dichotomy reveals that inherent tensions exist in the dual roles of military nurses.

A dichotomy of discourses: Balancing being a soldier with being a nurse

Compliance with commanders' priorities can challenge the ability of nurses to meet their professional responsibilities (Clifford, 2007). Nurses worry about the effects that spending time performing military duties has on the maintenance of their clinical skills which, in the absence of designated minimum hours, is often left to the individual to work out (Clifford, 2007; Finnegan et al., 2015; Jenkins et al., 2006; Kenward et al., 2017). Whilst the protection of clinical time is problematic for nurses who hold nursing posts, the issue is compounded for those who are assigned to non-nursing roles (Finnegan et al., 2015; Griffiths & Jasper, 2008). Some defence forces view nurses as a generic resource which can lead to nurses being posted for significant periods of time to general military jobs. When nurses in those jobs are required to return to nursing practice, questions of clinical competence arise. Addressing the issue of lost

competence can involve the need for nurses to undergo extensive and expensive reorientation yet because commanders do not always understand the need for competence maintenance, the ability for nurses and nurse managers to negotiate reorientation or indeed clinical release and professional development time, can be stymied (Kenward et al., 2017). Barriers to competence maintenance serve as a major and ongoing source of frustration for nurses (Foley et al., 2002; Jenkins et al., 2006; Kenward et al., 2017).

A common refrain appearing in the literature is that a military nurse is a soldier first (Lundberg et al., 2014; Thompson & Mastel-Smith, 2012; Zägenhagen & van Rensburg, 2019). Soldier first thinking reflects military ideology that irrespective of trade or profession, all defence personnel must as their primary purpose, prioritise the skill of arms (Harding, 2016). Notwithstanding matters pertaining to clinical practice, nurses agree that as defence employees they must maintain military competence (Agazio, 2010; Kenward et al., 2017; Lundberg et al., 2014). Although nurses experience frustration with balancing their clinical and military time, some studies report that nurses are able to find solutions to competing demands.

In Britain it is reported that Army nurses subscribe to the wearing of two metaphorical hats; one representing nursing and the other, the military (Griffiths & Jasper, 2008). The nurses describe putting on their warrior hat when physical threat is present and then exchanging it for a nursing hat once the threat has passed. Ease of changing roles is also reported in a study from South Africa where nurses are said to compartmentalise their dual responsibilities but to change readily when required (Van Rensburg & Zagenhagen, 2017). However researchers in Sweden claim that military nurses find it difficult and stressful exchanging soldiering orientations for those of nursing, especially during periods of high operational tempo (Ekfeldt et al., 2015). Difficulties have also

been reported in the US (United States of America) where novice Air Force nurses are said to struggle balancing officer commitments with those of nursing (Chargualaf, 2017).

There appear to be several reasons behind the differing findings. Participants in Griffiths and Jaspers' study were with few exceptions, very experienced both as nurses and as military personnel. In addition, many of the participants had deployed multiple times. This suggests that experience has a part to play in facilitating seamless transitions between nursing and soldiering orientations. Participants in the South African study consisted of two groups: experienced military nurse educators and inexperienced nursing students. Nurse educator participants were reported to be concerned about the need for students to be able to effectively balance their nursing and military roles so the educators provide specific teaching on ways that early career nurses might manage dual loyalty conflict.

The two studies that report on nurses struggling to make role adaptations represent both experienced and inexperienced nurses. The investigation of Ekfeldt et al. (2015) was conducted with experienced nurses on military operations who were deployed as soldiers who possessed nursing skills, not as nurses who possessed soldiering skills. This primary military orientation was explained as being necessary because their military force was positioned in a combat zone. The constant presence of threat may have had a bearing on the major challenges with multitasking that the nurses reported and with the rapid reorientation to nursing that was required when casualties presented.

In contrast, Chargualaf's US Air Force study participants worked in non-deployed nursing specific roles. Support in the form of preceptorship and role modelling for this group of novice nurses was conspicuously absent. Lack of guidance balancing nursing and officer responsibilities was reported to have contributed to feelings of stress and

frustration (Chargualaf, 2017). Chargualaf's concerns about the effects that managing dual roles can have on the wellbeing of inexperienced nurses is shared by Van Rensburg and Zägenhagen (2017) but novice participants in this latter study were provided with the skills to deal in a practical way with dual loyalties. Thus it appears that nursing support in the form of preceptorship, role modelling and education may compensate for lack of experience but neither support nor experience compensates for decisions that place nurses in roles that career soldiers would normally perform.

Although the soldier first mentality clearly presents ethical challenges for nurses, only one study reported nurses offering resistance to it. Zägenhagen and Van Rensburg (2019) who examined the influence of rankism on the ethical competence of military nurses, found a covert programme operating within the ranks of nurses where nurses worked to undermine the influence of the military in clinical areas (Zägenhagen & van Rensburg, 2019). The programme appears to have evolved following reports by student nurses that a culture exists in the military that commodifies patients. Nurse educators are said to believe that such a culture presents a challenge to nursing's ethical standards so educators began colluding with students to facilitate the retention of patient autonomy. Advice is provided on assertiveness and patient advocacy so that students can be confident enough to prevent military commanders from entering health clinics and to confront commanders if they attempt to interfere with clinical care. A finding of the study was that the South African Defence Force authorises the discrimination of patients based not on their medical condition, but on their rank (Zägenhagen & van Rensburg, 2019).

Rank as a contested space

The issue of rank for nurses is vexed. Rank is an historic system of power that ascribes grades of authority according to criteria based on leadership and military value (Mattila

et al., 2017). With few exceptions, armed forces assign rank to nurses using the same criteria that is applied to other military personnel (Bassett, 1992; British Army, 2020; McNabb, 2015; RegisteredNursing.org, 2020; Royal Navy, 2020). According to Cole (2006), rank applied to nurses in this way provides a mechanism for institutional control that instrumentalises nurses within the power paradigm of defence organisations which results in nurses appearing not as healthcare professionals, but as enforcers of authority. Perceptions of nurses as authoritarians impedes effective communication and interferes with the empowerment of patients (Cole, 2006; Varpio et al., 2018). Thus rank is believed to negatively impact upon the therapeutic alliance (Cole, 2006; Foley et al., 2002; Van Rensburg & Zagenhagen, 2017). It is claimed by some authors that nurses recognise the risk that rank presents to patients so they make a conscious effort to use their rank in ways that are appropriate for the care delivery environment (Bassett, 1992; Elliott et al., 2017; Finnegan et al., 2016).

Kiernan et al. (2013) contend that nursing in the military holds a privileged position that actually transcends all ranks. Possessing the ability to transcend all ranks is not however always evident in what nurses have to say about hierarchies. Low ranking but professionally experienced nurses claim their clinical expertise is not always recognised in decision making so patient care is not always optimised (Beaumont & Allan, 2014; Conlon et al., 2019). Claims of lack of professional recognition provides evidence that an incompatibility exists between rank and the conventional skills based system the nursing profession employs to assign leadership and status (Beaumont & Allan, 2014). In addition to its direct impact upon care, rank is believed to have a secondary effect on patients by the way in which it creates barriers to effective interprofessional collaboration and communication, and because it is a source of confusion for nurses

who are new to military service (Chargualaf, 2017; Cole, 2006; Varpio et al., 2018; Zägenhagen & van Rensburg, 2019).

So while nursing may be thought to hold a privileged position, in practice many nurses appear unable to balance nursing's traditional hierarchy with the authority of military rank. Instead rank appears to be a contested space punctuated by interprofessional conflict and patient risk (Beaumont & Allan, 2014; Varpio et al., 2018; Zägenhagen & van Rensburg, 2019). Yet despite the challenges that it presents in clinical practice, there is general agreement that rank reflects advanced levels of leadership and military competence (Beaumont & Allan, 2014; Chargualaf, 2017; Griffiths & Jasper, 2008). The literature is rich with description of the conditions on operational deployments that contribute to military expertise and therefore to rank.

Materialities of deployment

Operational deployments are often places of austerity (Conlon et al., 2019). Care may be required to be delivered in tents, trailers, warships, cargo aircraft, shipping containers, trucks and armoured vehicles (Cox, 2005; Lindblad & Sjöström, 2005; Richie-Melvan & Vines, 2010; Scannell-Desch & Doherty, 2012). The surroundings can be confined, crowded and noisy with care commonly compromised by the presence of dust, mud, rain and toxic chemicals, and by infectious diseases and extremes in temperature (Agazio, 2010; Aronson et al., 2006; Cariappa et al., 2018; Cuellar, 2009; Finnegan et al., 2016; Fullerton & Ursano, 1994; Scannell-Desch & Doherty, 2010; Tollerud et al., 2011).

Nurses report that medical stores are often scarce (Agazio, 2010; Cuellar, 2009; Ekfeldt et al., 2015). Supply lines are a challenge attributable to extended distances between tactical locations and a contingent's country of origin, and by disruptions caused by the

interdiction[5] of materiel[6] by enemy forces (Kress, 2002; Ross et al., 2008). Compounding the difficulties that nurses experience with resupply is climatic thermal damage to stores that exacerbates increased demand for logistics (Agazio, 2010). In addition, there are times when the availability of equipment and supplies can be wholly dependent upon the ability of nurses to physically carry them (Lundberg et al., 2014).

Compounding environmental difficulties are risks associated with battle. Nurses working in combat zones are vulnerable to injury from not only small arms fire but mortar attacks, rocket propelled grenades and improvised explosive devices (Cuellar, 2009; Kelly, 2014). Nurses' safety is further compromised when they are required to work with enemy detainees because prisoners of war do at times attack their carers (Ross et al., 2008; Thompson et al., 2014). If a military nurse is the only health professional deployed to a location and that nurse were to become injured, his or her survivability has been noted to be less than if a soldier had been injured because first response soldiers do not possess the advanced emergency skills of health professionals (Ekfeldt et al., 2015; Lundberg et al., 2014). Overall the working environment for military nurses can be particularly challenging (Agazio, 2010).

Implications of military technologies on the self

Austerity and threat exact an emotional toll that can have a negative impact on the rest of the force (Finnegan et al., 2016; Thompson et al., 2014). Nurses report high levels of stress due not only to the difficulties that deployments present to care delivery, but to lack of privacy, overcrowding, inadequate rest and sleep, poor facilities to manage personal hygiene, and fear (Cox, 2005; Kelley et al., 2017; Rushton et al., 2008; Scannell-Desch & Doherty, 2010). Wellbeing affects the ability of nurses to perform

[5] The delaying, disruption or destruction of an enemy's troop or supply lines.
[6] Equipment, apparatus, and supplies of a military force.

their roles effectively because when nurses are not in optimal health, patients are impacted (Scannell-Desch & Doherty, 2010; Stanton et al., 2017). In addition, while nurses may be subject to the same stressors as their combatant colleagues and therefore susceptible to the same effects of stress, they are required to manage not only their own anxiety, but to support others in theirs (Lindblad & Sjöström, 2005). The maintenance of nurse wellbeing is an important contributor to mission success because one of the fundamental purposes of a military health service is to support the morale of the combat force (Vogt, 2015). Without morale, service personnel are reluctant soldiers and when soldiers are reluctant to fight, missions are placed in jeopardy (Shephard, 2001; Squires & Peach, 2020).

Despite this seemingly dismal situation, military nurses are not discouraged but instead report high levels of job satisfaction (Finnegan et al., 2016; Pierce et al., 2018; Zangaro & Kelley, 2010). Reasons contributing to military nurses' job satisfaction are significant degrees of autonomy and confidence, high levels of collegial support, trusted leadership, and the intrinsic motivation of military nurses to serve others (Agazio, 2010; Chargualaf, 2017; Pierce et al., 2018; Rushton et al., 2008). While all factors that contribute to job satisfaction do not always exist concomitantly, the presence of significant levels of other role satisfiers appear to compensate so that on the whole, job satisfaction is consistently high (Foley et al., 2002; Jumat et al., 2014; Pierce et al., 2018).

Several underlying factors that contribute to job satisfaction relate directly to operational missions. New skills are introduced during pre-deployment training that incorporate the sharing of knowledge gained from those who have previously deployed, and from the reinforcement of specific military skills (Finnegan et al., 2015; Steele et al., 2010). Confidence is built when nurses receive additional training however although

it is acknowledged that no amount of additional learning will ever completely prepare an individual for operations, it appears that irrespective of their level of experience, nurses believe in their ability to adapt their existing knowledge to whatever situation that might arise (Agazio, 2010; Baker, 2007; Beaumont & Allan, 2014; Conlon et al., 2019; Ekfeldt et al., 2015; Lindblad & Sjöström, 2005; Rivers & Gordon, 2017). Therefore the confidence that contributes to nurses' job satisfaction plays an important part in operational preparedness.

Limitations of knowledge in the international sphere

Publication of military nurse studies tend to correspond with periods of armed conflict, particularly in relation to US defence nurse studies and conflicts within which the US engages. The US Armed Forces TriService Nursing Research Programme was established in the 1990s and due to the support provided by congressional funding, military nursing research is more advanced in the US than in other countries (Hatzfeld & Jennings, 2017). Consequently much of the research included in this literature review originates in the US so the review's findings tend to reflect the experiences of American military nurses more than they do the experiences of nurses from other nations.

Locating the archive of New Zealand military nurse knowledge

What is known of contemporary military nursing in New Zealand is limited to two peer reviewed academic reports, one non-peer reviewed journal article, a masters' degree thesis, and the official NZDF website. This information advises that RNZNC nursing officers work across a range of specialty areas of practice monitoring and promoting the wellbeing of military personnel and others (Sheard et al., 2016). New Zealand military nurses work collaboratively with members of the wider healthcare team, undertake health surveillance and planning, provide health education, undertake casualty

evacuation, and deliver nursing care to sick and injured servicemen and women at home and on operations (Argyle, 2015). Like their colleagues in the Royal New Zealand Army Medical Corps, RNZNC officers can be required to care for members of other military forces, for civilians and for enemy prisoners of war (Sheard et al., 2016). In addition, nurses may be asked to work in roles that sit outside the ambit of nursing and to advance into health management and higher leadership positions (New Zealand Defence Force, 2020).

In order for NZDF nurses to meet their regulatory requirements, it is necessary for them to adapt professional principles and nursing knowledge to the defence context however due to the unique nature of military nursing, articulating competence in terms that can be understood by both NZDF managers and civilian nursing agencies can be problematic (Argyle, 2015). Professional responsibility places the onus upon the nurses themselves to recognise how their working environment impacts upon the care they provide (Nursing Council of New Zealand, 2020c) however although a NCNZ approved NZDF Professional Development and Recognition Programme (PDRP) is in place to help facilitate interpretation of military nurses' competence in ways that meet both the needs of the NCNZ and the NZDF, the programme does not appear to have achieved this goal. The PDRP is criticised for its failure to adequately capture the nature of military nursing and therefore to meet its potential as a tool to assist nurses to reflect upon and improve their practice (Argyle, 2015). More worryingly is that such criticism raises concerns as to whether NZDF nurses are accurately recording their military work in PDRP, but are instead recording their practice in ways that can be recognised by civilian agencies but which are not a true reflection of the dichotomous competencies they possess.

Although there are a range of articles that describe the nature of military nursing internationally, the predominance of reports based on the experiences of nurses who work for the very large US Army, Air Force and Navy makes it difficult to extrapolate information that would be applicable to the New Zealand military nursing context. This literature review exposes a lack of knowledge on how military nurses in this country work to address their dichotomous positions. This absence forms the justification for conducting an exploration of how nurses while serving in the New Zealand Force, navigate professional accountabilities and role expectations.

Summary

This chapter has provided information on recurring topics in the literature that relate to professional issues that nurses in defence forces around the world experience in their work. The search strategy to find this information was explained as was the exclusion criteria that had been applied to ensure that the material yielded would provide the most relevant information for this purposes of this research. Major themes included the notion that military nurses subscribe to a distinct identity, that defence nurses are required to perform dual roles which can create uniquely military nursing ethical dilemmas, that rank can be problematic, and that operational deployments can present extreme challenges that have the potential to negatively impact upon the wellbeing of military nurses. Despite the challenges, the literature indicates that military nurses approach their work with an overarching sense of service and purpose which together with autonomy in practice and collegial support, contributes to significant job satisfaction.

The literature review contains a caveat in that due to a proportionately large number of studies originating from the US, the findings predominantly reflect the conditions for nurses in the US Armed Forces. What is not present in the literature are any published

studies of how military nurses in New Zealand balance the dual responsibilities inherent in their roles as nurses and military officers. The chapter concluded by stating that this gap in knowledge requires investigating and it is the intention of this thesis to report on my research that did that.

The next chapter will introduce the strategic environment and the employment arrangements of New Zealand military nurses so that the reader will have some understanding of the context within which RNZNC nurses work.

Chapter 3: Governmentalities, materialities and military nursing in New Zealand

Introduction

The first two chapters of this thesis introduced the topic of military nursing and my interest in it. I explored the literature to elicit what is known of nursing in defence forces globally and explained where a gap in knowledge about New Zealand military nurses lies. I now move on to explain more about the NZDF and the place of military nurses in the organisation.

Chapter three begins with a synopsis of the employment context of the NZDF. The chapter is divided into two sections with the first section introducing the NZDF as an arm of Government which situates the military within New Zealand's legislative and strategic environment. Governing structures and the systems that operate within the NZDF are described as are some of the key policies that interpret and connect legislation with resourcing and outputs. Basic military configurations are introduced and their primary purpose and functions discussed within a frame of military discipline. An overview of important military historical and cultural conventions is provided and the relationship of these conventions with organisational values explained.

A commentary on health services in the Defence Force forms the second section of chapter three. The purpose for and the configurations and systems of military healthcare are explained. An introduction to the groups of health professionals represented in the NZDF and the nature of their work is provided. A brief overview of systems of nursing governance in New Zealand follows which then segues into a description of the services that military nurses provide. The chapter concludes with more detailed information on the recruitment, training and the nature of work of members of the RNZNC.

The New Zealand Defence Force in the strategic environment

The mission of the NZDF described in the NZDF 2018-2019 Statement of Intent (2018) is to "secure New Zealand against external threat, to protect our sovereign interests, including in the Exclusive Economic Zone, and to be able to take action to meet likely contingencies in our strategic area of interest" (p. 7). The NZDF does not work in isolation; it is an instrument of the Crown that can be activated by the Government, alone or in conjunction with other agencies, to protect New Zealand's borders and interests (Ministry of Defence, 2018).

Whilst military officers administer the NZDF from within, civilians authorise, fund and preside over the organisation (Defence Act 1990). The State governs the Armed Forces through constitutional and legal frameworks that provide strict parameters within which the NZDF must operate. The Ministry of Defence works with the NZDF to design defence policy to ensure alignment with strategic Government priorities. In turn the NZDF must configure military force elements[7] in ways that will meet the security challenges for which the Government wishes to be prepared. Force elements are what constitute defence capability and include personnel. The ability to raise, train and maintain quality personnel is a major focus of the Defence Force for personnel are the organisation's greatest asset (Ministry of Defence, 2016b, 2019).

International humanitarian law

International law forms part of New Zealand law and therefore applies to the NZDF and members of the NZDF when they are deployed or at home. The purpose of the NZDF and the State sanctioned mandate it has to exert force to achieve military objectives

[7] Force elements are the range of military forces that contribute directly to the outputs of the NZDF. They must be prepared to operate independently for a specified period of time therefore require their own logistics and medical support (Ministry of Defence, 2019a).

makes international humanitarian law particularly important. These laws provide for the protection of non-combatants and civilian property from the effects of armed conflict. They also set boundaries around the ways in which wars are fought and subject combatants to the rule of law.[8] The Geneva Convention (International Committee of the Red Cross, 1949) is the most widely known constituent of international humanitarian law however other treaties and customary law also form major components. Respect for international humanitarian law together with regard for human rights and the rule of law underpins the ethos of the NZDF (Ministry of Defence, 2019; Weiss, 2012).

Defence Act and the role of the Armed Forces

The Governor-General is vested with the constitutional authority to raise and maintain Armed Forces (Defence Act 1990) however, under the United Kingdom's Bill of Rights 1688 which forms part of New Zealand constitutional arrangements, funding for the Armed Forces is dependent upon Parliamentary appropriation. The Defence Act 1990 specifies that the role of the Armed Forces is to defend New Zealand and New Zealand's other territorial dependencies such as Niue and Tokelau, to protect the interests of New Zealand, to contribute forces under collective security arrangements or in support of the United Nations, and to provide assistance in civil emergencies or for other public service. The Defence Force is a component of New Zealand's foreign and security policy and comprises the New Zealand Naval Forces, the New Zealand Army (Army) and the Royal New Zealand Air Force (Defence Act 1990).

[8] The rule of law is the fundamental principle that underlies the constitution of New Zealand. The principle asserts that power exercised by governments must be based on legal authority. This authority is underpinned by minimum standards of justice that safeguard against the abuse of power which in turn, prevents discrimination and the deprivation of civil liberties (Ministry of Justice, 2015).

New Zealand Defence Force strategy

The Government sets the terms of reference for the NZDF through Defence White Papers (Defence Act 1990). In the most recently released White Paper of 2016, the Government assessed that New Zealand's was unlikely to face any direct military threat however it was determined that terrorism will continue to be a challenge for the country as will fragility in the South Pacific region (Ministry of Defence, 2016b). Based on this security assessment, the Government has determined the ways in which the NZDF will contribute to the protection of New Zealand's interests. These include diplomacy, arms control, development assistance and supporting United Nations to maintain international peace and security and to protect the international rule of law (Ministry of Defence, 2016b).

The priorities of the NZDF are described in the Defence White Paper with particular reference being made to the special relationship that New Zealand has with Australia (Ministry of Defence, 2016b). Secondary only to the protection of New Zealand's sovereignty is the requirement for the NZDF to operate with the Australian Defence Force in order to protect Australia's territorial sovereignty. The White Paper also broadly defines how the NZDF will meet its obligations to the Government. The organisation must be equipped and trained for combat as well as for peacekeeping and for humanitarian assistance, to be deployable, and to be able to operate alongside New Zealand's principal defence partners.

Defence Force statements of intent describe in more detail how Defence assets will contribute to the Government's priorities (Ministry of Defence, 2019). New Zealand's strategic environment is interpreted in terms of NZDF contributions, known as operating intentions, to the Government's security outcomes. These operating intentions are then categorised into military employment contexts that represent those security

events for which the Government is most likely to require a military response. Having clearly specified operating intentions enables the NZDF to understand where resources should be concentrated, how military capability should be configured, and what planning and training will be required to achieve the defence outputs required by Government. The statements of intent separate strategic security challenges into domains, each containing a number of related threats.

The majority of employment contexts require a New Zealand military response to be self-sufficient in terms of logistics, personnel and health support. In cases where New Zealand is not the only contributor to a Defence outcome, such as when the NZDF works in collaboration with other New Zealand agencies or when the NZDF forms part of a multinational military response, elements of capability that are normally assigned to the NZDF may be provided by other bodies or by the militaries of other countries. In turn, the NZDF may be required to provide support to external organisations or militaries (Ministry of Defence, 2019).

Military capability

Military capability is described as "the power to achieve a desired operational effect in a selected environment and to sustain that effect for a designated period" (New Zealand Defence Force, 2013, p. S1-7). NZDF doctrine describes the major components of military capability. These include personnel, research and development, infrastructure, concept of operations and collective training, information technology, and equipment and logistics (New Zealand Defence Force, 2017d). According to doctrine, fighting power is optimised when each of these components are combined effectively with performance, readiness and sustainability. The physical components of fighting power are configured in ways that are designed to achieve different capability effects. These

groups, known as task groups, provide options that can be used to meet those security threats described in the statement of intent (Ministry of Defence, 2019).

While Defence policy captures larger configurations of health services in output classifications, health elements embedded within non-health units are not so clearly represented. Frequently primary health service sub-units are organic[9] to combat units with the combat unit featuring as the only capability output. Smaller health elements do not contribute directly to combat capability outputs however their existence is necessary to support force elements to achieve a state of readiness (New Zealand Defence Force, 2019a).

Output plans are produced each year to provide direction to the Armed Forces. The plans explain in more detail than statements of intent how military capability is to be configured to meet the operating intentions of the NZDF. The plans hold information on where health elements in the NZDF are held and also describe the reporting lines and roles of health personnel. The terms 'medical' and 'health' are used interchangeably in these documents although comparisons with earlier output plans demonstrate a shift in language with the military's use of these two terms beginning to align more closely with those of the civilian health sector. However as there are no definitions provided in output plans, it is unclear whether there is intended to be a distinction between the medical and health elements described.

Structure of the New Zealand Defence Force

The NZDF is structured in a hierarchical manner under the three single services of New Zealand with responsibilities and accountabilities aligned to the capability outputs of each of the services. Each service is comprised of Regular Force and Reserve uniformed

[9] The term organic in a military context refers to a capability that is assigned to and forms an essential part of a military unit or organisation.

personnel and a significantly lower number of civilian employees. Regular Force personnel are mainly employed full-time while Army Reservists are part-time. Reserve personnel train with the military in order to be adequately prepared to provide support to operational deployments and to any other tasks where the Regular Force requires supplementation.

Command is the mechanism through which military power and authority is exercised. How command operates and over whom is an important feature of the Defence Force. When personnel are working or training at home in New Zealand they remain under the command and control of their posted unit however, when personnel deploy on operations they may not necessarily depart with this unit. Depending on the operation and the task to be performed, personnel may deploy with an element of their own unit or as an individual attached to another unit or to a composite unit that has been raised especially for the deployment. In these latter circumstances personnel fall under what is known as the operational command of the new unit (New Zealand Defence Force, 2013).

The most senior commander in the NZDF is that of the Chief of Defence Force. The Governor-General appoints the Chief of Defence Force to the role to enable a serving member of the Armed Forces to hold overall command of the RNZN, the Army and the RNZAF (Defence Act 1990). The conduit to the role of Chief of Defence Force has been almost exclusively through warfare branches of the Defence Force, these being the Armoured, Infantry and Artillery Corps of the Army, pilots and navigators of the RNZAF and principal warfare officers of the RNZN. Since 2009 only warfare branch officers have held the necessary rank for selection to Chief of Defence Force and up until 2007 these branches excluded women (Ministry of Defence, 2014b).

Discipline

The Defence Act authorises the Chief of Defence Force to issue orders to enable him to carry out his functions. The Chief of Defence Force can in turn approve others to issue orders under the Act but any orders must comply with the provisions of the Defence Act, the Armed Forces Discipline Act 1971 (AFDA) and every other law of New Zealand. The AFDA is the basis for discipline in the NZDF that applies only to uniformed personnel or in very exceptional circumstances, to civilian employees and those attached to the NZDF. The AFDA is designed to support the power of commanders to carry out their duties under the Defence Act so actions or behaviours that undermine the achievement of Defence objectives can be punished. In addition, any offence under civil law is also an offence under the AFDA. The AFDA provides the mechanism by which discipline is enforced and all members of the Armed Forces are made aware of the enforcement process.

There are inherent risks with serving in the Armed Forces which a service person accepts upon attestation.[10] Members may be called upon to place themselves in harm's way in order to protect the interests of New Zealand. They may be required to exert lethal force in the course of their work and they may in turn be subject to such force. On operational deployment military personnel may be separated from family, exposed to harsh environmental conditions and experience fatigue and loneliness. Training exposes individuals to the types of pressures they might expect on deployment thereby preparing and improving the ability of service members to contribute to mission goals. The AFDA supports training objectives by ensuring that individuals learn to obey orders in the supervised training environment where patterns of behaviour are established and the

[10] Military attestation is the process whereby a new recruit affirms an oath of allegiance to the Sovereign. From the time of the swearing the oath and until the military person is released from service, he or she commits to serve whenever they are needed (Defence Act 1990).

impacts of failure to obey orders are less significant (New Zealand Defence Force, 2011).

Offences against the AFDA are dealt with through the command chain. Commanding officers are required to record allegations of offences and ensure they are appropriately investigated. If offences are found to have occurred, the offender will be charged and will then be required to account for the actions or inaction that led to the investigation. If an individual is found guilty, a range of punishments can be awarded that are assigned according to the seriousness of the offence (Armed Forces Discipline Act 1971; New Zealand Defence Force, 2011). Fines, reduction in rank and extra duties are common punishments however discharge from the Armed Forces can be an outcome for serious offences that are incompatible with continued service (New Zealand Defence Force, 2011). Records of offences under the AFDA remain on a service person's file for a minimum of two years however, offences that are punishable with a fine of seven days' pay or more remain on file permanently (New Zealand Defence Force, 2010). These records are accessible and can result in careers being negatively affected.

It is no defence under the AFDA for a service person to refuse to undertake any type of lawful work in the NZDF even if that work is dangerous. The NZDF must adhere to all elements of New Zealand's health and safety legislation so organisational policies and processes are designed to reduce risk but due to the nature of military service and the purpose of military forces, some risk of injury or fatality remains. Service personnel are required to work to reduce risk but are expected to accept that which cannot be eliminated (New Zealand Defence Force, 2011; Wilson et al., 2013) . There are serious operational implications if service personnel refuse to carry out work or if they create situations where the quality of work is negatively affected. In such instances military

personnel can be charged (New Zealand Defence Force, 2011). The AFDA therefore serves as a deterrent to behavioural noncompliance.

Rank and corps

Rank structure in the NZDF, inherited from the British Armed Forces, is divided into two main groups: commissioned officers and those of non-commissioned rank. Commissioned officers are managers who undertake planning functions and who, through the utilisation of orders, lead others in the execution of operations. Officers are expected to demonstrate a range of leadership competencies that inspire trust and confidence in subordinates (New Zealand Defence Force, 2019b). In general, officers lead non-commissioned officers and ordinary ranked soldiers, sailors and airmen and women however as non-commissioned personnel progress through their rank tiers, there is an expectation that non-commissioned officers will take on more leadership responsibility. There is no longer a relationship between rank and the level of leadership required to command certain sized groups of personnel. Now rank advancement is recognition of an individual's ability to exemplify the ethos and values of the NZDF, demonstrate professional expertise, and display competent leadership (New Zealand Defence Force, 2017e).

A regimental corps in the Army is a configuration of personnel who have a common function. In practice this means that many corps are comprised of a variety of related professions. Like the Army's rank structure, corps arrangements are based on the British Army's regimental system which in turn has its foundations in ancient military traditions. Notwithstanding the cultural significance of corps' histories, corps are still a useful way in which to structure professional groups in modern militaries. A corps provides a mechanism through which technical governance and command and control can be exercised. A corps also provides a rallying point for members, a sense of pride in

common purpose and achievements, and a vehicle for the demonstration of military ceremony. Corps-specific insignia provide immediate visual recognition for members and others of a service person's corps affiliation (King, 2014; McGibbon, 2000; van Wijk & Finchilescu, 2008). Loyalty to a professional corps serves as a powerful tool for the facilitation of one of the Army's key values, camaraderie. Other New Zealand Army values are courage, commitment and integrity (New Zealand Army, 2019).

Typically Army corps consist of both non-commissioned and commissioned personnel however a small number of specialist corps comprise officers only. Specialist officers are individuals who have been educated and gained experience in the civilian sector and who practice in domains that are critical to military capability. Examples of such domains include health, law, education and chaplaincy. Specialists are officers because officer rank gives the advice provided by specialists the requisite priority needed to inform command decisions and also authorises the use of orders to ensure subordinates comply with critical advice (Armed Forces Discipline Act 1971; New Zealand Defence Force, 2010). The AFDA can then be used to charge personnel who fail to follow the advice of specialists.

Conditions of service

Broad principles of terms and conditions of service for military personnel are set out in the Defence Act. As a way to ensure that the rights of servicemen and women are protected, these terms and conditions seek to maintain fair relativity with employment conditions outside the NZDF. The Defence Act enables the State Services Commission to be consulted in the formulation of employment policy on behalf of members. This serves an important governance function for Defence personnel as the Employment Relations Act 2000 does not apply to members of the Armed Forces therefore collective bargaining is not available.

Customs and conventions

Several customs and conventions of Government have direct significance for members of the Armed Forces and for civilian employees of the NZDF. The convention that the defence of the country is the fundamental function of Government has obvious implications for the NZDF given that the NZDF is the only military force authorised in New Zealand. However the NZDF does not determine whether New Zealand is under threat or what response may be appropriate given any perceived threat. The Government is the body that makes the decisions on how and where the Armed Forces operate and these decisions are not justiciable[11] (New Zealand Defence Force, 2011).

The custom of political neutrality directs that personnel must not publicly criticise the policies and decisions of the Government or the leadership of the NZDF (Public Service Commission, 2010). This does not mean that members of the Defence Force do not possess the same rights as other citizens to freedom of choice and freedom of expression because as citizens of New Zealand they do, however such freedoms apply only when service personnel are off duty (New Zealand Defence Force, 2011, 2015c). Loyalty to the organisation and to the Government is necessary in the course of the service person's work and is reinforced at all levels of the NZDF, and is measured in key performance indicators (New Zealand Defence Force, 2017e).

The convention of civilian supremacy speaks of the relationships the Armed Forces in New Zealand have with the Government and with other public institutions such as the New Zealand Police (New Zealand Defence Force, 2011). While the understandings relate predominantly to security arrangements, certain principles have implications for the military's relationship with other organisations such as the Ministry of Health and

[11] Liable to trial in a court of justice.

health regulatory authorities. The Defence Act also requires all Defence Force orders to comply with New Zealand law therefore, according to the convention of civilian supremacy, the military is always subordinate to civilian authorities. The law and constitutional conventions do then subject New Zealand military health professionals to international humanitarian law and to the country's health regulatory frameworks.

Healthcare in the New Zealand Defence Force

The health of service personnel is an integral part of the NZDF meeting its outputs (New Zealand Defence Force, 2018). The Defence Health Strategy (2018) specifies that for Defence personnel to optimise the performance of their duties, they must be good health. Services that assist in the preservation and restoration of health are therefore vital to ensuring that any risks to mission success presented by substandard fitness or ill health are minimised. In order to support the health and wellbeing of military personnel, free primary health and dental services are available in garrisons throughout New Zealand with arrangements for primary care for personnel posted to some smaller military formations outsourced to civilian providers (New Zealand Defence Force, 2000, 2018).

When they are at home in New Zealand, servicemen and women receive specialist, secondary and tertiary health services through the public health system but due to the type of care required and the risks presented to those providing it, the NZDF has in place an intrinsic system of healthcare arrangements for when service personnel deploy. These arrangements are modular and depending upon the type of deployment, can include a selection of basic first aid and evacuation responses, through to general practice, medical and surgical services (New Zealand Defence Force, 2018). Due to the inherent risks on deployments and the requirements for speed and flexibility, the NZDF

employs uniformed health personnel who are trained and prepared to respond to the unique demands of operational missions (Ministry of Defence, 2019).

Deployable health services in the NZDF consist of logistics, facilities and equipment, and health personnel (New Zealand Defence Force, 2018). The bulk of military health personnel are medics. Medics are unregulated health professionals who are initially trained as soldiers, sailors and airmen and women and who then receive an education from within the military system to enable them to provide medical care under the direction of a medical officer. Medics work under the direction and delegation of health practitioners or they work to the provisions of a comprehensive set of standard operating procedures known as the Defence Medical Treatment Protocols (DMTPs) (Principal Nursing Officer, Headquarters Joint Support Group, personal communication, October 8, 2020). In order to ensure compliance with the Medicines Act 1981, management of DMTPs falls to medical practitioners however recruitment and retention of doctors in the NZDF is an ongoing challenge for the organisation. Medical officer vacancies impact not only upon other members of the healthcare team, but also upon the ability of the organisation to meet its stated commitments (Deputy Surgeon General of the NZDF, personal communication, May 15, 2015).

Doctors and nurses are joined by health practitioners working in the oral and allied health scopes of practice to form the specialist officer ranks of the NZDF health services. NZDF allied health practitioners represent physiotherapy, radiography, pharmacy, medical science and dietetics. Environmental health officers, while not considered health professionals in the civilian sector, are grouped with health services in the military due to the significant impact the environmental field has as a health enabler. In the past, militaries have lost more manpower to illness and disease than to the direct effects of combat (McCallum, 2008). Whilst the survivability of combat wounded

soldiers has significantly improved since the Crimean War, dramatic reduction in disease rates did not manifest until environmental health became a feature of disease preventative measures in armies in the twentieth century (Mosher et al., 2008). Therefore in New Zealand, environmental health officers belong to health units and, together with health planners from the General List of officers, physical training instructors, medics and health practitioners, constitute the personnel of the New Zealand military health services.

Health services in the Army

The majority of health professionals in the NZDF are in the Army (Sheard et al., 2016). With the exception of nurses, dental, and physical training staff, all Army health personnel belong to the Royal New Zealand Army Medical Corps. The purpose of the Medical Corps is to provide health support to the Army and, when it is deemed necessary by command, to the wider Defence Force. Health support in the Army is designed to preserve the fighting force by reducing health threats, preparing personnel for deployment, and caring for them if they become sick of injured (Thomasma, 2003; Commander Joint Operational Health Group, personal communication, May 29, 2015).

New Zealand's land-based health services were initially modelled on those of the British Army however post-colonial independence and changes in New Zealand's strategic security arrangements have resulted in modifications to the way in which the Army shapes its capabilities (McGibbon, 2000; Treanor, 2008). New Zealand's recent military engagements have necessitated the transformation of the NZDF so that it can undertake peacekeeping roles whilst still maintaining alignment with modern combat systems. Mobile warfare and asymmetric conflict have become features of hostilities and the types of weaponry employed by opposing forces have resulted in a change to the nature of injuries and to those who suffer them. New Zealand's commitment to the

United Nations requires NZDF health personnel to be prepared to operate in a variety of contexts including humanitarian and disaster relief, and to care for not only military personnel from New Zealand but those from other countries, for civilians and enemy prisoners of war (International Committee of the Red Cross, 1949; Ministry of Defence, 2019).

Casualty evacuation has become a major priority for the Defence Force's health services. The facilities that house smaller and more mobile forward surgical teams have limited capacity to hold patients, and previously fatal injuries are now survivable if tertiary care is expedited, so the ability to transfer patients rapidly is vital (Blackbourne et al., 2012; Mabry & DeLorenzo, 2014). With the exception of military ambulances, dedicated assets for medical evacuation in the NZDF are rare due to demands placed on the limited number of RNZAF multi-role aircraft (Ministry of Defence, 2014a). This makes close cooperation between the Army and the RNZAF crucial if medical response during operations is to be seamless and consistent with international standards. Close cooperation is also necessary between the health services of the NZDF and those of the military forces of other countries when the NZDF operates in coalition environments.

In 2006 New Zealand gained membership of the ABCA Armies' Programme.[12] This programme aims to advance interoperability through promoting the standardisation of organisation, tactics and equipment across many military functional areas including medical services (*ABCA Coalition operations handbook*, 2008; Cody & Maginnis, 2006). Membership demonstrates the endorsement at a high level of the principle of medical service standardisation between the British, New Zealand, Australian, Canadian and American Armed Forces. Sharing of resources through capability integration in

[12] America, Britain, Canada and Australia Armies' Programme. The title of the programme is now America, Britain, Canada, Australia and New Zealand Armies' Programme.

coalition environments optimises desired mission effects which is an important consideration for a small military health service that may not be in a position to deliver or sustain the full continuum of care needed in a theatre of operation.

Standards for care

A key motivator for soldiers to fight is knowing that if they become injured, experienced health professionals will be there to provide the care they need (Carver, 1989). Notwithstanding extreme operational circumstances, the NZDF aims to ensure that the treatment that service personnel receive meets national standards. Consistency in standards is necessary due to the Defence Force's obligations to comply with New Zealand's statutory and regulatory frameworks for health services, whether these are delivered at home or off-shore (New Zealand Defence Force, 2000). However, because the health services of the NZDF are small and the majority of deployable health personnel are medics, considerable responsibility is placed on health practitioners to provide governance and leadership to ensure that the healthcare expectations of service personnel can be met. This responsibility tends to fall to the largest group of military health practitioners, nurses (Defence Health Directorate Workforce Advisor, personal communication, September 12, 2018).

Nursing governance in New Zealand

Health practitioners in New Zealand are governed by the Health Practitioners Competence Assurance Act 2003 (HPCA Act). The primary purpose of the HPCA Act is to safeguard members of the public by providing for structures and processes to ensure that health professionals are competent to practice. What this means is that a consistent governance regime for the management of all health professionals is in place. Registration authorities are delegated the responsibility for defining the scopes of

practice, specifying the requisite qualifications for the scopes of practice and setting the standards for the professional competence of their members.

The NCNZ is the registration authority for registered nurses. The NCNZ explains that nurses "use nursing knowledge and nursing judgement to assess health needs and provide care, and to advise and support people to manage their health. They practise in a range of settings in partnership with individuals, families, whānau and communities. Nurses may practise in a variety of clinical contexts depending on their educational preparation and scope of practice experience" (Nursing Council of New Zealand, 2019a). While it is acknowledged that other health professions may perform functions that overlap nursing, and nurses may extend into the practice roles of other health professions, this is the definition that governs nursing practice in New Zealand.

The NCNZ authorises three scopes of nursing practice in New Zealand. Registered nurses are authorised to practice independently and to direct and delegate nursing care to others. The NCNZ (2012c) further states that registered nurses "provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making" (p. 3). Enrolled nurses deliver care under the direction and delegation of registered nurses or nurse practitioners (Nursing Council of New Zealand, 2012b) while nurse practitioners are expert nurses who manage people's health needs within specific areas of practice (Nursing Council of New Zealand, 2012d). The vast majority of nurses in New Zealand are registered (Nursing Council of New Zealand, 2019a).

In order to practice, all nurses must make an annual statutory declaration that they are safe to do so. This involves each nurse maintaining a specified minimum number of hours in nursing practice, management, research, policy development or education; by

maintaining professional development in their area of practice; and by meeting the competence requirements of their scope of practice (Nursing Council of New Zealand, 2020e) . The NCNZ provides mechanisms for nurses to demonstrate competence through employer-sponsored NCNZ PDRP. These programmes facilitate the tailoring of competencies to employment contexts and exempt nurses who are engaged with PDRP from being subject to NCNZ recertification audit processes (Nursing Council of New Zealand, 2020a).

Under their mandate to set the standards for nursing, the NCNZ has prescribed the Code of Conduct under which nurses must practice and the professional boundaries of nursing relationships (Nursing Council of New Zealand, 2012a, 2012e). The code of conduct is comprised of eight principles, each endorsing the values of respect, trust, partnership and integrity. Regard for the privacy and confidentiality of health consumers is an uppermost concern in the code. NCNZ (2012e) guidelines for professional boundaries support the code of conduct by setting the standards of behaviour for nurses. While the NCNZ acknowledges that it is not possible to speak to every possible situation that nurses may encounter, sound professional and ethical judgement must be exercised at all times. The guidelines explain that because New Zealand has a small population, there exist greater risks for boundary infringements in this country than for nurses working in more populated places. Furthermore the guidelines specify that certain communities present even more risk due to the multiplicity of roles that nurses in these communities perform. The military is noted to be one of these (Nursing Council of New Zealand, 2012e).

Specialty areas of practice and role designations in New Zealand are not defined or regulated by the NCNZ. It has been recommended by the National Nursing Consortium that specialty nursing group develop frameworks for knowledge and skills based upon

the needs of health consumers (Holloway & MacGeorge, 2017; National Nursing Consortium, 2017). Consequently, specialty nurses seek networks, guidelines and competencies for their specialty areas of practice through the New Zealand Nurses Organisation, the College of Nurses Aotearoa, or through other national bodies that represent the interests of specialty nurses.

New Zealand Defence Force nursing services

The configuration of nursing services in the NZDF reflects the requirements of service delivery in both garrisons and on operations. The NZDF health service is small compared to its international partners but it must still meet both internal regulatory requirements and military capability standards. Consequently a limited number of health personnel have been trained and are competent to deliver a bespoke range of services across a variety of military contexts (New Zealand Defence Force, 2018). This requires considerable collaboration between health professionals as well as flexibility in practice. Nurses are pivotal to the success of the NZDF health services but due to the often isolated nature of the work, all nurses working for the NZDF are registered (Defence Health Directorate Workforce Advisor, personal communication, May 13, 2015). There are two discrete groups of registered nurses in the Defence Force; military nursing officers and civilian nurses.

Civilian nurses

Civilian nurses work for all three services providing primary and preventative healthcare in general practices based in garrisons around New Zealand. Other than stipulated by the NCNZ, civilian nurses are not required to maintain the physical fitness or health standards required of uniformed personnel, nor is it mandatory for them participate in training or activities that sit outside their healthcare roles. Civilian nurses

are not subject to the AFDA so all the provisions of the Employment Relations Act apply to them.

The patients that present in military general practices differ from those in civilian general practice in that they are predominantly young males who are healthy and fit. Medical examinations conducted before a person joins the Armed Forces preclude individuals from enlisting who have pre-existing conditions (Ministry of Defence, 2014b; New Zealand Defence Force, 2000). This policy together with others that prevent the retention in uniform of people who develop long-term conditions or who are unable to fully recover from injuries, means that the work of civilian nurses is concentrated on health promotion, sexual health and the management of conditions and injuries that arise from communal living and a demanding physical fitness regime (Sheard et al., 2016).

On occasions there is an increase in demand for the services of practice nurses such as when cohorts of new enlistees or personnel preparing for deployment require health vetting and vaccinations. When these frequent situations arise, the work of civilian nurses is complemented with medics and military nursing officers (New Zealand Defence Force, 2000).

Military nursing officers

All uniformed nurses in the NZDF are members of the RNZNC of the Army (New Zealand Defence Force, 2015c). The RNZNC is a specialist officer only corps therefore all military nurses in New Zealand are officers. Nurses wishing to join the Army must not only meet the education and experiential requisites for service, they must attend a week long Officer Selection Board (OSB) to determine if they possess the aptitude and leadership qualities sought in military officers.

An OSB is a form of employment assessment centre for determining future job performance. During an OSB artificial conditions are created that place applicants under pressure while they carry out a range of intellectual and physical tasks. This pressure is designed to simulate the stress that military officers might be expected to experience in the course of their work and it enables the selection board to assess the performance of stressed candidates against a series of leadership measures. The selection board is then able to make predictive judgements of an applicant's suitability to serve as an officer in the Army (Benjamin, 2006; New Zealand Defence Force, 2019b). Given the challenges faced on OSBs, officer candidates must possess high levels of motivation and endurance. All military officers are leaders so the selection process for nursing officers is the same as that for General List officers (G List officers). Less than half of all nurses who apply to join the Army are successful on OSBs (Defence Health Directorate Workforce Advisor, personal communication, May 13, 2015).

If a nurse has been successful on an OSB they are commissioned into the Army and are posted to their initial unit where they begin work. Nurses are required to attend the next available Specialist Officers' Induction Course (SOIC) where they are taught basic information about the Army, are introduced to military routines, and get the opportunity to meet other newly commissioned specialist officers. The process for becoming a specialist officer differs from that of G List officers because specialists join the military already in possession of the professional knowledge and skills they require to perform the basics of their job. Officers on the G List complete a significantly different and longer programme because they must not only learn about military leadership, but about planning operations and executing a comprehensive range of combat functions (New Zealand Army, 2020a). For nursing officers, the SOIC is only the beginning of a career of progression because they are expected to attend many other Defence Force and

nursing professional development activities to prepare them for advanced roles in military healthcare and for specialty areas of practice (Sheard et al., 2016).

Prior to 1990 the RNZNC provided nursing officers to all three of the Armed Services however, as a consequence of the need for many New Zealand nursing officers to deploy to the 1991 Gulf War, the RNZN made the decision to replace all nursing officer positions with civilian nurses and to permanently withdraw from the tri-service arrangement. Since 1991 the RNZN has operated on the understanding that the maritime environment in New Zealand does not require deployable nurses. It is believed that any nursing needs in the RNZN garrison are able to be provided solely by civilian registered nurses while during naval deployments it has been deemed adequate for all health services to be delivered by physicians and medics (NZDF Health Information Manager, personal communication, May 14, 2015). Military nursing services in the NZDF are now provided by the RNZNC for land and air operational outputs only (New Zealand Defence Force, 2015a) .

The nature of military nursing in New Zealand

The New Zealand's Government's growing commitment to peace support operations and disaster response has involved a recent reorientation of focus and a reconfiguration of training for the NZDF. What this has meant for members of the RNZNC is that each individual must be skilled in a variety of specialty areas of practice and to be flexible in their application. These include practice nursing, occupational and preventative healthcare, medical, surgical and flight nursing, and nursing in the perioperative and intensive care space (Argyle, 2015). Nursing officers work in a wide variety of employment contexts but they must be ready to adapt quickly to change if patient needs or the security state alters. It is necessary then for nurses to not only be competent in multiple domains, but to also have their registration recognised in countries where they

may deploy. Overseas recognition is important because it provides reassurance to authorities in those countries where Army nurses may deploy, that any services they deliver to the local populace meet the requisite standards of the international nursing community (Defence Health Directorate Workforce Advisor, personal communication, May 13, 2015).

Summary

An overview of the context of the NZDF and the employment arrangements of nursing officers has been presented in this chapter. The introduction to the governance systems of the organisation provided a frame for understanding the legislative and structural boundaries within which military nurses work. Also explained were the positions that nursing officers hold in the Armed Forces and the type of work that they perform.

Having a basic understanding of organisational structures and the configuration of services will be necessary in order for a more complete appreciation to be gained of the experiences of military nurses when they come under examination in later chapters. Having presented the aim of this research and an overview of the context within which military nurses work, the thesis will now move on to describing the steps that were followed in the research process. The next chapter provides information on the Foucauldian tools employed in the study.

Chapter 4: Surveillance of the disciplinary theoretical paradigm

Introduction

The previous chapter provided an introduction to the structures that govern the NZDF and the authorised configurations of personnel who work for the organisation. Where nurses reside within those configurations were presented as was an overview of the responsibilities they hold. This thesis now moves on to explain how theory can be used to view such structures and ways of working in different ways. Chapter four will elucidate the theoretical concepts that I have employed to explore military nurses' experiences in the NZDF.

The chapter begins with the rationale for my decision to approach the research within an ontology of social reality. How that rationale led to the framing of the study within a structuralist paradigm is explained and why Foucauldian theory was selected for this research is covered. Processes through which social reality constructs particular ways of knowing are described using the categorisations that Foucault described. Foucault's project on these categorisations is examined within his overarching view of power. Disciplinary power as the fundamental concept through which information gathered for this study is investigated. Additional tools that have been employed to facilitate the understanding of phenomena are described by drawing upon ideas that range from structuralist notions of governmentality to micro relations that legitimise certain ways of being while at the same time restricting others. The chapter concludes with an examination of parrhēsia and the risks associated with nurses performing the roles of advisors.

Categorising the categoriser

My decision to employ Foucauldian theory in this research involved a deliberate intention to challenge assumptions of the primacy of quantitative methodologies that exist in the NZDF. The organisation's propensity for gathering and applying information that is measurable is evident in a multiplicity of ways from the assessment of the potential effectiveness of a fighting force according to its size[13] to the gathering of information on the human experience through the utilisation of Likert scales (Defence Health Directorate Workforce Advisor, personal communication, April 17, 2021). Efforts to address entrenched ways of using data and the thinking that arises as a consequence appear not to be gaining the traction needed for innovation (Simons, 2009).

It is remarkable that despite the armed services embodying some of the most extreme contemporary examples of the operationalisation of authority and force, that researchers rarely engage Foucauldian philosophy to gain an understanding of the behaviours of service personnel. The army was specifically targeted by Foucault as an embodiment of the conventional and historically contingent need for humans to understand phenomena by creating groups and rankings according to systems of value (Foucault, 2002). Yet although well-known as a qualitative epistemology, I found no studies of any New Zealand military population where Foucault's ideas have been employed to reveal information. Therefore underpinning this project with Foucauldian theory offers a new way to view the functions and effects of force and power in operation in New Zealand's Armed Services.

[13] See the NZDF Output Plan (2019c) for an example how the assumed uniformity of the composition of various force configurations informs the response of the NZDF to demand.

Foucault explores invisible forces in his project on power and discipline so I conducted a deeper examination of the ideas that underpin his theories. It became apparent that a Foucauldian approach would not only serve as a legitimate epistemological mechanism to reveal the nature of invisible forces that operate on military nurses, but it would also provide an alternative way to conduct an investigation of authority, governance and techniques of self-examination.

Although Foucault's work as a methodology provides insight into social systems and therefore structures, he rejected the assignation of the label structuralist and instead described himself as an archaeologist and a genealogist of thought (Burrell, 1998; Dreyfus & Rabinow, 1982). Foucault's dialectics traverse time and space to provide insight into the myriad of relations that operate between individuals, institutions and physical environments and to which individuals respond with an apparent free will, but which is free only so far as power relations permit. That Foucault's project to make visible phenomena that is subliminal, provides a commentary on the configuration of society at both macro and micro levels, therefore whilst it might be true that tracing the evolution of thought over time makes Foucault a genealogist and an archaeologist, his digging out of artefacts across multiple tiers of society to let us see what we normally cannot, also makes him a structuralist (Golder, 2015).

Foucault's work challenges us to apply the tools he provides for purposes of enlightenment and to use that enlightenment as a catalyst for change. Taking up that challenge has been another deliberate intention of this research. Eliciting how nurses navigate professional accountabilities and role expectations is not as an end in itself but a project to be used as evidence to support improvements in the way that military nurses work. This study serves as a conduit for Foucault's ideas to bring about enlightenment and to activate change by political means. This work then falls within the paradigm of

critical research and thus for this study, Foucault is employed as a structuralist of critical theory.

For this project, Foucault's work is taken as a variant of structuralism which provides an explanation of human phenomena through archaeological and genealogical methods of inquiry. The work may be thought of as archaeological because he traces ideas using an historical interrogatory lens, and it can be considered genealogical because he deconstructs ideas to determine the nature of the relationships that different concepts have with one another. Foucault's understanding of the way in which categories of thought and the threads that link different constructs provides a starting point for an examination of his work as it relates to this study of military nurses.

The untruth of autonomy

Military nursing does not have a long history but for Foucault, history is not represented by a chronological continuity of materialities. Instead materialities are viewed as physical and inherently traceable manifestations of the underlying discourses that disseminate social spaces. Discourses themselves are the history that Foucault seeks to describe and which are revealed by the methods he developed to show how ways of thinking emerge as both a causality and consequence of social change.

The conventional construct of time as that of a system based on a predictable chronology is problematised by Foucault. Foucault (2002) contended that ideas are not time-bound as conventional wisdom purports them to be, but are effects of technologies that seek to reinforce hegemonies of truth and to promote reason as a principle upon which the advancement of society is claimed to be predicated. In opposition to the dominant discourses of modernity that profess the only real truths being those that can be proven empirically, the fundamental tenet of Foucauldian archaeology is the notion

that progress or indeed any change of any sort, does not occur as a consequence of scientific reason but as a result of social transformation (Foucault, 2001, 2002; Weberman, 1995).

Social relations manifest in voice and conduct. Although it may seem that the participation and perpetuation of social relations is dependent on autonomy of thought and therefore individuals having control over their own conduct, the process of thinking is, according to Foucault (1990), a product of a multiplicity of pressures that target individuals according to the myriad of relations that contribute to a person's experience. These pressures place limits on the possibilities of thought which in turn places constraints on the way in which people are able to interact with their world. Social relations therefore form technologies of power that are dynamic but only as dynamic as the possibilities of thought permit (Foucault, 1990). Foucault problematised the term 'individual' and instead employed the word 'subject' when referring to humans because individual implies freedoms that do not in fact exist (Foucault, 1983). This is important for exploring the concept of military nurse autonomy because autonomy viewed through a Foucauldian lens is not possible.

Foucault (2002) traced in a genealogical fashion how power impacts upon social practices and how at both macro and micro levels, power uses discourses to limit possibilities. Discourse for Foucault is the manifestation of a strategic struggle between forces operating in the social world (Foucault, 1984b). Discourses depict the confluence of conscious and subconscious thought by revealing through language and visibilities such as text and images, the attitudes and assumptions that dominate a social realm. Foucault found during his project on the creation of knowledge that while the discursive landscape is constantly regenerating, one constant remains and that is, irrespective of the epoch within which discourses emerge, the way in which technologies support the

constitution of discourses and the consequential contribution that discourse makes to power, does not change. Thus technologies of power form an historical a priori upon which power's relationship with knowledge depends (Foucault, 2002). Dominant discourses of nursing and those of the military are by genealogies, opposing. The effects of the connections between opposing discourses is key to analysing the underlying motivations that lead to the choices that military nurses make.

Power of course is a notion upon which much of military force depends so it is appropriate that power forms a key theoretical concept for this research. However two different understandings of power are presented in this thesis: juridical power which operates in a hierarchical fashion as a direct bodily force for purposes of prohibition, and disciplinary power which does not prohibit but instead works through processes of normalisation to create at social levels, the will to compliance (Foucault, 1991a). Yet while not hierarchical itself, disciplinary power generates hierarchies because normalisation involves the formation of categories of inclusion and exclusion. To avoid the subordinating effects of exclusion, the desire to secure inclusion is created and through inclusion, an interdependent system of status is enabled. Status itself adds an overlay of reward and neglect that further disciplines the subject by assigning to them a place in a relational series with others (Foucault, 1983, 1991a). Inclusions, exclusions and status form catalysts for policing action so that entitlements may be protected and access to knowledge controlled (Dreyfus & Rabinow, 1982; Foucault, 2003).

Power is for Foucault a strategy, not an authority (Foucault, 1991a). Power operates by advancing back and forth among subjects and groups, not acting directly upon subjects as an agent of suppression, but acting upon the actions of subjects as an agent of production. The capacity for power to produce modes of thinking and consequential ways of behaving is not generated through any visible manifestation, but through

power's ability to be felt. This feeling, this perception of power, is a process that does not rely upon the senses of subjects but upon surveillance (Foucault, 1991a).

Surveillance is very important to this study due to the way in which military forces rely upon individuals to observe their environment and to make changes to themselves to ensure that their behaviour and physical appearance complies with the military's expectations. The nature of relations between subjects and between subjects and their environment is under constant inspection because inspection provides a technique for policing and therefore a tool for discipline. Surveillance compels compliance by providing the evidence to identify and report deviancy, but for practical reasons it is not possible for surveillance to be continuous. To compensate surveillance relies upon a *belief* that surveillance is omnipresent. When it is not known if external surveillance is in operation, subjects will undertake routine self-surveillance to avoid the risks associated with the detection of deviancy resulting from any active inquisitorial processes. Hence surveillance contributes to the normalising effects of disciplinary power (Foucault, 1991a).

The knowing of knowledge

Foucauldian constructs of knowledge are based on the understanding that knowledge is not a product of scientific disciplines but a modality constituted by social discourses (Best & Kellner, 1991). According to Foucault (1991a), understanding knowledge involves a comprehension of the relationship that exists between that which is sayable and that which is visible. Knowledge that is sayable is archivable and therefore retrievable, so it can be used as evidence for purposes of proof and censure. Knowledge that is visible is physical phenomena that support discourses by limiting some discourses from materialising and enabling others to continue (Best & Kellner, 1991). The construction of knowledge commonly occurs within institutional disciplines that

are themselves products of institutional knowledge with institutional knowledge being contingent upon interdependencies that exist between evidential repositories, geographical spaces and specialty discourses. These constituents of knowledge operate in a perpetual mode of self-gratification and reinforcement (Dreyfus & Rabinow, 1982). Military nurses must learn to combine two knowledge systems so understanding how knowledge can be conceptually constructed will help to deconstruct what nurses have to say about connecting the two knowledge systems to which they are exposed at work.

Discourse controls the selection from repositories of the sayable with that selection facilitating the development of a visible, physical environment that reflects the interests of the discipline (Dreyfus & Rabinow, 1982). The tangible nature of physical phenomena such as buildings and tools, both constrain and enable what can be said and when, and under whose authority a certain discourse might be spoken. Visibilities may therefore prevent the emergence of new discourses and any new associated knowledges, while at the same time making possible the emergence of others. Power is the strategy that controls discourse and thus power mediates the relationship between the sayable, the thinkable and the doable (Foucault, 2001, 2002).

Knowledge itself is organised and assigned designations that align with orders of discourse so that titles and categories reflect dominant discourses and make sense to those who operate within an episteme or indeed, at a more micro level of the present, an institution (Foucault, 2002). This is particularly relevant for how military language is incorporated by Defence Force nurses into their work and what this might mean for their practice. Knowledge is accompanied by privilege so that certain disciplines come to hold seemingly natural entitlements to governance discourses and to social and cultural institutions associated with a given knowledge. Stratification accompanies privilege so that value is assigned to those who are thought to be most connected to

knowledge that is central to a discipline and so those who are thought to be most connected come to hold the right to speak. The corollary of rights associated with privilege is the creation of a category of 'other' that represents lack. Lack of entitlement to knowledge, lack of authority, lack of the right to speak, and lack of value (Foucault, 2003). The notion of otherness underpins much of the decision making of military nurses which will become apparent in the analysis chapters of this thesis.

Knowledge that is discursively perpetuated becomes the truth (Foucault, 1984b). Exclusivity is connected to specialisation in that those who belong to a discipline control through the monitoring of discourse, the truths that may be repeated and by whom, and the activation of functions of force to disrupt the emergence of any truths that may threaten privileges. This does not prevent the emergence of new discourses and therefore new knowledge, however it does create a system whereby some voices are heard while others are silenced. Those who hold dissenting voices may choose to maintain their silence if they believe their place within their community, however subordinated that place might be, may be put at risk. For some of those who constitute the subordinated and the marginalised, the costs associated with revealing a subjugated discourse may be too great (Foucault, 1984b; Shapiro, 1984). For others, the risk is worth taking which will be evidenced in this study when the relations between nurses and medical officers are examined.

How subjects are positioned within social and cultural institutions are like knowledge, open to variability (Dreyfus & Rabinow, 1982). Subjectivity is susceptible to the confluence of environment and statements with a subject's worth calculated not as an independent variable, but as one that is comparative to others. Subjects who hold similar value become connected in groups comprising mutually recognisable members, not by conscious intent, but by the effects of power that segregates and ranks according to

relative worth (Dreyfus & Rabinow, 1982). Yet because power as a strategy is continually redefining the relationship between the sayable and the doable, the relations among subjects and therefore within and between groups is not stable. Furthermore subjects do not subscribe to singular institutions but possess a multiplicity of connections thereby creating a multiplicity of subject positions. Davies and Harre (1990) describe subject positions as "the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines. There can be interactive positioning in which what one person says positions another. And there can be reflexive positioning in which one positions oneself" (p. 48). The ascription of status and value for subjects are not only variable within institutions but variable between them (Dreyfus & Rabinow, 1982). Ideas of status and value are important to this research because rank as an official designation is not the only way in which status in the NZDF is determined. Examining status through subject positions has been a valuable tool to enable the hidden agenda of the military's combat orientation to be revealed.

The perpetual penality of not knowing the truth

While discourses may dictate the way truth is constituted, multiple discourses do not coexist comfortably but instead compete with one another so even when there is common acceptance within different discourses that a particular truth exists, different versions of that truth may be held (Foucault, 1984b). Subjects, in principle at least, are free to subscribe to versions of the truth which best align with their intentions for themselves so subjects are able to take up different subject positions. When subjects subscribe to versions of the truth that sit within discourses that differ from those to which power seeks to assign them, several versions of the truth may coexist in a single domain (Foucault, 1984b).

In addition, when subjects subscribe to alternative versions of the truth, they change their discursive orientation and in the process bring to discourses different perspectives of subject positioning, language and ways of behaving. Hence discourses do not remain static but evolve through both power relations impacting directly upon the actions of centrally positioned subjects, and by the indirect effects of power operating through techniques of subjectification (Foucault, 1997; Rabinow & Rose, 2003). The subjectification of military nurses to military discourses will be presented in the analysis chapters of this thesis to reveal how nurses become inculcated into the NZDF.

Power's purpose is the regulation of the population's conduct however, despite its seemingly pessimistic intent, power is not negative—but neither is it positive. Power is a neutral agent whose focus is the generation of knowledge (Foucault, 1991a). Through a matrix of relations that exist between discourses, knowledge, institutions, materialities and subjects, power produces an array of procedures that are in a state of perpetual tension. Finding ways to exist within that tension gives rise to modes of normality that over time take on the guise of a seemingly natural and unquestioned order of things (Foucault, 1990).

It is when the normal is defined that the category of other becomes significant. Feeling the effects of belonging to a category of other, and recognising that otherness constitutes the fringe and the abnormal, serves as a powerful motivator for those on the outer to find ways to join the group of the normal (Foucault, 1991a). Yet aligning with norms is not always possible when the knowledge upon which otherness is predicated contributes to the status of those who benefit from exclusionary practices. Foucault (1983) referred to procedures of power that create stratifications of status as a "system of differentiations" (p. 223). A system of differentiations is a hierarchy that emerges from within power relations to not only reinforce the centrality of subjects whose

characteristics do the most to perpetuate central discourses, but to restrict enlightened thinking and hold in check any challenges that might change the status of those who reside on the outside (Foucault, 1983).

The struggle to change outsider status and the counter-struggle to contain such changes is knowledge-generating (Foucault, 1991a). Foucault (1991a) asserted that knowledge can then be used by power to target further opportunity to replicate the production of norms and the creation of new categories of otherness. Yet while it may seem that being relegated to the category of other consigns a subject to a state of permanent desolation, otherness is a critical component of power because otherness constitutes the foundation for resistance upon which the effectiveness of power depends. Nurses' resistance to otherness and their efforts to align with what is perceived to be normal, form key starting points for exploring how military nurses navigate between the otherness of nursing and the centrality of the warrior.

A contest without conquest: Resistance to the power of power

When the same discourses that serve to constitute the state of otherness are employed for purposes of enlightenment, that which has been constituted as abnormal can no longer be considered so because the constitution of abnormality relies upon conditions of concealment (Foucault, 1991a). Once the strategies that power employs to position subjects have been given public voice, the covert systems of surveillance upon which subject positions are maintained are undermined. Thus public confession brings about legitimacy which forces power to seek other sites within which to operate covertly (Foucault, 1990). This research has as its intention, the enlightenment of the military nurse experience and as such serves as a point of resistance. Once revealed through its completion and promulgation, this project will provoke power to seek other sites within which to operate.

Power uses resistance to produce change because without resistance, relations between subjects, the groups with which subjects connect, the spaces which are inhabited, and the way time is allocated would remain static (Foucault, 1991a). Power needs change because disciplinary power is only effective when it is concentrated on the actions of "free subjects, and only insofar as they are free" (Foucault, 1983, p. 221). If there were no opportunity for freedom and therefore no opportunity for resistance, norms would remain unchanged and there would be no demand for compliance because compliance would be a fait accompli. Resistance then is a necessary feature of power and is a technology of change because each resistive action, even if it is not entirely emancipatory, modifies the norms that underpin conformity. Thus norms are mobile and thus surveillance and all its associated techniques, is necessary (Foucault, 1990, 1991a; Hutton, 1988).

Juridical discipline cannot alone invoke change because functions of force are themselves products of epistemic discourses and practices arising from governmentalities. Governmentalities are subject to the same technologies of power that give rise to resistance (Foucault, 1988b). Foucault exhorted those who wish to employ his technologies for the purposes of examining power, to go beyond a simple examination of juridical power by identifying the systems of differentiation that support the mobility of disciplinary power (Foucault, 1983).

A triple entente of governmentality, technologies of the self, and identity

Human existence involves connections with social and cultural institutions. Such institutions are places where rules of instruction and discipline demand recognition (Foucault, 1991a). For subjects, coming to an awareness of disciplinary rules constitutes knowledge of institutional truths that through the dictating of subjective positioning and through the work of the power knowledge paradigm, coerce the subject into becoming

perpetuators of institutional truths. By taking on subject positions and by perpetuating institutional truths, subjects become recipients of the characteristics that contribute to the formulation of identity (Foucault, 1991b).

Identity according to Liu et al. (2005) is a "fundamental organising principle in the enactment of power" (p. 15) thus a relationship can be seen to exist between truth, power and identity. While identity according to Foucault (1983) is fixed to the roles and purpose of a subject, it is also influenced by the techniques and choices available to him or her; techniques and choices that may either limit or provide opportunity for change. Technologies of choice are themselves products of institutional connections and of strategies of exploitation and domination that originate within systems of the state (Foucault, 1983). The formulation of a new identity is a product of the military nurse experience so it is appropriate that tools that enable the revelation of the processes that military nurses undergo to acquire that identity are presented.

In his archaeological examination of the enactment of political power, Foucault established how over time the state has usurped from the family and the church, the responsibility for pastoral care of members of society (Senellart, 2007). The state in turn has come to delegate responsibility for such matters as health, education and financial security to an increasing number of governmentally-reliant formations. Couched in the guise of securing the wellbeing of the population, state agencies and the myriad of social and cultural institutions that rely for their existence upon those agencies, have come to control and exploit subjects in an effort to guarantee the continued existence of systems of governmentality (Foucault, 1983, 1988a). These ideas are important to this research because the NZDF assumes the position of a state inasmuch as the functions and concerns of the institution mimic those of state governments. Thus the NZDF represents a world within a world.

Resistance to the state provider and recipient dependency arises at every level. Foucault depicts resistance as a pan-global phenomena that opposes domination in its many forms through the operationalising practices of the subject however those practices do not target the critical arterial power of the state, but instead focus on the intimate operations of power that appear at a personal level (Foucault, 1991b). Proximal resistance is marked with paradoxes in that on the one hand opposition is aimed at power that seeks to homogenise self-expression and identity while on the other, opposing the way in which power seeks to isolate the individual from their connections and therefore the discourses, visibilities and social practices that contribute to the individual's sense of identity (Foucault, 1983). Sitting within this antithetical struggle for and against identity formation lies concomitant tension with knowledge.

Knowledge is an instrument of privilege that creates compulsions, constructs barriers and, as previously discussed, generates categories of inclusion and exclusion (Dreyfus & Rabinow, 1982). Compulsion to the acquisition of knowledge exists because gaining knowledge increases the possibility for advantage, yet knowledge acquisition generates resistance because the enlightenment of one subject can alter the position of others, thus enlightenment constitutes a threat to status and an opposition to the delicate balance of knowledge hierarchies. The goal of resistance to knowledge acquisition is to tether a subject to their present place and therefore to their existing identity (Foucault, 1991b). Technologies employed in the tethering process contribute to repositories of knowledge that once recognised, can be turned against challengers and opponents alike in an ever-revolving helix of self versus power and knowledge (Foucault, 1983). It will become clear when the concept of competition in the military is discussed in the analysis and discussion chapters of this thesis, why the quest for advantage means so much to NZDF

personnel. Governmentalities of the NZDF systems reinforce notions of status and advantage which have unintended and sometimes negative consequences.

Notions of technologies of the self have significance for military nurses because much work on the self is needed for the military nurse to observe, to make decisions about change, and then to make the change in order for them to align with what they believe to be the expectations necessary for military service. Compulsion to improvement is motivated by subjectification. In his discussions concerning the knowing subject, Foucault elaborated on his use of the term 'individual' to describe how coming to know how to think and how to act are products of the impact that power has on the process of self-examination and transformation. Power makes the individual "subject to someone else by control and dependence, and [ties him] to his own identity by a conscience or self-knowledge" (Foucault, 1983, p. 221). The process is one of subjectification because the individual is the subject of power however, subjectification is not an act of absolute repression because the subject must possess enough agency to mobilise resistance because without it as described earlier, power would cease to exist (Foucault, 1991a).

Subjectification is a dynamic process. Ongoing compliance requires constant vigilance to ensure that knowledge of the truth and the discourses of knowledge are current and that the subject's self continues to align accordingly. Agency is thus not only a necessary feature of power but a necessary feature of the self for without independent thought, a subject's ability to respond to normalising processes would be absent (Foucault, 1983, 1990). Yet even agency is tempered with constraint because the ways in which a subject constitutes himself are moulded by the cultural practices of the subject's environment so not only is the subject made to respond to techniques of domination, the subject is made to respond a certain way and that way is dictated by technologies of power (Fornet-Betancourt et al., 1987).

Foucault conceptualised technologies of the self in different ways. For this study of military nurses it has been useful to consider technologies of the self through two perspectives; the first being an analysis of macro regimes of subjectification and the second being a more focused micro-examination of the care of the self. The two conceptualisations connect at the level of the self through what Hook (2007) described as the downward permeation of state power where certain vocabularies and instrumentations of subjectivity enable the operations of government to be articulated in terms of the knowledgeable management of the human subject . A distinction exists between ethical and disciplinary uses of technologies. Ethical technologies comprise the work of the self on the self while disciplinary uses of technologies refers to the broader application of governmental mechanisms of intelligence gathering and control (Weberman, 1995). Regimes of the state consist of multiple discrete domains each containing specialty knowledge, language and skills. Access to domains is like access to social groups; restricted to subjects who meet certain inclusion criteria, thus access arrangements create a corresponding category of exclusions (Weberman, 1995).

Mechanisms of subjectification create not only the conditions that compel a subject to make personal change but they also make available certain choices as to the types of change a subject may wish to bring about. If compulsion and motivation are sufficient, a subject will embark upon a project of self-reflection and self-improvement to gain domain access rights (Rose, 1996). Yet while it may appear that personal motivation is a factor in the operationalisation of technologies of the self, the notion of agency may be deceptive because choosing not to embark upon such technologies may result in the activation of juridical disciplinary processes that increase the degree of pressure that a subject comes under. Technologies that support governmentally-driven subjectification processes include timetables for the regulation of activity, and techniques of

surveillance for the monitoring and reporting of rule enforcement and for the detection of non-compliance (Foucault, 1988a, 1990).

Although technologies of the self are performed in the privacy of the self-confessional, the nature of the confession and any change to the self becomes public through consequential discursive and behavioural manifestations (Foucault, 1990). Failure to make change in accordance with expectations risks a subject becoming a target for institutional and social regulators; regulators that possess the capacity to record deviancy and to activate systems of public censure. Public censure invokes marginalisation that in turn reduces social capital and impacts upon identity by loosening a subject's connections with those who most closely epitomise an identity's social truths (Foucault, 1991b). As a result, while subjects may possess the agency to decline to undertake projects of self-reflection and self-improvement, the ethics of choosing not to embark on such a project may be called into question because either way, change will occur; it is simply a matter of whether the process will be self-led or externally imposed. Ultimately, the initiator of both self-reflection and marginalisation is the same, it is power (Foucault, 1982, 1990). The readily available tools of NZDF juridical discipline make the concept of regulation and its consequential public censure a significant issue in this research. How the proximity of discipline motivates self-change will be explained.

And a triad of governmentality, statistics and population

As can be seen, Foucault's archaeology of governance demonstrates how through insidious and protracted means, contemporary Western society has come to be regulated (Foucault, 1991b). The mechanisms that governmental agencies employ to achieve regulation involves a multiplicity of connections between the state, agencies of the state, and subjects. Agencies of the state operate as intermediaries between government and

the state's subjects which shows how over time the state has been able to create a comprehensive apparatus to enable the population to be governable. The development of intermediaries creates distance between subjects and the state which permits the modern government, unlike its familial and ecclesiastical predecessors, to be less concerned with the conduct and wellbeing of individuals than with the prosperity of the population as a whole. The mentality of government is thus concentrated on the political economy, a mentality that can only persist because the apparatus of state allows it to do so (Burchell et al., 1991).

The state's apparatus has for its intent, the control of all elements of society (Foucault, 1991b). Risk to the political economy presents risk to the common good so included in the apparatus of state are technologies designed not only for the fostering of desirable conduct but for the monitoring and disciplining of aberrancy. Monitoring and disciplining technologies include the judiciary and the constabulary, and the intelligence and security forces. Security apparatus creates what Foucault referred to as a complex of knowledge that uses in a mutually potentiating way, both juridical and disciplinary power to achieve its effects (Burchell et al., 1991).

According to Foucault (1991b), systems that foster economic strength are so vast that although they have been designed for the good of wider society and are therefore focused at the strategic level, they permeate to the capillary networks that operate between subjects and between subjects and institutions. This "downward continuity" (Foucault, 1991b, p. 92) mediated by the apparatus of state, ensures that even when representatives of state agencies are not in attendance, a halo of governmental omnipresence remains (Foucault, 1991b). Thus technologies of the government exploit similar disciplining compulsions to those utilised by the micro technologies of the knowledge, power and subject triumvirate. The NZDF as a world within a world has

through its extensive system of rules and juridically embedded command structure, perfected the downward continuity of the apparatus of the State. How the downward continuity affects the organisation's personnel is discussed in the analysis and discussion chapters of this thesis.

The apparatus that was designed to facilitate the achievement of the purpose of government has increased state complexity. According to Foucault (1991b), techniques such as the categorisation of knowledge and the measuring of the effectiveness of systems of government, has resulted in an increase in the number of governmental agencies and raised the importance of statistics. Statistics provide for government a system of surveillance that permits the assessment of the condition of the connections between the state's network of agencies and materialities, and the state's subjects. Being able to measure connections facilitates control. This means that the state is in a position to detect threats to the political economy and to respond accordingly which may involve the activation of the state's security apparatus or the formulation of new juridical rulings (Burchell et al., 1991).

Governments have gradually over time assumed responsibilities for upholding moral and religious standards from the church and the family (Foucault, 1990). This can also be seen in the NZDF where the multiplicity of functions performed by the family and church are provided by the organisation from the issuing of clothing to wear, the provision of food to eat, and the facilitation of care for spiritual and physical wellbeing.

The prioritisation of economic and political rationalities and the rise of the value of statistics and therefore the rise of that which is measurable, has led to the scrutinisation of fields that have in the past for reasons of competing status, been beyond external inspection. The church and the family are now examined in ways that enable their contribution to the state's political economy to be policed. Thus institutions that in the

past have been centres for the protection of philosophical ideals are themselves now being challenged by the imperatives of the new religion of the political economy and are now viewed as commodities of the government (Burchell et al., 1991). The value of statistics to the mentality of NZDF governance is being challenged by the critical approach taken in this research. The NZDF as an agent of government is required to subscribe to the politic of new public management.[14] This means that accountabilities are held for expenditure and all underlying conduct that consumes that expenditure. To present information that takes a different approach to the presentation of statistics, presents a form of resistance.

The truth about the truth

Foucault argues that while the law and its supporting structures may purport to protect the doctrine of justice and equality, this is a farce (Foucault, 1991b). The law according to Foucault, is not an assurer of freedom but an agent of the dominant classes whose purpose is to secure the extant social order in perpetuity (Burchell et al., 1991). If the position of dominant groups is dependent upon the truth of suppressive tactics not being known, then it serves the purpose of those who benefit from the existing social order to keep the truth from being revealed. Techniques of subterfuge rely upon social norms being maintained by the interdependencies that exist between disciplinary power, the subject and knowledge. The subject therefore constitutes a party to his own oppression.

When the truth is upheld by the subject, that which is different is problematised as false, so resistance may be perceived as subscribing to a flawed doctrine thus resistance is resisted and norms reinforced. Judging what is normal and what is not is, as will be evidenced in what nurses in this study had to say, commonplace. Foucault stated that:

[14] A system of public service management based on the notion that organisations within the public service must for reasons of efficiency, operate along business lines (Dziak, 2020).

> The judges of normality are everywhere. We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the social worker-judge; it is on them that the universal reign of the normative is based; and each individual, wherever he may find himself, subjects to it his body, his gestures, his behaviour, his aptitudes, his achievements. (as cited in Owen, 1994, p. 181)

Perceptions of external judgement add to self-judgement thus increasing sensitivity to the risks of marginalisation and to normalising compulsions. Marginalisation is a position of isolation that can have ongoing and self-perpetuating consequences including the withholding of resources and the implementation of restrictions that constrain choice (Foucault, 1983).

Systems and processes of institutions make possible the enactment of games; games where the result is the constitution of a truth and where the rules are dictated by institutional discursive procedures (Rabinow, 1997). Foucault (1980) identified what he referred to as an interstice where interactions between discursive forces occur during games. Truths that result from games occurring in interstices are not necessarily the same as truths approved by organising institutions or by overarching governmentalities however despite agreement or discrepancy, all institutional members subscribe to discursive games and consent to the rules. Subscribing to discursive games contributes in a mutually dependent way to the formulation of truths. Games contribute to subjectivity because game tactics and strategies become set pieces that are assimilated and used to create the self. Through the repeated re-enactment of set pieces, subjects come to understand the truth about themselves which when operationalised, informs future game rules (Rabinow, 1997).

Discursive procedures that dictate the rules for games of truth constitute knowledge, therefore because power is a strategy that operates between knowledge that is seen and knowledge that is so close it cannot be seen, power is also a constituent of the truth (Davidson, 1997). Any attempt to deny truths in conduct or in thought represents a violation of the rules of the game so players who infringe are penalised and punished. The purpose of punishment and the importance of making the nature of punishment public, is to establish an environment whereby the subject comes to fear non-compliance which in turn leads subjects to monitor themselves to ensure that their actions, attitudes and values comply with the rules of the game (Foucault, 1990). In games of truth, to be marginalised is tantamount to being sin-binned.

Foucault claims that truth games are the "general politics of truth: that is, the types of discourse which it accepts and makes function as true" (Foucault, 1980, p. 221). The notion of truth games has its place in ethics when a subject examines how truth games impact upon the self and how staying in the game, or returning following a sinbin, may involve training and self-improvement. Knowing what training is required in contemporary society is less clear than it has been in the past when the constituents of the identity of the self could be judged against the doctrine of religion.

Nowadays, that which serves as an ethic of the truth is shaped by dominant discourses yet despite the disruptions brought about by the rise of contemporary governmentalities and innovations associated with modernity, Foucault (1984a) claimed that no comprehensive, adaptive doctrine has emerged to replace religion in society. Thus contemporary discourses do not represent a complete severance from the ethics of religiosity but cleave onto attenuated versions of ecclesiastically inspired philosophical ideals. A subject may seem to create their self according to the truth of their perceived ideals, but the real truth is that a subject's work on themselves is simply a reflection of

what dominant discourses need the subject to be. There is no knowable truth about the subject because the subject is continually being reconstituted by their own practices in response to their changing world (Foucault, 1984a). The notion of game-playing not only forms a useful tool through which to analyse relations between individuals and groups of individuals in this study, it is a concept that nurses themselves referred to as a way in which advantage might be gained. Thus game-playing is connected to status so is used to advance thinking about the contribution that status makes to the more experienced nurse's developing sense of military nurse identity.

Parrhēsiatic processes for the promulgation of the 'truth'

Foucault described in his archaeology of the care of the self, the Athenian practice of parrhēsia (Foucault, 2005). Parrhēsia involved individuals applying principles to guide conduct as opposed to the practice of individuals obeying specific rules. Parrhēsia also required the alignment of an individual's actions with what that individual voiced. What was spoken was carefully considered and based on the speaker's understanding of their relationship with knowledge and their knowledge of themselves. Foucault found that in classical times as now, knowledge was the conduit to the truth yet Foucault's archaeology shows how the constitution of the truth has changed over time. In contemporary society the truth is represented by what most people believe it to be but in Athenian society gaining access to the truth involved young people undergoing a process of change that involved retreating from society, undergoing routines, training and self-discipline (Foucault, 1976, 2005). The truth then was guarded because knowledge of the truth was believed to save individuals and therefore was difficult to achieve (Foucault, 2005).

Once having gained knowledge of the truth the parrhēsiast was obliged to pass it to their leader. Speaking the truth however involved considerable risk because leaders had the

right to punish advisors if decisions that had been based on the parrhēsiast's advice turned out to be unfavourable (Foucault, 2005). Parrhēsia endures today in relations between leaders and followers in that leaders wish to hear the truth from followers in order to make informed decisions yet the truth can only be told if followers feel confident and supported to do so (Harter, 2016). Parrhēsia is important to this research because one of the responsibilities of the military nurse is to provide advice to commanders. What happens when nurses perform this function is examined using the Foucauldian tools discussed here.

Harter (2016) explained that exercising integrity through speaking the truth can be self-defeating in that if integrity is exercised and courage undertaken in order that the truth be told, if the truth is not wanted or not understood, relations between the subject who speaks and the subject who hears may be impaired. If relations are impaired, both the speaker and the subject who hears may be negatively affected. One way Harter claimed that negatively impacted relations may be repaired, is through reciprocity whereby individuals seek to realign their ideas and perspectives. This involves individuals coming to a mutual understanding of what constitutes the truth. This then requires subjects to review their positioning in relation to knowledge and being courageous enough to make change. Thus reciprocity not only serves as a foundation for effective leadership but as a tool for re-establishing functional relationships.

Resistance to traditional ways of knowing

The NZDF bases its professional military development on empirical knowledge founded in the positivist tradition (Simons, 2009). Simons claimed that prioritising certain approaches to knowledge acquisition limits the quality of learning outcomes and therefore the ability for military personnel to reach their potential. Simons indicated that scientific methodologies when imported and applied in isolation, restrict the

pedagogical possibilities of knowledge acquired in other important and contemporary ways. Shirley (2018) joined Simons in a call for the application of a more modern pedagogy in her proposal for a new approach to military education yet Shirley reported that success with her project is challenged by a prevailing positivist mentality that normalises the empirical and problematises alternative ways of knowing.

The prioritisation in the NZDF of scientific methodologies is evidenced in the proclivity of those in the organisation to quantify experience using numbers, tables and percentages, and by drawing conclusions and making plans based almost exclusively on these (see for example Ministry of Defence, 2014b; New Zealand Defence Force, 2015d; Werder, 2018). Foucault (2002) claimed that institutions gain authority from that which is accepted and repeated but although Foucault was referring to authority gained through the repeatability of statements and visibilities, this same notion might also be applied to practical knowledge thus providing ontological support for Shirley's and Simon's claims that norms in ways of learning are self-perpetuating and exclusionary.

Latta (2018) asserted that strategic conditions are becoming increasingly complex therefore military personnel must not base their responses to that increased complexity on information gained solely from evidence that is objective for as Shirley (2018) claimed "if we [those in the NZDF] continue to do the same thing, we will get the same results" (p. 67). Therefore if progress is to be made, thinking must as Latta purported, overcome traditional habits by incorporating new perspectives and alternative ways of knowing. It was within the context of Defence Force conditioned mind-sets that Golightly (2018) noted that military decisions based purely on the usual ways of knowing fall short of the thinking required for future military operations. So whilst non-positivist methodologies challenge norms of rationality and therefore risk being considered 'irrational', I have accepted that risk and taken up Foucault's project of

offering new perspectives on knowledge so that Shirley's call for different results might begin to be realised.

Summary

Chapter four has introduced the Foucauldian theoretical underpinnings of this research. Justification for the epistemological approach has been provided by a commentary on the governmentality of military forces that must find new ways of gaining knowledge if knowledge is to address the complexity of the modern strategic environment. The Foucauldian theoretical tools that have been selected to facilitate the examination of information contained in this study were detailed. Foucault's knowledge power paradigm has been explained so that the way in which power projects across strategic arenas and down into private spaces might be understood when participants' information is analysed in later chapters of this thesis. Individuals have been introduced as subjects that are products of power who are free only within the constraints that the power knowledge paradigm permits so that it will be able to be seen how the ability of military nurses to navigate between their dual accountabilities is constrained by their environment. Chapter four provided information on technologies of power that as effects of social constructs, change norms so that it is realised that when norms change the truth is impacted. The next chapter will provide information on the systematic procedures followed to plan for, gather information, and analyse material used in this study.

Chapter 5: Operationalising a Foucauldian methodology

Introduction

Foucauldian theoretical concepts that inform this research were presented in the preceding chapter. The notion of validity in relation to parrhēsiastes and ontology discussed in chapter four is relevant for chapter five which will present the steps followed to process information in this study of military nurses. The methods that will be described in this chapter are not those of the militarily valued quantitative approach but of the 'other' qualitative design. Rationale for that design and the steps that were followed for the collection and analysis of information are presented. The processes for ensuring that academic standards for qualitative research methodologies have been met will be described. How participants are protected within the ethical constructs of confidentiality and conflicts of interest is explained as are the methods used to seek and select participants. Justification for the nature of material that was chosen and the steps followed in the analysis of data will be discussed. Techniques and processes for navigating successfully between data sources and the formulation of concepts are presented together with the way in which literature was tracked and used to enrich the knowledge gained from this study.

Methodological considerations

Establishing how nurses serving in the NZDF navigate professional accountabilities and role expectations involved designing processes that would guide the way in which information would be gathered and analysed. Approaches to research are informed by research traditions that operate within different domains and by what is already known of topics under examination. When little is known, projects lend themselves to qualitative approaches because qualitative methodologies help researchers to identify

themes in previously unexplored phenomena upon which further research employing different epistemologies might be based (Clarke & Braun, 2013; DePoy & Gitlin, 2011).

Most military nurse studies identified for this project's literature review were focussed on how nurses interact with patients on deployments or on how nurses adapt to life during or following overseas operations. As previously explained, the majority of studies were conducted with military nurse populations from the US with a significantly smaller number of studies examining nurses from other military forces. The dearth of research investigating professional aspects of contemporary military nursing in Australia and New Zealand together with the call for new ontological approaches to research discussed in chapter four, provided an early indication that my research into New Zealand military nurses should take a qualitative approach.

Research design and ethical consent

It is common for those who utilise Foucault's methods for research to undertake a discourse analysis but because very little textual material from the NZDF was publicly available that had any focus on military nurses, I chose to employ a thematic analysis using Clarke and Braun's (2013) method following Foucault's archaeological and categorical processes. Employing a thematic analysis is useful for new domains of inquiry because it enables emerging regimes of truth to be categorised and their constitutive interdependencies to be examined in ways that reveal connections between previously unreported and seemingly unrelated constructs (Clarke & Braun, 2013).

In accordance with safe research practices and as a student of Massey University, it was necessary for me to provide to the Massey University Human Ethics Committee (MUHEC) the processes I intended to employ to conduct the research. The Massey University online human ethics submission process was followed. Section 14 of the

Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants (Massey University, 2015), states that researchers must consider the implications of conducting research that may conflict with their professional roles. Being a researcher who is also a member of the RNZNC indicated that such a conflict existed so a full application to the MUHEC was made. Guidance on ethical processes for research was provided by Denzin and Lincoln (Denzin & Lincoln, 2011).

The project was approved by the Massey University Human Ethics Committee: Southern B, application 16/26 (see Appendix A). The initial approval was for three years but because the project had not been completed within that timeframe, an extension was sought and granted in July 2019 (see Appendix B).

The NZDF have in place mandatory research application processes that must be followed for any studies conducted on NZDF personnel. This is necessary to ensure that certain groups are not burdened with involvement in multiple projects and to ensure that risks associated with the release of information that is of a restricted nature are minimised. Approval to conduct research on a section of the serving NZDF population was sought and provided (see Appendix C). Approval was given on the proviso that a copy of the research report would be provided to the NZDF and that any publications arising from the study would be sent to Organisational Research for review prior to external publishing. This condition conveyed to me the understanding that I am to control the dissemination of the findings of this research in ways that align with the governmentality of knowledge in the NZDF. That the NZDF approved this study indicates that the organisation is becoming more accepting of new ways of learning and that critical epistemologically-based studies may make a useful contribution to the Defence Force's repository of knowledge. The mandatory review of publication manuscripts may be viewed as a technique for institutional control but because

manuscripts must be read by NZDF personnel if approval is to be provided, it may also serve as a useful mechanism for sharing within the NZDF the findings of the study as well as what the NZDF might view as a novel research methodology. While the NZDF ethical processes undertaken at the outset of this project appeared to seek to control facets of the work, at no time has the NZDF attempted to influence the direction or the findings of this research, nor have I as a researcher been subjected to any coercive tactics by members of the organisation or its representatives.

Defence Force research approval processes involved the appointing of an organisational sponsor who would serve as a conduit for the distribution of invitations to prospective participants and for the management of any queries relating to specialised military information. The sponsor was readily available throughout the conduct of the research and became an important resource for specialist military information.

Initial consideration was given to seeking a breadth of information from a range of different sources including texts, patients and those who work with and for nurses, however it was ultimately decided to restrict data collection to material provided by nurses alone. This decision was based on the premise that the best source of information about the subjectification of individuals are those individuals themselves (Harter, 2016). In order to maintain confidentiality and for the purposes of gathering person specific data, it was determined that interviews would be selected as the sole information-gathering technique and that interviews would be conducted one-on-one.

Due to the way in which personnel describe joining a defence force as contracting to a new way of life that involves becoming part of the military family (Moskos, 1977; Vuga & Juvan, 2013), it was determined that the focus of the study would be on uniformed nursing personnel only. Unlike civilian nurses employed by the NZDF, commissioned nursing officers must comply with military law and be available for operational

missions which requires meeting all the standards that belonging to the deployable officer corps demands. Factors that distinguish nurses in uniform from NZDF civilian nurses subjects the two groups to different regimes of truth, therefore only nurses who were members of the RNZNC were invited to participate in the research.

Developing ways in which to navigate professional and role accountabilities within the military health service is something that takes nurses time. It was assessed that nurses need to have served for a minimum of five years before it can be assumed that they have gained a full understanding of the military contextual conditions that lead to the constitution of the nursing officer. Military contextual conditions include the governmentality of the NZDF, military institutional registers, and the conditions of possibility that limit or create opportunities for the navigational strategies that drive nurses' performative routines and their responses to disciplinary technologies. Furthermore, many military nurses will have within five years of commissioning, undertaken operational deployments or exercised with other military forces and therefore been exposed to the variabilities of conditions and shifts in power relations that these experiences bring. Thus only nurses with more than five years military service qualified for inclusion as participants in this research.

In addition to serving nursing officers, military nurses who had left the RNZNC in the preceding five years were also sought as participants. The reason this latter group of nurses were included was due to a supposition that the ways in which recently retired nurses had addressed professional boundaries and role expectations during their time in the RNZNC may have influenced their decisions not to remain in the military. It was thought that gaining an understanding of the navigational techniques that retired nurses had utilised during their employment with the NZDF would provide dimensions that would enrich the research.

Bounding the study for a qualitative inquiry did not include any specification for the size of the participant group. It was not known at the outset how many participants would be required to provide for a rich and detailed understanding of information. It was anticipated that data analysis would be undertaken concurrently with participant interviews so that when the identification of new themes would be seen to be reducing, the recruitment of further participants would cease. An estimate of between 15 and 25 participants was initially proposed. It was considered prior to the conduct of the research that the depth and breadth of information sought may not have been achievable with 15 participants so I was prepared to recruit additional participants if the need arose.

Managing conflicts of interest

The potential for a conflict of interest that had triggered the full ethics application process arose because the RNZNC is a small corps and because I had previously been a DNS for the NZDF, I knew all prospective participants and had in the past been a line manager for some. My subjectification as a nursing officer has been constituted through a multiplicity of relations, both personal and professional, with some of those relations being of a similar nature to those that have led to the constitution of study participants. However each individual's subjectification creates personal and unique truths to which others are unable to subscribe. Therefore to ensure that the research process was ethical and valid, it was important to protect the truths of all participants, not by suspending my own truths which in itself would not be possible, but by acknowledging that the connection that would occur during the interview process between my truths and those of the study participants would constitute additional power relations that would have an effect on the generation of knowledge. Throughout the process I needed to be aware that relations that had arisen not just in the workplace but during the interviews, would

influence what participants elected to divulge and what information I would later select to use and the ways I would interpret it to achieve the study's aims.

A singular aspect of the constitution of a prospective participant's own truth is that because I had been a DNS for the NZDF, I may have represented a personification of some aspects of governmentality. Power relations at both individual and institutional levels that discipline and order conduct may have created impediments to the recruitment of participants or limited the information participants were prepared to share. As it was not possible to remove the conflict of interest, I sought to mitigate it by adhering strictly to Massey University's principles for the protection of human subjects (Massey University, 2015) through ensuring that participants understood that decisions relating to their involvement in the research would not impact upon their careers. The NZDF organisational sponsor was a serving member of the RNZNC who agreed to assist by providing to the population of immediately past and currently serving members of the RNZNC, a participant information sheet (see Appendix D) and instructions on how to make contact with me should those who were eligible wish to participate in the study. The role of the sponsor in relation to engaging with potential and actual participants was restricted to disseminating the participant information sheet. I was advised by the sponsor that no nurse made any direct contact with him about the research so he was unaware of who may or may not have been interested in becoming a study participant. The sponsor was therefore never in a position where coercion could have been used to influence participants.

The information sheet sought to address any preliminary concerns participants may have had relating to the potential for a conflict of interest by introducing me as a researcher without reference to my military role. The sheet, designed as an invitation for participant engagement, specified the precise purpose of the study together with the

nature of their involvement should members of the targeted population choose to take up the invitation. The information sheet highlighted that throughout the research process, participation would be strictly voluntary. Prospective participants were advised that even if they initially consented to becoming involved in the research, they retained the right to refuse to answer any interview question or to withdraw from the study at any time prior to their information being analysed. Any individuals who may have had questions relating to the research were encouraged to contact my supervisors or me.

The information sheet clearly specified that whatever participants shared during the research process would be used for no other purpose than the research aim, and that participant information would be kept in the strictest of confidence and under no circumstances be divulged to representatives of the NZDF nor anybody else. This approach was designed to provide potential participants with as much information as possible to alleviate any concerns relating to the potential for a conflict of interest. The mitigating points described here were reiterated at the commencement of participant interviews.

Confidentiality

In accordance with the principles upon which safe research is established (Denzin & Lincoln, 2011) and with Massey University's Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants (2015), the identities of those nurses who agreed to participate in this study needed to remain confidential. This was important because all the participants were registered nurses and many continue to serve as members of the NZDF so it was necessary for provisions to be put in place so that information that was provided during interviews would not be connected to individuals and therefore risk impacting upon their employment or their reputations. Protecting

confidentiality posed some challenges given the small number of nurses in the RNZNC and the sometimes unique roles performed by some individuals.

While I had committed to maintaining the confidentiality of participants by separating their identities from their information by means of participant chosen pseudonyms, and by ensuring that processes and locations for the storage of information were secure by means of locked cabinets and electronic password protection, this did not address the risks presented to confidentiality that Denzin and Lincoln (2011) warned about by the cumulative effects of multiple pieces of information leading to the identification of a single member of a small community. Some nurses during their interviews spoke of experiences that were already known to others thereby increasing the likelihood that their identities as study participants would become apparent.

A number of participant quotes have been paraphrased due to the quotes containing highly identifiable material or distressing detail. Participants at times referred to people whose identity or that of the participants, would have been revealed had their true names been used. On the occasions when for the purposes of clarity a person's name has been required, that name has been substituted for a pseudonym. Similarly, to reduce the risk of revealing the identity of some participants, certain identifiers such as locations, missions and formations have been either removed or replaced with generic terms.

Interviews were conducted between August and September 2016 at a time when New Zealand's commitment to military operations in Afghanistan was winding down and when New Zealand's initial support to national security forces in Iraq was coming to an end. A twenty year period of increased operational tempo for the NZDF was deliberately reducing so that developments in training methods and tactics could be taught and embedded (New Zealand Defence Force, 2015e). This pause created time for

nurses to concentrate on individual development and it also optimised the availability of potential participants for this study. Sixteen nursing officers responded to an email released by the NZDF sponsor containing the information sheet calling for study participants. The nurses were divided into two tranches with the first tranche comprising 10 nurses selected according to those who responded earliest.

Written informed consent was obtained from participants prior to their interviews (see Appendix E) In addition to consent being sought for information related to the research, participants were also asked to consent to their interview being audio-recorded and for information contained in their transcripts to be released for reports and publications. Members of the RNZNC, and those who have served as members of the RNZNC and who met the criteria for inclusion in this research, are not considered to be a vulnerable group so no special considerations were required during the research consent process. Participants were offered the opportunity to have their interview recordings returned to them and to have their desires recorded on the participant consent form.

Access to participant information was restricted to my academic supervisors, the professional interview transcriber and myself. A professional typist was engaged to transcribe verbatim the audio recordings into text. Before employment, the typist signed a transcriber confidentiality agreement (see Appendix F) that committed the transcriber to maintaining the confidentiality of the information contained in the transcripts and to not making copies or keeping records of the information. Upon completion of the transcription, the typed documents were checked with the original audio recordings to ensure that the text was a complete and accurate account of what participants had had to say.

Once this research is complete, paper copies of study data will be transferred to a secure room at the Massey University School of Nursing where together with a universal serial

bus flash drive containing copies of all electronic information, they will be stored for five years and thereafter destroyed. All electronic copies of the research data remaining on my personal computer will be erased upon the lodging of the flash drive with the School of Nursing.

Data collection

Participants were given the option to be interviewed in a private office within their local military establishment, at Massey University, or at a place of their choosing such as their own homes. As a serving member of the NZDF, I held the necessary security clearances and approvals to access military establishments throughout New Zealand and was therefore able to obtain permission to use interviewing offices in any NZDF camp or base. Interviews of an average of an hour's duration were held in Manawatu, Wellington and Christchurch. Brinkmann (2013) provided direction for processes relating to the interviews and for guidance on interviewing techniques.

Preliminary formalities prior to the interviews included obtaining informed consent, discussing the interview process and answering any questions that participants may have had about the research process. The interviews themselves were unstructured with information gathering beginning with deliberately broad based inquiries followed by more probing questions that sought rich and detailed information that would help to address the aim of the research. The schedule that was used to guide the interview process can be found at (see Appendix G).

During the two month period in which the first tranche of interviews were underway, a planned concurrent review of emerging themes was conducted. This dual process confirmed when no new themes were emerging in interviews, and when the ideas and concepts underlying what participants had to say were becoming predictable. Saturation

was believed to have been achieved after 11 participants had been interviewed. It was not however only patterns of concepts that were being sought at interview. Unique participant experiences were also sought so that insight, alternative perspectives and depth could be added to analysis. Sufficient additional material was also acquired after 11 participant interviews.

Data analysis

Information contained in the transcribed documents of participants' interviews was analysed using the thematic analysis method designed by Clarke and Braun (2006) . According to Clark and Braun, thematic analysis is an extremely flexible analytical technique that can be used to categorise and interpret information gathered through a variety of data collection methods and from a range of theoretical positions. Clarke and Braun's thematic analysis allows for the detection and interrogation of unusual or interesting cases alongside recurring themes of both institutionalised and non-institutionalised discourses. The selected method allows researchers to employ both inductive, also referred to as semantic, and theory-driven, latent information categorising techniques. Whilst Clarke and Braun state that researchers typically select only one of the two categorising processes, due to the dearth of research on my study population and therefore lack of information on what might constitute an area of interest, I chose to employ both semantic and latent data categorisation processes and to code the entire data corpus.

Following Clarke and Braun's (2006) method, I initially coded textual data into categories that reflected participants' narratives of knowledge and the ways in which they navigate their work as well as participants' perspectives of the ways in which others navigate theirs. An alphabetical system with an explanatory key was employed to assist with the management of the considerable number of codes. During this step of the

process, codes that shed light on other codes by providing insight or a counterpoint to an idea or a position were journaled. Some data extracts were found to pertain to several codes so were coded multiple times. This became problematic during the writing of the analysis chapters. To avoid repetition I elected to directly quote in the analysis chapters each multiply-coded extract only once but made reference as necessary to those extracts when discussing other themes.

Latent coding processes involved a secondary analysis of the data corpus, this time using a Foucauldian interpretative approach—one that problematised the semantic understanding of the order of things so that new and alternative perspectives might be uncovered. This approach resulted in the formulation of further themes and a repository of an extensive amount of seemingly valuable information. A table was developed to help manage and make sense of that information. The table comprised all codes grouped into their corresponding semantic and latent themes, with columns containing ideas and concepts that connected the themes to one another. Relationships between participant information and material that had appeared during my review of the literature soon became evident so to ensure that connections between emerging themes and the literature were not lost over time, hyperlinks were made using the EndNote reference management software tool.

Codes were depicted by their original alphabetical assignations to ensure that during the writing phase of the project, codes could be tracked back to their original data items, a process that continued throughout the thematic analysis to ensure accuracy of information transfer and to ensure that analysis took into account the context that gave rise to what participants had said. Throughout the process of the formulation of themes and the development of the thematic table, I had been conducting an ongoing in-depth inquiry into the value of each theme and its relationship with others. This analysis

revealed that some themes were so closely related to others that they could be combined within a single overarching theme while other themes were, as work progressed, becoming redundant so were removed from the table.

Once the thematic table and corresponding journal notes appeared complete, consideration was given to the way in which the information would be presented in the research report. The development of working outlines of draft analysis and discussion chapters allowed concepts under inquiry to be tracked so that ideas would not be misplaced or duplicated. While it was not expected that the research would reveal a systematic and chronological progression of a military nurse way of navigating their professional accountabilities and role expectations, a macro analysis of themes was suggestive of nurses experiencing an evolutionary journey albeit one punctuated with as Foucault (2001) found in his archaeological projects, interdictions, disruptions and discontinuities. Notions of a journey therefore led to the creation of chapters that represented in a chronological way, surveillance and the identification and enforcement of military norms, opportunities arising in the grey space between nursing and the military's ways of working, and the constitution of a collective group of nurses.

In the discussion chapter of this thesis, the constituents of the analysis chapters were subject to an in-depth inquiry drawing on Foucauldian concepts of power, governmentality and technologies of the self. Emerging under examination were also notions connected to Foucault's interpretation of parrhēsiastes, a concept that I had not up until that stage considered employing as a philosophical tool for the research. An analytical construct consisting of the will to truth that reflected the parrhēsiastic experience of nurses was therefore added. Throughout the formulation of the discussion chapter, findings were constantly compared and contrasted with the literature. This action process served to highlight commonalities and differences between the

experiences of nurses in this study and the experiences of military nurses in other places. These commonalities and differences provided further material for discussion and helped to contribute to the drawing of conclusions for the research.

This study has involved iterative thinking and action processes that DePoy and Gitlin (2011) describe as typical of qualitative research methodologies. The preliminary literature review was revisited multiple times to ensure currency of bibliographic referencing, to inform theoretical direction, and to compare findings in the literature with those of this study. Similarly the chapter describing the philosophical foundations of the research has been reviewed to ensure that all theoretical constructs used in the research process have been explained. This methods chapter has also been an iterative process worked up alongside the development of themes and concepts that have helped elucidate the way in which military nurses work.

Summary

This chapter has explained the methodological considerations that were employed during the process of conducting this research into military nurses. While the rationale for selecting a qualitative approach using Foucauldian theoretical underpinnings was explained in chapter four, chapter five has detailed the sequence of steps taken during the research journey that led to such decisions. Chapter five also presented the background to other choices that were made for the provision of the protection of participants and for the management and protection of information provided by them. This thesis now moves on to describe what was found during the analysis of participants' information. The next chapter, the first of three devoted to reporting on the data, will explain how nurses come to understand what it is like being a nurse in the NZDF.

Chapter 6: Surveillance and the identification and enforcement of norms: Exploring nurses' understandings of the martial environment

Introduction

The previous two chapters have provided the frame for the conduct of this study. Processes that led to my decision to challenge the dominance of quantitative methodologies in the military by selecting a qualitative approach underpinned by Foucauldian theory for this research have been explained. Positioned ready for use are the Foucauldian concept management tools of power and knowledge, governmentalities of institutional authority, truth as a product of dominant discourses, and the problem of parrhēsiastes.

Considerations of how the research process would be managed were presented in chapter five along with the steps that were subsequently followed. Each of the preliminary steps in the research process that were designed to safeguard participants were done so in respect to the unique relationship that I as a knowing researcher have with study participants. The nature of that relationship was explained so that steps to protect the confidentiality of participants and their information during the research process could be justified, not just in relation to ethical research processes but to reassure participants in advance that additional care would be taken.

This next chapter is the first of three that analyse what participants had to say during the information gathering phase of the study. Chapter six presents an examination of the transition of nurses from civilians into Army officers. The culture of the NZDF will be brought into view and key concepts that reinforce the culture will be revealed through the impact that these have upon novice military nurses. Nurses' subject positions will be

described in relation to nurses' perceptions of status and control. The chapter will conclude with a depiction of nurses' views of their place in military health services.

Control of the Defence Force culture

The article "What makes us the New Zealand Defence Force?" (New Zealand Defence Force, 2015h) summarises the collective findings of interviews with senior leaders and focus groups comprising of volunteers from the NZDF workforce. The NZDF is described as possessing a "winning culture" (New Zealand Defence Force, 2015h, p. 11) that reflects attributes such as the upholding of a strong sense of community, the existence of strong leadership, and individual members having a clear sense of purpose. Top priorities are said to be the maintenance of safety, and service personnel being well-trained.

Senior leaders in the NZDF are said to recognise that local cultural variants exist with reference being made to the importance of developing trust when individuals begin working in new environments (New Zealand Defence Force, 2015g). Guidance provided to assessors to assist with the formulation of performance and development reports states that all personnel are required to understand the significance of culture in order that they may increase their personal acceptance within groups and therefore their influence (New Zealand Defence Force, 2017e). Once individuals have attained the rank necessary to lead teams, they are required to recognise the relationship between culture, performance and organisational outcomes. The NZDF leadership development and performance assessment system places increasing responsibility on individuals as they progress in their careers to reinforce, impact upon and ultimately drive organisational culture while at the same time requiring leaders to remove impediments to those

outcomes said to be desired by the organisation (New Zealand Defence Force, 2017c, 2017e).[15]

The expectation is that all personnel including nurses, comply with desired cultural practices and that they conduct ongoing self-surveillance to ensure that their speech and behaviour evidence institutionally accepted conduct and attitudes. Kerry described how he became accustomed to these ways of being observed:

> I got acculturated into the military and I spent that first few years probably just being coached, groomed, mentored and walked through what's required from me; not necessarily contemplating too much on high level policy or high level issues about what we do and how we do it. (p. 20)

The success of the breadth to which the communication of strategies that raise organisational values as a cornerstone of cultural practice is apparent in nurses' descriptions of the way they work. It is also apparent that nurses are aware that they are not only under surveillance to ensure compliance with expectations but that they are also expected to place others under surveillance. Alice commented that:

> I don't know how people outside [the health services] feel but certainly people inside, when they see people rolling up to work late and going home early which happens at times, it's not a good look. From the day I came here people were going "you've got to uphold the standards because that's what everyone judges you on". (p. 7)

[15] The New Zealand Defence Force Competency Framework requires individuals to seek "opportunities to build social capital with members of other units, organisations or cultures in order to maximise the success of relationships" (New Zealand Defence Force, 2014, p.8).

The outcome of surveillance must be reported through the NZDF performance and development reporting system (New Zealand Defence Force, 2017e). The performance and development system makes it clear to leaders that any deviation from expectations is to be actively managed and because all personnel are considered to be leaders, all personnel are required to judge and manage others. In addition, the very first category of assessment for performance review is the requirement for individuals to lead themselves. Reporting on the success of an individual modelling the organisational ethos and values at all times is the first category to be assessed. This indicates that a service person is required to continuously review themselves to ensure that their behaviours align with their understanding of cultural expectations.

Alice did not question being judged or that undertaking the judgement of others was an expectation of the "everyone" she referred to. The assumed right of nurses to judge traverses rank and seniority. In comments relating to the gender positioning of members of the RNZNC Andrew explained that "I judge [my commanders] on their competence and their decision making rather than on anything else" (Andrew, p. 3).

Conducting critiques and formulating opinions of what is of value occurs across NZDF professional, hierarchical and social structures and are promoted by the way in which institutional assessment criteria such as that contained in the performance development framework, requires personnel to constantly inspect the conduct of others. Juridical structures that require individuals to monitor not only their own compliance with cultural expectations but that of others, evidences Foucault's comments that governmentalities exploit the propensity of subjects to constantly seek alignment with norms as a means of reinforcing the value of the institution as well as its means of controlling the population (Foucault, 1983, 1991a).

The NZDF do not have in place 360-degree feedback reporting although Andrew gives the impression that he possessed an inherent right to assess the performance of those who did not report to him. Andrew's position is supported by Alice in her comments that everyone judges everyone else which in turn confirms Foucault's assertion that "the judges of normality are everywhere" (as cited in Owen, 1994, p.181). When the judges of normality are everywhere, organisationally sanctioned reporting extends beyond gathering information for performance assessment to the promotion of a system of widespread interrogatory surveillance for other purposes. These purposes do not have formal reporting mechanisms but are nonetheless disciplinary. The criteria is subjective and dependent upon noticing what a "good look" is meant to be like.

Disquiet in difference

The constitution of a good look, the manifestation of desired conduct, can be defined by that which it is not (Foucault, 1991a). When relaying the experiences of working with a doctor whose conduct was later found to be in breach of the AFDA, Duncan described that:

> The medical officer, he had a couple of charges while I was there in a short period of time. The medical officer certainly did things very differently and I was a lieutenant brand new to the system, so it was all so very awkward. (p. 6)

Doing "things very differently" is a euphemism for more pointed criticism of the conduct of the medical officer who was not only more senior to Duncan but also a member of a different profession. Nurses tend to voice their judgement of non-nurses in veiled ways. Their avoidance of direct criticism may indicate that nurses are aware that there is often no legitimate reason for them to critique those who sit outside their

reporting lines or outside their profession however they are no more candid when it comes to judging one another.

George when relaying what it was like to work in a G List officer appointment, made a number of observations about other nurses that had become evident to him only after he had been posted to a non-nursing role. While acknowledging the professional isolation that his position presented, he described a growing divide between himself and another nurse that was collocated in his formation:

> She's been driven by just doing her nursing job in the MTC without worrying, like without thinking too much around those extra officer commitments or responsibilities that could come ... The nurses who I have had in [my formation] have been interesting to say the least anyway, who I couldn't really see as my peers as nurses, or peers as officers anyway. (p. 13)

George measured the value of other nurses by critiquing where these nurses' priorities lay which was within the practice of nursing. Like Duncan, George employed a euphemism, in this case the term "interesting", to describe the failure of other nurses to live up to his expectations. The judgement of failure can only occur as a result of surveillance and subsequent assessment against a criteria that are influenced by the discourses to which George had been exposed. These discourses were more likely to be of a martial nature than discourses of nursing because George was in a G List appointment. It is therefore unsurprising that George concluded that despite the other nurses being located in close geographical proximity to him, they did not possess the characteristics he deemed necessary to be his peers. Discursive influences are key factors in the compulsion for compliance (Foucault, 2002). The problem for George was that the compliance that he was seeking as a nursing officer working in isolation from

other nurses, was not the same as the compliance that other nurses were in pursuit of. George was not compelling marginalisation upon his colleagues by turning away from them, he was risking the marginalisation of himself.

Duncan working in a nursing role and George not working at that time as a nurse, both provide judgements on what they considered to be the noncompliance of military behavioural norms. Foucault (2002) advises that norms are perpetuated by discourse which in turn surfaces deviancy. In this case deviancy is judged and surfaced in the coded terms of "interesting" and "different". Discursive codes become the lexicon of the profession which serve to both reward and punish:

> I've said to my bosses, "I can't do a run RFL"[16] and they've said "We don't want you for your strength, we have young nurses to do that, to be able to deploy. We want you for what's up top"…. I offered to leave… and they've said "No, we want you to stay. We know what your limitations are and we're happy to accept that." But how other people view that, I don't know. They may view that as me getting special treatment or not, I don't know. (Alice, p. 8)

Despite her seniority Alice feared the detection of deviancy and looked to her bosses to reinforce her worth. Alice raised the issue that others may have been judging her for her non-deployability. Despite receiving reassurance of her continued worth, there remained with Alice a real sense that she was positioned on the margins of military nursing.

Fear of the effects that deviancy may bring on the individual was described by George:

[16] Required fitness level comprising a minimum number of press ups and curl ups, and a run that must be completed within a specified time.

> I had a two day orientation that ended up saying “Oh, there's your desk. Oh, there should be a computer somewhere” you know ... and I got given DFO something and DFO something else, like “you need to read these” ... I can remember walking from barracks to work in uniform, hoping somebody wasn't going to salute me because I had no idea what I was going to do ... But yeah, it was just like “Read this, these are the unit standing orders, you'll need to know them by tomorrow” and it's like holy fuck! Yeah, it wasn't a nice time for me. (p. 5)

The period George described was when he had been new to the NZDF and unsure of the extent of the organisation’s ability to enforce activity regulation through the military judicial system. George worried that he was running the risk of unknowingly stepping outside expected behavioural norms yet the enforcers of the judicial system were not and are not, omnipresent. Disciplinary techniques according to Foucault (1991a) rely upon self-surveillance so that when direct surveillance is absent, desired conduct continues uninterrupted. The reward for conformity is the avoidance of punishment but the issue for novice nurses like George is that not knowing when juridical enforcers are likely to be present nor what the behaviours they might be seeking look like, creates considerable stress.

Others also spoke about being new to the Army as stressful:

> It's an overwhelming culture. You know, you come into this beast of an organisation where there is so much you don't know ... We don't even talk the same language as a nurse coming into the organisation ... You know even just following normal military language and conversation they struggle at every step; the blimmin' acronyms that

> we use and the command, aspects to command and leadership and the structures within the organisation. It's like a different world… some of this stuff must just be overwhelming… just how different this environment is to a normal sort of health care delivery environment. (Kerry, pp. 20 -21)

When nurses join the military they become subject to a novel range of disciplinary technologies. Such technologies include new sets of disciplinary techniques as well as new juridical regimes. Kerry believed he held some advantage over other nurses by having had previous military experience because he already knew how to conform. Being "lucky" by having had this experience implies that there is adversity attached to the military initiation process. Initiation and normalisation is supported by surveillance which ensures that non-compliance will be diagnosed and treated (Foucault, 2003). The treatment for non-compliance is marginalisation and the fear of marginalisation is uncomfortable as George found out. Kerry expressed sensitivity to those who had yet to discern dominant regimes of military truths while at the same time providing evidence that he himself had progressed to become a proficient practitioner of conformity and expert diagnostician of deviancy.

Working out worth

Attributes that NZDF career managers seek in military nurses are not the same as those that civilian nurse employers seek. Performance review for registered nurses working in the civilian sector are focused on the NCNZ of New Zealand's Competencies for Registered Nurses (Nursing Council of New Zealand, 2012c). Inter-professional collaboration and responsiveness to patients' needs are key principles underpinning civilian nurse performance assessment yet while reference is made in the NZDF to the need for service personnel to consider stakeholders in their decision-making, the focus

of performance appraisal for nurses is not on how they might deliver services to patients, but on how a nurse contributes to organisational outputs (New Zealand Defence Force, 2017e). Unlike in the civilian health sector where collaboration is used to facilitate care, collaboration in the NZDF is assessed according to how it is employed to influence others (New Zealand Defence Force, 2017e). Thus despite the association between collaboration and the comradeship espoused in the organisation's values (see New Zealand Army, 2019), collaboration serves as an instrument of coercion. Such instruments according to Foucault (1991b), work as technologies in the service of governmentality to reinforce disciplinary power.

Yet despite its varied usefulness, collaboration is not always evident in what some nurses reported about the conduct of other nurses:

> There wasn't the game play [in non-health units]. Within the medical units for instance I remember two different nurses saying to me when I went to work for them and they were senior to me: "You are a threat to me. I will get rid of you from the Army". And I said "Why would I be a threat to you?" "You're a threat to my position and where I want to go" ... He had a career pathway mapped for himself and he felt… I was a threat to him ... I was there to do my job for not only the OC or CO, for the organisation, but for the patients and we were also there for the medics to help train the medics and teach the medics. (Duncan, pp. 4-5)

The goal of the senior nurses that Duncan referred to was to meet organisational career advancement expectations yet as evidenced here, advancing careers pits organisational expectations against nursing's mandated collaborative practice behaviours. Processes for performance reporting whereby senior staff report on subordinates, performance is

measured against military competencies, and recommendations for rank advancement are formalised, serve to subjugate important nursing competencies such as collaboration.

Duncan referred to conduct as game play. All members of institutions engage in discursive games and agree to the rules (Rabinow, 1997) so the game that was being played could only be recognised as one because Duncan was part of it. What is missing in what Duncan had to say about the game was the part that he played.

Games involve competition and competition is a concept actively promoted by the NZDF. Competition in the NZDF is used to foster camaraderie and to encourage individuals to work hard to improve their performance (New Zealand Army, 2020b). Competition also enables commanders to observe how people work with one another and to assess levels of determination. The effects of working hard to be competitive benefit the NZDF, not just by having personnel better prepared to perform their duties, but by enabling the organisation to gain visibility of those who possess the best attributes for coveted roles.

Duncan described coming to an early career realisation that demonstrating individual prowess is sometimes of more value in the military environment than is providing support to colleagues:

> "Do your RFL", so I thought I'd do it with one of the nurses and good Lord, she was two minutes over the time in the run! I'm like I didn't realise there was timing for the run. Whoops! She should've known, so when we did it the next time behind a grader because it was snowing so hard and everything, everyone else's times increased by about a minute and a half but mine reduced by about four minutes. (p. 8)

Surveillance such as Duncan being aware of the RFL times of others, is critical to competition if competition's purpose is to be achieved. The RFL is a compulsory test that serves as a timetable for the regulation of activity and as such is a disciplinary technique in the manner described by Foucault (1991) as supporting regimes of power and control that have multiple benefits for institutions. These include training subjects in compliant conduct and providing the impetus to conduct surveillance of others to ensure theirs. In addition to the latent advantages articulated by Foucault, benefits of the RFL for the NZDF include having a workforce that is physically fit and mentally prepared to engage in demanding tasks, and having personnel familiar with the ethic of competition (New Zealand Army, 2020b; New Zealand Defence Force, 2017b). The NCNZ does not require nurses to demonstrate that they are physically fit to practice because unless advised otherwise, it is assumed that a nurse is physically able to perform their duties (Nursing Council of New Zealand, 2014). In the NZDF the standard for physical fitness is mandated primarily because fitness is an enabler for deployment.

While physical fitness provides an example of how competition can be beneficial to the NZDF, competition is not always positive. Rivalry can escalate to bullying if the onset of unhealthy competitive behaviour is not recognised and held in check (Oliker, 2017). Bullying and discrimination are common behaviours in both the military and in nursing (Blackwood, 2016; Huntington et al., 2011; Weekes, 2017). It has been reported that because nurses are predominantly female, they are at greater risk of being bullied in the military due to the effects that the masculine culture has on workplace aggression (Koeszegi et al., 2014). Bullying, once established, can be self-perpetuating (Johnson, 2015).

> It wasn't, it wasn't competency based. It was… purely personality and I think that you know, new nurse [to the unit] that just thought she was far superior to [us] and took a dislike to me ... She certainly had a number of nurses on her side that—and her motive—how she bullied people was she off-sided, so people that I used to get on with, she off-sided them to me so I was very much alone. It's hard to explain… she intimidated other people. (Bonnie, pp. 5-6)

Discrimination as an effect of competition is said to be deliberately exploited by organisations due to the way in which discrimination preserves desirable existing conditions and reduces risk to organisational outputs however, for individuals belonging to minority low status groups, discrimination interferes with positive group relations and attracts further discrimination (Mialon & Yoo, 2017; Sion, 2016; Stainback et al., 2011; Tropp & Pettigrew, 2005). Nursing is a minority group and, in a theme that will be described later in this chapter, believe they have low status. Sarah described feeling discriminated against when she sought to secure a contested role on an operational deployment:

> I said "look, personal thing, personal thing: I'm this age…. I want to crack on with having a family. I'm going to have to do that sooner rather than later. I really want to go [on a particular operational deployment] now, because that's six months and then when you come home, if you get pregnant straight away then that's nine months, so from a personal situation this is where I'm at", and they still chose this other person too. And 'cause I thought ... they can just do it the other way round ... so there was no consideration of anything… I'd let my

> personal situation be known. I knew this chap's personal situation and they chose him because it was the old boys' club. (p. 4)

Discourses of rivalry encouraged in sport permeate other domains where they serve as instruments of productivity that can be detrimental. Competition for deployments is fostered by the way in which the preparation for operations is conveyed to personnel, concentrated upon in training and assessed in performance review. While the organisation, and therefore the service person, has a primary focus on operational missions, individuals do not always get the opportunity to deploy. In her thesis on becoming a soldier in the New Zealand Army, Harding (2016) described how in the opinion of soldiers, the Army is thought to be more about getting ready to act than actually acting. Harding explained that soldiers in her study believed they were recruited to deploy; a belief borne out by the New Zealand Government's core purpose for the NZDF which is to deliver "Armed Forces ready for combat" (Ministry of Defence, 2016b, p. 45) and the stated core task of the NZDF which is "to conduct military operations" (Ministry of Defence, 2014a, p. 8), yet these missions do not occur frequently enough to satisfy the expectations of soldiers (Harding, 2016). This leaves soldiers believing they will remain perpetually training for a type of assignment that may never eventuate.

When deployments are perceived to be rare and an opportunity to deploy opens up, personnel will compete for selection. This competition runs the risk of undermining both the military value of comradeship and the nursing value of collaboration. Sarah's choice to compete for deployment was she believes, unsuccessful due to the existence of an "the old boys' club" however, the underlying issue that enabled the suspicion of gender discrimination to arise, was the way in which the culture of competition in the NZDF interferes with positive inter-professional nursing relationships.

Winning any competition for deployment provides individuals with the opportunity to apply their skills in employment contexts that are exclusive to defence forces. This exclusivity creates not just the opportunity to gain specialty knowledge and further skills (Finnegan et al., 2015) but it also adds to an individual's prestige because according to Gergen (1997), exclusivity begets status.

At no point in Sarah's deployment narrative did a discourse of nursing competence appear. The absence of nursing discourse suggests that there was no question that all those contending the deployment possessed the necessary nursing skills for the role therefore any requisites selectors were seeking lay beyond those of the nursing realm. It might however also suggest that whether or not nursing competence is a specific criterion for deployment, it does not rate as highly as military competencies do in the selection processes.

As a counterpoint to the assertion that nurses will actively contest operational rewards, Alice who was not able to deploy on operations, decided against bidding for non-operational but attractive overseas activities:

> They've got more than enough other registered nurses who can do the roles that, the deployable type roles. So in saying that I never ever put my hand up for the vets' trips or any of those types of trips, because I think that's not fair. (p. 17)

Alice's decision provides insight into a selective egalitarian positioning that moderates nurses' conduct by considering others ahead of themselves. Teamwork for Alice was particularly important and further evidenced by her description of her experience attempting to work collegially with another more senior nursing officer. The narrative

indicates that competition traverses work that is not only of a deployed nature, but also that which is routine:

> When I took up this position and the other nursing officer who was promoted at the same time in the same area, it was a great opportunity for us to work together and move nursing forward. But I think that person didn't want to have that sort of relationship. To me it's like they wanted everybody to think of them well ... There was a deliberate attempt to make that person the one that people would go to because it made them feel good, and to not recommend that people come to me because that's how it felt. And [that person] only ever came to me when there was something they didn't want to tell people and then [that person] would go back and say "[Alice] has directed", so everybody probably thinks I'm a real b-i-t-c-h. (Alice, p. 11)

This example of a lack of collegiality between two nurses of the same rank suggests that both nurses had engaged in a discursive competitive game. The second nurse used the game to strengthen their position with other nurses through the reinforcement of collegial relations which had, deliberately or otherwise, an effect that resulted in Alice feeling marginalised. Power relations are unable to exist without resistance (Foucault, 1983) which can be seen when Alice chose to actively participate in the game by raising the issue directly with the second nurse by saying "'you've gone out you've told everybody that.' I said, 'that is a slur on my name and I expect you to go out there and rectify it'" (Alice, p. 11).

Individuals tend not to confront others in the workplace when they feel targeted or marginalised; an approach that can lead to an exacerbation of the issue (Blackwood et al., 2017; Catley et al., 2014; Einarsen, 1999). Alice however, did not seek to avoid a

confrontation which suggests that Alice possessed a significant degree of confidence in her ability to manage any potential conflict that may have arisen from the discussion.

Alice was trying to make sense of the other nurse's conduct and her interpretation of its effects but was also aware that challenging the other nursing officer would carry risk. One way Alice attempted to mediate that risk was to refer to a line manager who possessed more juridical power than her:

> I don't know whether [nurses not coming to me has been] directed, or that's the way that they have been brought in and told that "this is what you do" ... I've raised it with my boss whenever something happens that I'm a bit concerned that may have repercussions. (p. 12)

Alice was not only prepared to tackle head-on the conduct that she believed interfered in the advancement of nursing in her unit, she also accessed the institutional hierarchy to counter any potential negative effects that may have arisen from the other nurse's actions. Alice was using her existing influence to limit her possible marginalisation; a situation that had paradoxically arisen as a result of the very lack of collaboration that the NZDF had intended for personnel to use to build influence. Using influence in this way is an action motivated by power that results in the modification of knowledge relating to collaboration.

Forces for moulding the nursing officer into shape

"This is what you do" (Alice, p. 12) constitutes norms of conduct and is a procedure of power that does not remain exclusively within the field within which it first emerged. Procedures of power become knowledge that defines what subjects are permitted to do, think, discuss, and not do (Foucault, 1991a). Signs exist that the isolating of individuals may be a feature of service in the NZDF. George referred to feeling distanced from his

peers due to his role in an extra-regimental appointment[17] as well as the location of his posting:

> I see—like when we go to a Corps conference—and a lot of the nurses are within the central area, so they spend a lot more time together. They're interacting, they're talking about nursing matters, they're talking about military nursing matters, so they have that cohort there where they can be having those sorts of discussions, where I feel quite isolated both I guess in the position that I am but geographically as well. (p. 4)

The conversations are not about military matters but about *nursing* military matters and those who are holding those conversations are centrally located, thus indicating that when nurses collect together, military nursing matters are central to nurses' thinking. While conversations about military nursing matters might be expected when military nurses collect together, where these conversations occur serve to highlight what Foucault referred to as the interdependent relationship between visibilities and discourse (Best & Kellner, 1991). Here, nurses who are not central to military nursing in role do not form part of the centrally located group thus reinforcing what George described as his isolation and what Foucault would have described as his marginalisation.

As a technology of power, marginalisation has a purpose. It seeks to make individuals want to be more like those who hold the central ground (Foucault, 1991a). The desire to make a subject want to change their subject position is evidenced in Duncan's report of occurrences on a SOIC. Despite considerable effort, counteracting forces were working against Duncan:

[17] An extra-regimental appointment is one which is not restricted to those belonging to a specific corps.

> No one would help you bash your beret and you were all expected to know how to bash your beret; no one was there to show you how to iron your uniform properly because they couldn't be bothered, and it wasn't something that was being taught on the course, whereas if you'd all been new they probably would have. (Duncan, p. 8)

Bashing a beret is subjecting the beret to a moulding process so the beret comes to look like all other berets. Duncan was undergoing a moulding process to become more like other military nurses however the process of moulding individuals is intentionally challenging. To enforce learning, the Army relies upon both juridical and disciplinary power. The withholding of information is used to encourage self-resourcefulness whereby the individual is required to teach him or herself necessary skills, or to learn to use influence to gain the assistance of others.

In Duncan's situation, institutional power was reinforced by Duncan's efforts to activate social networks to gain help however, the resistance of other nurses to Duncan's approaches served the purposes of disciplinary power by creating an opportunity for those others to gain competitive advantage. If Duncan were prevented from meeting the uniform standards, those who did meet the standards would rate comparatively higher. The multiple effects of withholding knowledge suggests that it is a useful tool in the transformation of the novice nurse into one who possesses an understanding of not only how to bash a beret but of how factors such as influence, uniformity and competition feature in military work.

Duncan was not the only nurse to report transition difficulties early in their military careers. Angela described how her grades on a course might have been improved if she had had preparatory support from colleagues:

> No one, not one person in our unit who might've done the course gave me any information on it. I was angry when I got back from the course and said “Why weren't I taught? Why wasn't I told anything about this course? I didn't even know what they were talking about”. (p. 3)

When questioned, Angela denied that competitive advantage lay behind the withholding of information and instead blamed the way in which her colleagues were so focused on delivering clinical care that officer skills such as those that were to be taught on the course, did not feature in the nurses’ thinking. This suggests that in the unit to which Angela was posted, discourses of clinical practice dominated discourses of collegiality and completely subsumed those that were martial in nature. Yet like Alice, Angela was not averse to directly challenging her colleagues about their lack of collegial support which indicates that despite being relatively junior, Angela possessed enough confidence to question those who were more senior.

In order to gain the officer competencies the course showed she needed, Angela ultimately sought a posting to another unit:

> I was not happy and really [that unit] was not good for me in that way; had to get away from [there] to actually progress, to progress as an officer in the Army, not a nurse in the Army but as an officer in the Army. (p. 4)

Once in the operational unit Angela believed she developed the officer competencies necessary to become a well-rounded military nurse:

> People [in my first formation] would do things for you, like Captain Upton. When you asked for leave or you wanted to go overseas or something, she'll bang it out for you, you know ... by the time I got

> back to [my new formation], Major Trass was the OC and she used to tell you "just do it". (p. 6)

Whilst it might appear that doing things for another nurse might exemplify collaborative practice, it does not support professional development. Being given the autonomy to "just do it" contributes to independence and allows individuals to become self-resourceful. This then enables the further development of officer competencies which includes individuals possessing the confidence to undertake untried activities as part of the learning process, even if that process raises risks (New Zealand Defence Force, 2017e). Recognising and managing risk is an indicator of nursing competence because the lack of risk management can have serious consequences (Nursing Council of New Zealand, 2012c) so juridical power is a strong disincentive in nursing to risk-taking however juridical disincentives to risk-taking do not exist in the NZDF. Personnel are directed to be "risk aware, not risk averse" (New Zealand Defence Force, 2017e, p. 11).

The colonisation of competition

As has been seen, judges of the normal are omnipresent conducting concentrated examinations of others to seek out difference and make assessments of what difference might mean (Foucault, 1995). Alice stated that:

> When you see the standards slipping or people being allowed to do things that other people aren't allowed to do, so there's a question of fairness I think coming into play here, that what's okay for one may not be okay for another because ... [one nurse] might not fit the in-crowd personality. (p. 7)

Judging norms within the health unit exposes degrees of what is permitted and for whom. Egalitarianism which is not only a principle of the NZDF (New Zealand

Defence Force, 2015a) but a national characteristic (McLean, 2003), is not guaranteed when existing alongside egalitarianism are other invisible but weighty factors. A judging examination detects those factors and sorts them according to worth so such phenomena as the existence of an "in-crowd" can result in valued principles like egalitarianism slipping to a subordinate position.

The judging examination is however not focused in a single direction but is instead mobile (Foucault, 1991a). Alice was both subject to examination and an examiner herself when she noted that standards must be *seen* to be complied with but that exemptions exist. The concept of egalitarianism is subordinated when members of the in-crowd receive benefits that others who are not members do not enjoy. The notion of the in-crowd extends beyond personalities and into practice as Alice again observed:

> When we talk about nursing and people—like when we did the interviews this time around—people would state "Oh I want to be a full member of the Nursing Corps" and to them a full member of the Nursing Corps meant that they're deployable and ... doing their clinical: "I need to be doing my clinical so I'm a full member". (p. 8)

Meeting the criteria to be classified as a full member of the RNZNC, meaning working in clinical practice and being deployable, may qualify an individual for inclusion as a full member of the RNZNC but higher rank appears to disqualify them. This is because promotion presupposes the movement of a nurse out of clinical practice.

Promotion in the RNZNC involves expanded leadership and management responsibilities which reduces the time that a higher ranked person has available to spend in clinical care. Higher rank also attracts increased remuneration so it is not considered fiscally responsible for a higher ranked person to undertake work that can be

performed by someone of lower rank (Joint Support Group Executive Officer for Health, personal communication, May 18, 2020). So although rank provides financial privilege, it reduces an incumbent's ability to work in clinical practice and therefore reduces their ability to be considered a full member of the RNZNC. Not being considered a full member of the RNZNC would therefore almost certainly exclude a nurse from becoming a member of the in-crowd. Thus higher ranked nursing officers may hold more status in the traditional military hierarchical sense but less status amongst nurses than those who are more junior.

Other factors also feature in the social value of individual military nurses. Specialty areas of practice are ordered and ranked in terms of worth so nurses whose expertise lies in an area of practice that is rated higher than others, claim increased status:

> I think there was a lot of professional jealousies ... There was a lot of "Oh, you're just a theatre nurse; we are intensive care nurses" or "you're just a nurse that works in the MTC. You're not a combat nurse that's going out with the field hospital or whatever". So I think there was a lot of role argy-bargy and professional jealousies and just maybe the military attract nurses with strong opinions and personalities. (Bonnie, p. 4)

At no point in Bonnie's narrative of nurses discussing nursing was the value of nursing itself questioned. Internal dissention rotated around the value of different aspects of nursing. Bonnie believed that professional jealousies were to blame for nurses arguing and that individual nurses who are naturally opinionated deliberately seek military service as a way of expressing that natural inclination. However Bonnie's observation of "role argy-bargy and professional jealousies" equally supports the notion that competitive discourses of the wider military context has permeated the nursing domain.

The NZDF is a small military organisation so NZDF nurses work and in some cases live in close proximity to other service personnel. Nurses conduct surveillance of the wider Defence community, observing and becoming subjects within power arrangements of the type described by Foucault (1991a). The norms of interaction between members of this wider community constitute knowledge which generates performative routines. Nurses become parties to this knowledge, moderating and contributing to it at the same time as acquiring the knowledge's consequential routines. These routines include those of a competitive nature.

Nurses import into the nursing domain knowledge and routines of wider Defence competitive behaviours. Surveillance is then conducted in nursing in similar ways to that operating externally. Knowledge gathered about the relative worth of individual nurses is used to inform negotiations with perceived competitors as nurses attempt to improve their personal condition. Nurses new to the NZDF become aware over time of these power relations and as part of their transition to becoming a military nurse, assume the competitive profile of experienced Defence Force nurses.

The lack of what Duncan referred to as game-play reported earlier, is likely to be a reflection, not of low levels of competition in that unit, but an indication that at that time Duncan constituted no threat to the value of others. It was only when Duncan returned to nursing and back to nursing games, that his relative worth in relation to other nurses created a concern. How Duncan managed the game-play was, as already described, to simply get on with the job caring for patients and training medics which, if done well, may be a strategy that increases Duncan's worth and therefore presents him as a threat to others. Thus the place where some nurses choose to escape the competitive military environment is the same place where the intrinsic value of nursing lies in the NZDF.

Inculcation: Resistance, compromise and acquisition

Centring patients in the delivery of care takes courage. Sarah explained that

> I don't think that senior people in [another unit] like me very much because I'm not in their command chain and when they tell me not to do things I'll do them anyway if I believe that the patient's interest is not being served correctly or in the best way ... I am an agitator and for all the right reasons. I don't agitate I don't believe unnecessarily. (Sarah, p. 20)

Sarah's resistance to following orders demonstrates a conviction to do what she believed to be the right thing despite the threat of military discipline. Besides requiring personal courage, making a decision to do the right thing requires an individual to possess enough autonomy and technical knowledge to develop an alternative course of action.

Advocating for nurses so that they in turn can acquire the skills to act autonomously can be problematic as Andrew discovered when he attempted to set the minimum standards for the acquisition and maintenance of clinical skills in his department:

> My problem is that ... you need to invest time in [developing nurses] and it's not a quick time. I can't send a nurse to hospital for more days to make them get cleverer quicker, if you're talking about well instead of them doing three days a week, let's send them for five days a week and in two months they will be ready to do ICU. The answer is well "No". It'll take time and layering there for them to feel safe themselves in what they are doing ... I don't think command understands that. (p. 8)

Andrew asserted that health professionals must be firm about what skills maintenance and the development of what he referred to as "top notch care" (p. 8) requires. Gaining the knowledge and confidence to know when military circumstances may negatively impact upon patients, and how nurses may safely resist takes time because as described by Kerry earlier, the military culture is overwhelming and there is a lot that nurses new to the organisation do not know (pp. 20-21).

The "normal military language" (p. 21) that Kerry referred to is not necessarily recognised as discrete or exclusive by those who work in the NZDF so no dispensation is provided to initiates. This can be problematic when prospective recruits are seeking information from those who fail to recognise differences in military and civilian terminology. This may lead to misunderstandings that in turn can have significant implications for nurses beginning their military careers:

> I didn't know anything. I went down to recruiting and the recruiter. I said to them, "Well what do you do?" And they said, "Oh you just do nursing stuff". I said "Well do you have to put a pack on or have a gun or anything?" "No, no, none of that stuff". I thought, "Oh well okay, that's alright. I'd just be doing this job and get in there and see what it's all about." And of course I went and did OSB, got through, joined up and it was like "Go on SOIC, here's your pack and here's your rifle" and I'm looking at myself thinking "What?" (Alice, p. 1)

A number of nurses reported being unprepared for the extensive cultural reorientation required when joining the Army. Bonnie described having felt "frustrated because I didn't understand it. You weren't fully integrated but you were expected to know how the military worked" (p. 1). Angela asked herself "Why am I failing? Because everything I did for nursing I was very good at" (p. 12). Duncan questioned whether

there was a deliberate strategy to create impediments to the smooth transitioning of new personnel into the Army and claimed that “sometimes within the military there are underlying currents or meanings or deceptions” (Duncan, p. 3). Others expressed anger about the lack of support they received. George recalled thinking that “the military was so bloody anal that if you didn't walk properly you'd get bloody charged or something” (p. 5).

The pressure to learn, adapt and conform led to some nurses reconsidering during the SOIC their decision to join the Army:

> We got to come home [at Easter] and I came home and I thought “I don’t really like this, I don’t know if I want to go back” but then I thought “No, you promised that you would do it for three years so get yourself back up there” so back up there I went. (Alice, p. 1)

By the time Alice undertook this technology of the self, she had already assimilated a military approach to personal conduct that Andrew referred to as “a culture that says ‘when the decision is made the decision is made’ and you get on with it” (p. 1).

Kathy described the SOIC experience as a period of “self-testing” (p. 6):

> I didn't know how I would do it. I didn't know if I could do it. I hadn't really thought about what would happen if I couldn't do it or if I did. I hadn't got that far. I just kind of did it, came out the other side, so I think it was ... part of that sort of journey of self-discovery, of finding my own sort of depths that I could draw upon. But then also seeing that other people go through that same journey with you at the same time ... I think it's a bond. (p. 6)

Kathy's reflections provide insight into the role that other members of the team play in supporting nurses to successfully make the transition from an individual nurse who has a focus on acquiring the skills to deliver care within a military context, to a nurse who is part of a military team whose role it is to deliver care.

On another level, military nurses believe they possess enough agency to control their conduct and to some extent, their environment. Kerry stated that "We're pretty good at asking ourselves about what we think that we need from the organisation and what roles we are prepared to do, or where we think we're going" (p. 19). Yet agency is not so straightforward. Wenger (Wenger, 1999) discussed how during the course of gaining access to a community of practice, individuals undertake a process of self-reflective bargaining so that a reformed self that conforms to the new context can be created. Foucault (1997) would argue that power residing in a community of practice is the determinant of any new self with technologies of the self serving as an instrument of power in the process of subjectification. Agency is an outcome of subjectification that permits certain forms of resistance but forbids others so nurses can only ask what the NZDF may be able to provide for them if power permits the question in the first instance. That nurses feel they are able to ask suggests that there are freedoms available to them that enables them to shape their military careers in directions that they choose.

For nurses subjectification involves finding an alignment within two co-existing power knowledge paradigms where one, the Defence Force, is omnipresent, demanding and constantly visible. The other, the nursing profession, sits beyond the visibilities of daily life but endures as the preparatory system and experiential basis upon which the individual gained access to the Defence Force, and the one to which respect must be accorded on an ongoing basis if the relationship with the Defence Force is to continue. Therefore despite there being a culture in the military of just getting on with it, nurses'

technologies of the self must take into account both the expectations of their role and the accountabilities of their profession. Their continued employment is predicated on it.

Focusing on roles is a routine of those who have advanced within a community of practice while beginning practitioners tend to focus on the acquisition of personal skills (Davis, 2006). Novice nurses in this study were concerned with learning those skills that visibly represent military nursing such as being able to bash a beret adequately (Duncan), being able to salute at the correct time (George), and being able to maintain and operate military equipment in a professional and safe manner (Alice).

Change is particularly conspicuous in Alice's criticism of nurses who Alice said "we're bringing in who have got a lot of experience, who've been [nurses] for a while, when it comes down to it they're not keen to take a leading role in the area that they're in" (p.4). Alice herself had been required to make a rapid transition from novice to proficient military practitioner and in doing so may not have recognised that transitions occur at varying rates depending, as George observed, on "where one goes and then who the mentors [are] in those areas" (p.7). Those inexperienced military nurses that Alice referred to may still have been in the process of learning the fundamentals of military skills and were therefore not confident to take on leadership roles within their new settings. A lack of knowledge of the employment context may have been perceived by these nurses as a place of personal risk.

The notion of the importance of role for more experienced nurses is evident in Bonnie's comments regarding role argy-bargy and professional jealousies (p. 4). In contrast to Alice's observations of the experienced practitioner but inexperienced military nurse, Bonnie's associates sought to sift through various sets of skills and knowledge in order to tease out what was of most value in the military health domain. Nurses inexperienced in the Army but accustomed to being regarded well in nursing, sought to negotiate their

place in a field populated by nurses with already established reputations in the Army. Ultimately as Bonnie discovered, worth was determined not by the possession of nursing expertise nor skills in military endeavour but by the roles that were expected to be performed (pp. 5-6). Those who it was believed possessed the ability to successfully amalgamate both nursing and military knowledge assumed the elevated positions.

An important factor in the transformation of the novice to proficient military nurse is the presence of social representations of expert practice. Experts help individuals to locate a centrality of understanding by modelling desired behaviour and thinking (Davis, 2006). Expert thinking and conduct are supported by the images, language and ideas of the community. Those who are bedded within the community possess a repository of shared and valued stories, discourses and relics so while new military nurse initiates may over time undergo a change, their initial propensity to take on the physical guise of what appears to be that of the expert is not unimportant to the establishment of a military nursing identity. Visibilities do not lose their value but are reinforced by the acquisition of knowledge upon which the visibilities are founded. Sarah gave an example of how a popular television series had provided a backdrop to her first military deployment: “I went over there and by golly it was amazing, it was just like M*A*S*H. You know, we're doing operations, surgery out of tents and the helicopters would come in and ... we were so tight and tolerant” (pp. 1-2).

Physical manifestations of group membership is not restricted to artefacts and attire. Like other military personnel, athleticism as both a manifestation of competition as well as a requirement for deployability, is valued by nurses. Appearing physically fit led to Bonnie being retained in an expert level role despite Bonnie believing she no longer met fitness standards. Bonnie stated that “I obviously looked younger than what I was [even though] my health had deteriorated” (p. 21). Physical fitness was repeatedly referred to

as an important enabler of expert military nursing practice. Another feature of expert practice is the exemplification of service to others. This is evident in Sarah's observation as a nurse new to the military environment watching those around her:

> Now the one inspirational nurse that stood out by a long shot was Lieutenant Chrisp ...boy, she was on her game! She was like this, she always offered to do the night shifts. She was always putting herself first and would do the worst jobs and so I was like "Oh, I'll do that too", and so I just really liked how she operated. She was always really positive; no question was stupid, she was supportive. She was just a natural leader and I thought "I could do that". (p. 2)

Social orientation is said to be of greater value to the initiation of an individual into a new working environment than is formal learning (Davis, 2006) so the nexus of a successful transition into a new community of practice is located with preceptors, mentors and role models. Inculcating within a social structure involves the acquisition of the common characteristics of that community so that over time an individual comes to take on a new identity. Identity is a concept of self that manifests as patterns of thinking and conduct that whilst having their foundations in the past, change in response to a multitude of influences that are not only social, but economic and political (Liu et al., 2005).

Bonnie explained that when she joined the Army:

> We weren't operating every day, so you had all this time to learn and absorb and observe what the military was all about. So you learn not just from studying. I mean there's observing what people are doing and living it isn't it? (p. 2)

Duncan also described how more experienced staff contribute to a nurse's development stating that "you're always learning. There's people there that guide you. We've got quite a varied job. I think yeah, you've got to be able to ask. You've got to be able to not be afraid of admitting what you don't know" (p. 2).

A feature in the development of a strong identity is the clarity with which a novice understands what knowledge needs to be acquired and what work needs to be performed (Liu et al., 2005). This then suggests that lack of clarity around role or performance expectations will lead to a delay in the development of a professional identity. After many years as a nursing officer in a range of nursing and non-nursing roles, George was able to offer the following insights into what might prevent other military nursing initiates from experiencing the difficulties he encountered early in his career:

> I think it's probably really important that we're able to capture and orientate our nurses in the one place, so that we can deliver the same message so that they know what our expectations of them are. We can explain what we expect from them and then they go out into the units so that there's this consistent message that's delivered. (p. 7)

After her discouraging start, what Alice claimed had helped her to adapt to the military was spending time in familiar settings such as health clinics: "When you came back and you come into the environment here it's totally different from the environment [for training] where you've got your pack on and your rifle and you're out there walking round the tussocks in the horrible weather" (p. 2). Elouise also enjoyed the clinical aspects of her early employment "I just loved every moment of it; being in that acute clinical environment" (p. 1).

Yet for Angela, although the location to which she had initially been posted had seen her "mostly working in the wards and just going to PT"[18] (p. 2), she had, as discussed earlier, recognised that as competent as she felt after several years working in military healthcare, in order to gain a greater understanding of the wider military and to progress as an officer in the Army, she needed to change the unit where she worked.

Marginalisation of the lesser

Every two years Research New Zealand undertakes a poll of New Zealanders' trust and confidence in a range of professions and occupations. Doctors and nurses consistently rate in the top three groups surpassed in the 2017 survey only by members of the ambulance and fire services (Research New Zealand, 2017). While nurses are known to be valued, making a calculation of the actual worth of nurses is thought not to be achievable (Reeves, 2009). Yet despite the actual worth of nurses not being known, what is known is that nurses form a critical component of health services and health services are of such value to New Zealand society that the funding committed by Government to the sector is second only to that committed to social security and welfare (The Treasury, 2020).

The NZDF also recognises the importance of health but the purpose for delivering health services in the Defence Force is to not to enable personnel to enjoy healthy and independent lives as in the civilian sector (Ministry of Health, 2017a), but to ensure the force is "fit to fight" (New Zealand Army, 2017a, p. 78). Nurses form a key component of the military health service and are described as a respected NZDF specialty that contributes to operational readiness and to deployments (New Zealand Army, 2017b; New Zealand Defence Force, 2015f). Yet despite repeated high-level reference to the

[18] Physical training.

contribution that health services and nurses make to the organisation, the value of this contribution is not always evident in day-to-day military life.

Harding (2016) provides insight into how soldiers view health service personnel by referring to them as "pogues"[19] (p. 198). Infantry Corps instructors teach recruits that a Battalion contains non-infantry personnel referred to as "hangers on" (Harding, 2016, p. 57) which includes a Health Services Support Platoon. The platoon commander told the soldiers "Remember, you're infantry. That makes you better than 99.99% of the rest of society" (Harding, 2016, p. 198). Harding made the assertion that a deliberate campaign is undertaken to indoctrinate infantry soldiers into believing they are of greater value to the NZDF than are members of other trades and professions. Harding's study participants were coached to denigrate non-combat troops and to purposely separate themselves from others in order to develop a group identity that positions infantry soldiers as superior.

Foucault describes how disciplinary power relations helps subjects to identify possible actions through the minimisation of other options (Foucault, 1991a). Harding's research illustrates how power relations prevented infantry soldiers from choosing to avoid contamination by limiting social contact with support personnel. The way in which combat personnel denigrate other groups is very apparent to nurses:

> So right from the get go OCS marginalises the lesser; what are perceived to be the lesser corps within their culture. The culture of SAS is very much about breeding combat leaders ... if you even go into the officer selection process and the recruiting process, it's all about attracting the 'A' type personality ... people to come in who are

[19] A pogue is a "dismissive and derogatory term" of long-standing and forgotten origins assigned to individuals who belong to Army support trades (Harding, 2016, p. 198).

> focussed on being combat leaders, going overseas and leading troops in combat. So when you combine that with a culture of marginalising the lesser, what are seen to be the lesser corps ... Health ... Log to some extent, SIGs and those lesser ... support corps within the mind set and mantra of both the instructors and the students ... they spend 12 months at OCS getting indoctrinated in that mindset. (Tony, p. 1)

Those groups that Sørensen referred to as "the people 'in power' - the bourgeoisie" (Sørensen, 2014, p. 4) who possess the status and the value in the NZDF are according to nurses, personnel in combat corps. Senior positions in the Defence Force are held almost without exception by those from warfare branches, while in the Army there are proportionately more service personnel in combat roles than in service support posts (New Zealand Defence Force, 2017f). This creates a system whereby it is common as well as advantageous to belong to combat trades. It is clearly critical that if the NZDF is to meet its obligations to Government that sufficient numbers of personnel opt for careers in warfare branches, so it serves the interests of the NZDF to have combat positions held in high regard. According to Harding (2016), this social inculcation achieves its objectives because individuals seek warfare positions in part to acquire the status associated with belonging to combat groups. In this way juridical power benefits from disciplinary power. If the central positioning of combat roles did not serve the interests of the NZDF, juridical power would, as Foucault argues, activate a prohibition ruling to prevent any alternatives from disrupting the desired culture (Foucault, 1991a).

A new assignation of status

Foucault claimed that intentionality has unintended consequences (Foucault, 1991a). When a group is assigned high status, a corollary exists whereby the status of others

outside that group is impacted. Tony explained how the prestige of combat personnel influences the value of nurses:

> When you look at the nurses, we get treated on a whole other level, because we're seen as second class officers because we haven't been through the 12 months at OCS ... the problem is because you're seen as a lesser officer, right from the get go you can't shake that. That's the way nurses are treated for the rest of their career. (p. 2)

Tony was not alone in his sense that nurses are not valued. Several other participants described being surprised upon joining the NZDF that nurses are thought of in the same way as they are in the civilian sector. George provided a typical observation:

> Quite a bizarre transition really from coming and being a nurse in the wider world, and if people know you're a nurse, it's a reasonably honourable profession where people are very appreciative of what you do and they understand what you're giving. And then you come into the military and it's almost the exact opposite in that we're there as a default, that we shouldn't be there as officers, we haven't done what the G Lists have done. (p. 14)

The notion that nurses do not do what G List officers have done may be based on the way in which specialist officers undertake an attenuated officer training course. Upon recruitment, nurses already possess the knowledge and skills to perform their clinical roles so only the fundamentals of the military employment context are delivered in their initial training course. In contrast G List officers must learn the skills of their professions as well as the context in which these skills are to be exercised.

Despite receiving some military training, participants described struggling to adapt to the military environment:

> There was a certain expectation that you needed to know all of this information about what the military was all about and what, you know, all the terms and the acronyms and the courses that you do to learn about warfare, and the you know, all those levels of combat support and all that sort of thing. But when you're not fully working in a situation full time it takes you longer to understand and learn that. (Bonnie, p. 2)

Bonnie believed that one of the reasons why nurses are able to push through initiation barriers is because the type of nursing officer sought and the rigor of officer selection processes ensures that only nurses who possess significant confidence and "strong personalities" (p. 4) are permitted to enter the organisation.

Yet despite strategies that position nurses as inferior, some nurses remain suspicious that the G List community actually view them as superior:

> There are so many traps to fall into and some of our colleagues will even help you fall into some of those traps. Some of our G List colleagues will take delight in helping you fall into some of those traps ... we had this instructor on SOIC that I would've liked her to fall into a few traps actually. She always used to say "I know you people are much smarter than me, but I need you to do this", and I wonder if there's an element of, you know, we bring some pretty smart people into our Corps, some very smart people into our Corps. And maybe there's a sense of intimidation. (Kerry, p. 21)

If G List personnel were in fact entirely confident of their central positioning, there would be no requirement for nurses to be sabotaged or consciously unsupported during their military training.

George felt that some nurses did not even try to counteract their institutionalised stereotype:

> I think in some respects some of the members of the Corps didn't help themselves and ... turn up to an ANZAC parade and you're wearing the wrong belt, or you've only got two epaulettes on here and three on here or things like that that people from the outside world look at and help fuel the fire of saying “Oh, look at that sack of shit over there” or “how they're presenting themselves”. Whereas now I think we have people who in the majority are coming who want to represent themselves well, who want to represent the Corps well, who want to get things right; who it's important that if they're meant to be wearing a green belt rather than the corps belt that you wear that, rather than having mixed dress and things that may not be important when the shit hits the fan and nurse needs to be called upon to do nursing care. (p. 15)

Although George realised that how a nurse materially presents themselves is no indication of competence in their primary role, he claimed that nurses consciously work on their dress and bearing in order that their appearance does not serve as a point of difference which others may use to marginalise them. The way in which George depicts how individuals work on their uniform indicates they do not do it for personal gain but for the collective good of the Corps. This then suggests that nurses seek through their conduct to serve their Corps in a way that places military nurses alongside the wider

military fraternity. This bonding together of nurses may in part be a collective resistance to, as well as a consequence of, the assignation of low status.

Strong personalities and a desire to dispel the thinking that nursing officers are as Tony put it "lesser officers" (p. 5) may underlie nurses' efforts to demonstrate expertise in skills that are valued by those who hold high status. Because nurses' primary expertise lies in the caring dimension, a paradox exists when they demonstrate deftness in the combat domain. This paradox is not lost on the nurses who seem to enjoy surprising others by being unexpectedly competitive:

> You always knew that people expected you to be less good at everything. And so you almost overcompensated by trying to be faster, stronger, know more about your weapon or have fired your weapon more because they just weren't expecting you to do that. So it's almost like that little brother syndrome a little bit where you just feel you have to be that little bit sharper. (Andrew, p. 15)

Andrew's use of the term "you" indicates that it is not him alone but him as a nurse that people expect to be "less good at everything". Andrew's choice is to respond as if responding to a challenge by becoming not just good, but better at those activities that are expected to point out deficit in nurses. This technology of the self is a form of resistance. The desire of nurses to be faster and stronger than others serves as an attempt to renegotiate the institutionalised nursing stereotype but there is as Foucault claimed, a penalty to pay for such resistance (Foucault, 1991a). If a nurse succeeds in challenging stereotypes "you're seen as a bit of an upstart, as a bit of a, you know, you're stepping well outside your lane here. You need to get back in your box ... unfortunately all the way through you're fighting. You're fighting the paradigm" (Tony, pp. 11-12).

Traditional hegemonies and resistance

The NZDF is a conservative organisation with many contemporary practices and attitudes retaining recognisable features of their historical roots. Some of these practices and attitudes have not kept abreast with evolutions in the civilian sector. The continued perpetuation of traditional masculine ideologies is conspicuous and cause for some concern (Ministry of Defence, 2014b). Challenges exist in the NZDF for women seeking to advance their careers with some of these challenges directly attributable to gender and others related to the roles women have been permitted to perform (Ministry of Defence, 2014b). Men currently form 40% of all nurses in the Corps (Defence Health Directorate Workforce Advisor, personal communication, December 13, 2017). The proportion of male to female nurses in the NZDF is considerably greater than that of the New Zealand civilian nursing population where males form only nine percent of the registered nursing workforce

While gender differentiation in the RNZNC is not significant, gendered attitudes towards nurses remain:

> When you say nurse in the military everyone sees a female. I remember being told, when I posted to [a particular formation] that the officers of [that formation] were very excited that there was a new nursing officer coming, assuming that it would be a new female nurse and got me instead. It was a quite joke thing but I could see how they would have gone well nurses are female; doctors are male. They're kind of stuck in that little reality. (Andrew, p. 2)

Traditional male doctor and female nurse stereotypes are enabled when gendered states exist within patriarchal medical hegemonies. These are common in modern defence

forces (Southby, 2003; Woodward & Winter, 2007) however the negative effects of persisting medical hegemonies is compounded when they coexist within a system that has already positioned nurses as low status:

> We work within what I believe is a very old school paradigm within health, where as a nurse within health you're pretty much seen to be a handmaiden to the doctors. So it's still a very doctor-centric organisation. The problem is that that's perpetuated on a continual basis, because the rest of the organisation is so immature that they still treat health that way. So if you have a nurse and a doctor giving you advice and the nurse's advice is the correct advice, they will still take the doctor's advice and do whatever the doctor's telling them to do, because they see the doctor as being a higher level, having higher status and greater expertise, no matter what the subject area is, than a nurse. (Tony, pp. 5-6)

When medicine holds such a position, there seems to be less room for nurses:

> I think the perception is that a lot of the medics felt that they didn't need nurses, but I think that also came from the G List officers in the Medical Corps and the wider military. We don't need nurses. Why do we need nurses in the military? (Bonnie, p. 20)

Bonnie had reflected earlier "I'd have to say both from within the medical fraternity and the non-medical military fraternity ... they just did not value nurses in the military at all" (Bonnie, p. 3). Nurses' response to the way in which they perceive their worth in the healthcare team is to add value, primarily by advocating for patients:

> [Nurses are] just seen as an honorary rank type of thing, but the fact is that nurses are more than that ... a major doctor turning round to me and saying to me "You'll look after that chap overnight before he goes to hospital and you're going to monitor him. He's having IV Dilantin" and I went "Oh no, I'm not because we're only a sick bay. We shouldn't even have anyone on IV Dilantin. That should be done in hospital. They should be actually monitored and cardiac monitored," and I said "No, no, no, no, no for these reasons." That was quite a debate that went on. I got 21 extra orderly officers because I could have been technically on charge, but it was outside my scope. I didn't have the skills. We didn't have the equipment to look after that. I said "Why aren't we taking him to hospital now?" (Duncan, p. 17)

Extra orderly officer duties are unofficial punishments for non-compliance with expectations. Duncan was punished for defying orders but was not officially charged under the AFDA. Had AFDA processes been activated, Duncan would have been permitted to present a defence which may have established the doctor's orders to have been unlawful so delivering an unofficial punishment avoids this risk for the organisation.

The AFDA is a juridical technique that seeks to secure the docility of subjects by employing legislated systems of punishment. The enforcement of discipline through the AFDA is public and serves two functions; that of punishing the resistant subject through the awarding of material penalties such as fines and imprisonment and secondly, that of by making visible the subject's transgression through court processes and publicity associated with those processes. By making the subject's transgression visible, the individual is isolated from their institutionally desirable docile peers. Both functions

serve as future deterrents to not only the resister but to any other potential resister (Foucault, 1991a). The fear of the public effects of resistance reinforces the normalisation of compliance thus juridical power is in a mutually supportive relationship with disciplinary power because each paradigm seeks the same effect. Although individuals have the choice to be charged under the AFDA or to take extras, because of the heightened publicity surrounding charges, individuals will often select extras which together with the risks to the organisation of charges being defended, serves to reinforce extras as a military norm.

Despite the hazards associated with offering resistance, nurses will still knowingly pursue avenues that could lead to discipline. For nurses, the interests of the patients override their own as exemplified earlier in what Sarah had had to say in relation to her belief that senior people do not like her very much because she agitates on behalf of patients (p. 20).

Nurses will at times confront medical hegemony but this seems to occur only if patients are being put at risk. Nurses are more likely to acquiesce to doctors encroaching upon the nursing domain when they are working with unfamiliar medical practitioners and when they are working with doctors from other countries. Kathy described a situation where she prioritised the maintenance of relations between two countries' militaries over defending her autonomy as a health practitioner:

> [The American medical specialist] was doing investigations, so he was just doing a quick little endoscopy and having a look at people's nasal passages and I got to clean the instruments, so I was handmaiden to doctor. I didn't do any nursing. I just got to clean the scope for him ... I don't think he had any idea who I was and he had zero interest. He wasn't interested in making conversation or anything with me. I just

> needed to clean the scope and he would sit like this and wait for it as well if it wasn't ready ... So I got the two minute rundown and then that was it, "go forth and clean". So that's what I did. (p. 16)

When there is shared understanding of nurses' scopes of practice, nurses and doctors appear to work well together with the status of medical practitioners being exploited to achieve common goals. Interprofessional collaborative effort is not however always successful and collisions between health professionals and command do occur. When such occasions arise nurses seek workarounds:

> A number of the nurses have access to MO eyes only[20] ... I had been taken off and I put up a minute[21] about this and said "Well I have had it and now I haven't had it" and the senior doctor in [in my formation] has recommended that I still have it, because I deal with ... people with issues of a sensitive nature, and it came down from [command] that I am not to have it. It's political ... I don't care for politics. I care for the soldier on the ground and providing him the best care. And so I wrote an incident form two or three months ago around this and said "Look, this document's been scanned in. Its MO eyes only. If this chap came in and required assistance and none of the nurses can see it, this is potentially a safety issue because nurses need to be able to see what's going on for this chap" ... I sent a reminder to someone yesterday. (Sarah, p. 16)

Andrew's point introduced earlier about an NZDF culture that says when the decision is made, the decision is made and you get on with it does not apply for Sarah in this

[20] "MO eyes only" is a section of a patient's medical file that is only permitted to be accessed by medical practitioners. The separated section is usually of a sensitive nature.
[21] A minute is a form of written military communication designed to expedite the transfer of information.

circumstance. Motivated by her belief that patients were being negatively impacted, Sarah activated multiple pathways of resistance in full knowledge of the sensitivities and expected practices in what Sarah called “the politics” of the circumstances. At the time of her interview Sarah was in the process of exploring further avenues of resistance in the hope that she would achieve the outcome she was seeking by wearing down the resistance of command to her own strategies of resistance.

There appears to be opportunities in otherness because if those belonging to central groups think that nurses are different, then nurses can comfortably confirm that difference through their conduct in the reasonable expectation that their non-conformance is expected. Even when nurses know what is expected and are capable of conforming, they might choose to not comply depending on the benefits associated with a non-compliant pathway. Notwithstanding what serves to be gained and the risks that personal resistance might present to the individual, when there is a culture that says when the decision is made you get on with it, multiple, singular instances of nurse non-compliance contribute in a cumulative way to the othering of nurses.

Summary

This first analysis chapter provided an examination of the transition of nurses into the military culture. Concepts of marginalisation, status and competition have been revealed as cultural artefacts that position nurses as deviant. Through processes of subjectification nurses import these cultural artefacts into their relationships with others and into the work that they perform. The value of rank has been presented as subordinate to the value of clinical expertise with clinical expertise being indicative of deployability. Within the culture of status and competition, nurses compete for position and to experience the self-perpetuating opportunities that competition generates. The chapter concluded with a commentary on nurses’ observations of traditional

hegemonies and notions of resistance within a judging culture. Suggestion that there are advantages to be gained in notions of difference was presented. The next chapter builds upon nurses' military transition experiences to nurses' learning to apply ways of working within the constraints and enablers of military service.

Chapter 7: Opportunities in the grey space: Exploring nurses' Strategies of acceptance and of resistance

Introduction

The previous chapter presented an exploration of nurses' experiences transitioning into the Army. Concepts relating to nurses' perceptions of the military culture and nurses responses were introduced. The exploration revealed notions of otherness and isolation that provoke hypervigilance in nurses. Hypervigilance in turn leads to nurses seeking ways to counteract their sense of lack and low status. Competition as an institutional norm was seen to have infiltrated the nursing workplace revealing categories of nurses jostling for places in various military nursing hierarchies. It is becoming apparent that novice nurses want to be thought of as belonging to the military and for them, belonging means being deployable, and being deployable means working in clinical practice.

Foucauldian investigatory techniques demonstrated how despite holding superior rank, nurse managers and leaders appear as subordinate to nurses who work in clinical practice. Ideas that military personnel should just get on with it when decisions are made were found to be resisted when expectations of compliance with traditional military medical hegemonies do not agree with nurses' goals for patients.

The next chapter extends the exploration of nurses' cultural inculcation to examine nurses' strategies of integration, assimilation and resistance. Interpretations of the nature of military work, ethical conduct and discipline will be presented. How nurses respond to their environment as their experience grows will be examined in ways that problematise fundamental aspects of military governmentalities and which provide an exposé on nurses' decision-making processes. The ways in which nurses navigate complexities of their role will be presented with the chapter concluding with an

interrogation of the influences that impact upon nurses' professional and military orientation.

Acme of the ethical working self: 'Don't be jack'

It is apparent that nurses make an effort to avoid negative judgements by attempting to align their conduct with that of those who sit outside health. One of the ways in which they do that is to comply with expectations that irrespective of trade or profession, work will be completed on time and that individuals will help others to complete their work (New Zealand Defence Force, 2015g). Supporting and perhaps more importantly, being *seen* to support others, is so deeply embedded in the military culture that the term 'jack' has been coined for those who fail to consider others. Jack according to Harding (2016) is:

> An expression of what is meant by the 3CI value of comradeship. Jack is selfishness. If you pile up your plate at the mess while there is a line of people behind you that might miss out, you are jack. If before a barracks inspection you spend all your time focusing on your own bedspace and don't vacuum the bedroom or clean the bathroom you are going jack ... Going jack on your mates is the number one cardinal sin in the Army". (p. 156)

The existence of the jack phenomena has a binary in industriousness. Power operates within this binary so that an individual is motivated to industry in order to avoid the assignation of the disciplinary label of jack. Thus jack works as an instrument for the subjectification of the individual in the social sphere but through motivating industriousness, jack also serves to assist the organisation to achieve its outputs. Andrew gave an example of how subjectification operates in practice:

> It’s pretty much a given if you were [performing the role] of the patrol medic ... you often drove and almost always cooked the meals as well ... I think that most things were shared, with lots of health. It wasn’t the medic who always cooked but you did your share and that was again part of that culture of “not being jack” would be a standard statement ... it’s all about everyone being seen to be working hard at all times. That’s just I think a Defence culture. It’s almost like if you’ve got nothing to do you go and find something to look busy at because you should be busy ... I remember peeling lots of potatoes and carrots and stuff just to help out. (pp. 16-17)

Supporting subjectification processes for the purposes of outputs are timetables that regulate activity. Timetables are dependent upon surveillance for their effectiveness as evidenced in what Angela had to say about the effects of ongoing 12 hour shifts during a humanitarian operation that lasted for some weeks:

> [Some nurses] really start falling to pieces when you start to have to do 12 hour shifts day after day. I think this 12 hour shift malarkey that we keep banging on about just doesn't work well when it just keeps going and going and going. You have to have a certain type of work ethic to maintain it ... up here [points to head] really has to be strong, where you can say “I can cope with getting two hours sleep and then I could go back on work”. That's really important. You get some, they just fall to bits 'cause they haven't got their six hours’ worth. (p. 22)

Despite Angela believing the 12 hour operational shift pattern to be a “malarkey”, Angela subjectified herself to a process of introspection that resulted in support for the timetable and a corresponding judgement that those others whose subjectification

processes had failed to produce the desired results, were not strong. This indicates that the strong personalities that Bonnie believes military nurses possess when combined with the culture that Andrew says exists of military people just getting on with it, does not always translate into action when what is being asked is extremely demanding.

Elements of the 'get on with it' culture are however exemplified in Angela's conduct. Just getting on with it normalises overtly compliant behaviours whilst driving resistance underground. Because work continued unceasingly under the challenging deployment timetable, no negative effects on mission outputs came within view of command. The apparent success of younger nurses' 'fall to bits' resistance to the military's expectations of them may however have consequences for them. Whilst teamwork disguises jack behaviour, the team will have a part to play when the disciplinary technique of performance reporting comes into effect because the attitude of peers towards an individual is surveilled, noted, and used for purposes of reward and punishment.

The enterprise of service to others is not only driven by fear of being seen to be jack, but also by positive role-modelling. Sarah's report described in chapter six of the inspirational nurse that offered to do the worst jobs and the worst shifts, served as a career model for Sarah who described deliberately trying to exemplify in clinical practice the selfless behaviours of Lieutenant Chrisp.

Both Sarah and Angela serve power by perpetuating valued behaviours and in doing provide an indication that industrious conduct is not restricted to generic tasks such as peeling potatoes, but that industrious conduct also translates to nursing work. In addition, the exemplification of selfless service in nursing contexts serves to prove that the binary of industriousness, jack behaviour, coexists because industriousness is reinforced by the threat of discipline from being jack.

Time to create conditions of possibility

Foucault claimed that timetables are a valuable juridical control technique because they serve as an unequivocal means for controlling the population through their 'met or not met' compliance functions and for their ability to be translated into numerical measurements for statistical purposes (Foucault, 1991a). Foucault identified the military as an exemplar for the intentionality of timetables where they constitute part of a suite of techniques to manage behaviour (Foucault, 1991a). Despite their value to juridical control, timetables can be turned against forces of authority. Although there are several instances where nurses can be seen to have exploited timetables for purposes for which they were not intended, Andrew's use of the quantitative aspects of time to achieve a qualitative output provides the best example of a nurse overcoming the barriers that time presents to the achievement of nursing goals. Andrew said:

> I told the CO that I think that every nurse needs to do 400 hours [working in their specialty area of practice] as a minimum, if they're working in the Role 2. If they are new nursing or new to the area then that's obviously going to increase. My CO has been supportive in that ... The reason we put a number on it is that commanders seem to like numbers, so we used to say we need to maintain currency and that seemed to be too fluffy. And so we gave them a number. (p. 7)

Andrew and his OC recognise that time is the customary tool used in the military for determining training requirements. According to Andrew, command had previously experienced difficulties with understanding nursing's clinical requirements so although the earlier language of the "need to maintain currency" represents nursing requirements in a more comprehensive way than does the specification of hours, a timetable has been selected as the mechanism through which nurses can receive the necessary approval for

clinical release time. The utilisation of a timetable effectively dispenses with any repeated need for Andrew to invest in educating command on the profession's requirements for competence-based learning.

In the civilian sector, maintaining currency through experiential practice is not only desirable, it is routine. Each time a nurse attends work, currency for that particular work is being preserved. Whilst the NCNZ specifies minimum hours necessary for nurses to maintain overall competence, there is no stipulation for minimum hours for the maintenance of competence in nursing specialties (Nursing Council of New Zealand, 2012c). Because nurses are responsible for their own competence maintenance and because each time a nurse attends work, currency for that particular work is being preserved, there is no requirement for civilian nurse employers to specify that a minimum number of hours be worked in order for nurse employees to be fit to perform that work.

The overarching purpose of the employment of nurses in the military is to undertake work on operational missions so working in garrisons does not automatically equate to military nurses being fit to undertake work on operations. The hours-based approach endorsed by the Army for Role 2 nurses represents recognition of the difference between maintaining skills for practice in civilian settings and maintaining skills for practice in military settings. It is a compromise between the multi-faceted competence requirements of the NCNZ and the accepted time-based practices of the NZDF, but it is a compromise which Andrew believes aligns with the military's way of operating while at the same time facilitating the currency requirements of military nurses. Satisfying currency requirements ultimately serves the NZDF by assisting with the clinical preparation of military nurses for operational deployment. However by lacking those other elements the nursing profession mandates as being necessary to ensure the safe

practice of nurses, the compromise conveys the notion to the wider military that for nurses, hours spent at the patient interface equates to competence; a notion that is not supported by the NCNZ (2020b) which describes competence as “the combination of skills, knowledge, attitudes and abilities that underpin effective performance” (para 1).

Andrew himself reported on flaws to the time-based approach to nursing competence when he stated that developing an intensive care nurse will require not only significant time commitment but the need for the nurse to determine for themselves whether they feel competent in their new specialty area of practice. Andrew commented that commanders “think you get a nurse off OSB and that nurse can do nursing, and that spectrum is from primary health care all the way through to whatever” (Andrew, p. 8).

The ability to describe to command the different types of knowledge and skills required for different specialty areas of practice and the different ways in which proficiency can be achieved within nursing specialisations becomes limited when command is of the understanding that competence can be measured in hours. This understanding will also create an impediment to any negotiation for variations to the agreed time allocation. If it is believed that currency for all Role 2 nurses can be maintained on one day a week, any time spent away from the unit on clinical placements in excess of a day per week will be viewed as unnecessary.

Addressing shortages in specialty domains in order that nursing capability is at a state of operational readiness, requires nursing leaders to have the ability to vary the hours that individual nurses need to spend in clinical practice. The time-based system agreed to by command is therefore an impediment to operational readiness. Set timetables do not permit nursing leaders the professional autonomy to identify when individual nurses require additional investment for the benefit of the organisation. Furthermore, command remains uninformed about the complexity of nursing practice and the challenges that

present when nurses move between specialty areas. For Andrew, attempting to mediate the disciplinary technique of the timetable for the benefit of the organisation by varying what has been agreed upon creates the risk that he will be personally viewed as non-compliant and punished accordingly.

While timetables are an effective disciplinary technique, the lack of a timetable can also present as such:

> What it is to be a leader, the important traits there, the welfare of the troops, the expectations of being rung at many different hours during the night because of things that had gone on ... my wife and I, she kind of felt your job finishes at 4:30. “Why are you dealing with this at nine and 10 o'clock at night?” type thing. And it was around well, you know, it's not just an 8-4:30 job, I need to be there for whatever may eventuate. (George, p. 3)

The imposition of military activity into the personal time of subjects disciplines the subject in such a way that the central position in the subject’s life comes to be held not by the subject’s family or any other significant social relationship but by the military. This orientation aligns with the governmentality of the Army that raises the mundane of everyday work to an altruistic activity in the service of the country: “Loyalty to New Zealand means that the greater good of the nation comes first and the soldier’s personal needs often come second” (New Zealand Army, 2020b, p. 12). George exemplifies what Best and Kellner (1991) describe as a desirable work ethic that carries moral value; that of the subject possessing the sense that they need to work as opposed to the subject choosing to work.

Disciplining effects of juridical power

Augmenting social and cultural expectations that drive a service ethic are techniques of juridical power. The governmentality of the military that provides for authority relies for its operational effect upon the NZDF performance appraisal system. Performance reporting deliberately seeks irregularities in attitude and behaviour to enable deviant conduct to be managed through systems of coercion (Foucault, 1991a). Coercive techniques may involve the removal of opportunities for rank advancement and for limitations to be placed on operational postings. Ultimately however, individuals who demonstrate persistent non-compliance may have their employment in the NZDF terminated.

Creating a culture where subjects believe they need to work has some foundation in the performance expectations of senior leaders who are required to "shape the desired culture for their organisation including creating a culture of commitment" (New Zealand Defence Force, 2017e, p. 13). Commitment is according to a pamphlet provided by the Army to all soldiers and officers, "displayed when personnel work together as one team in serving the interests of all New Zealanders, putting others before self" (New Zealand Army, 2019, p. 1). Putting others before self, not being jack, is not a behaviour for home but one for work. George felt he must explain to his wife that work needed him because he was unable to explain the pressure he felt to avoid being thought of as jack, nor could he explain the negative effects that resistance might attract should he refuse to take calls from work in the middle of the night.

Commitment to work does not necessarily extrapolate to commitment to authorised ways of working. Alice explained:

> I start sending emails out [about compliance with PDRP directives] when we come back from the Christmas break, because they're all due by the end of March, so I start with emails in the beginning of February, saying "Compliance blah blah blah" and I send the forms: "These are the ones if you have to do your initial one, these are the ones if you're doing your annual one". I explain it all, put all the references and then remind people at O Groups and stuff and then a couple of weeks before the end of it I resend it, because there's always at least half the people haven't even done it ... It's a professional responsibility. We're all professional people and yet they don't think it's important. (p. 6)

The resistance of nurses to comply with deadlines and the regulation of professional activity was recognised by Alice. Despite her frustration, Alice entered a game with the nurses whereby Alice's initial reluctance to send reminders to staff to meet their deadlines constituted a counter-resistance to the nurses' original resistance however, Alice ultimately bowed to pressure by sending the reminder but in doing so, lost the game. A reminder is not a censure so any fear that nurses may have had in relation to being disciplined for non-compliance was removed. Consequently nurses may now feel a certain freedom to resist nursing directives.

Fear of censure in relation to nursing responsibilities seems less than nurses' fear of censure for non-compliance with military responsibilities. George's dread as a junior nurse of what he was going to do if somebody saluted him (p. 5) serves as an example of the latter. Nurses' general lack of concern about being censured by more senior nurses may be because nurses know that other nurses are reluctant to apply juridical processes:

> He wouldn't do anything that I basically asked him to do and I remember him one day saying “Oh Bonnie, are you going to order me about?” when I asked him to do something. I said “Well it's ...” Karyn stepped in at that point and she said “Yes, she is actually so you'd better do it” as I was drawing breath thinking “How the hell am I going to answer this?” (Bonnie, p. 9)

Angela attributed the reluctance of nurses to activate disciplinary processes to the “softness” (p. 10) that remains with nurses throughout their military careers:

> Having the confidence to actually charge somebody was really quite frightening, yeah, because you didn't really want to get them into trouble. You know, that soft, softness of a nurse is still there. They're only late for five minutes you know ... half past six is when they started ... and they didn't turn up 'til half past seven you had, you got to go okay I'm a nursing officer, I have to charge them ... so I did. It was a big deal for me to do that. (Angela, p. 10)

In contrast to Angela’s struggle to conquer her resistance to activating the AFDA, Alice continued to resist applying the juridical processes available to her:

> The nurse, the PDRP, she has never ever done one and she'd been given at the beginning of the year to July to complete it and it’s now August and there is none forthcoming, so the issue’s going to have to be tackled again ... what are the consequences? ... there are no consequences because if you tell their command chain, they don’t think it’s significant and there’ll be nothing done. (pp. 12-13)

When resistance to nursing policy is not firmly counter-resisted and when the responsibility for controlling resistance is consigned to non-nurses, the autonomy of nursing is negatively affected. When professional autonomy is not optimised, the status of nursing is impacted (Mrayyan, 2005).

Collision or collusion: Contests with command

Unlike in the health sector where the focus on the patient remains constant, the focus of work in the military is dynamic. The NZDF determines where and how Defence personnel concentrate their efforts with the need for flexibility being critical. This means that where the employer's focus lies at any given time, is where the service person's focus lies. Therefore, although the role of a nurse is to assist patients to optimise their health in order that they may regain independence, the function of the military nurse is to focus with the rest of the organisation on strategic goals. Andrew was quite clear about a military nurse's mission:

> Hospitals are all about clinical standards and achieving clinical effects whereas being attached to essentially the front, you know the main body, your mission is to support their plan whatever that plan is, and health is just a consideration rather than the end state. (p. 14)

This attitude suggests that military nurses believe that their professional responsibilities sit subordinate to a nurses' obligations to their military employers. Yet how do nurses who are, as described in the previous chapter, prepared to disregard orders to prioritise patient care, lead themselves and others successfully in the conduct their duties when fundamental differences lie in the philosophical underpinnings of nursing and military service?

Health systems are amongst the most complex in the world (Kannampallil et al., 2011). It has long been recognised that in order for health systems to function adequately it is necessary to have health leaders who understand the constituents of that complexity (Ledlow & Stephens, 2018). This knowledge is not something that can be acquired in a short space of time which is why health organisations have tended to develop future leaders from within the sector. This is also one reason why the selection of nurse leaders has been focussed on those who have demonstrated clinical expertise (Stanley, 2017b). A nurse leader who is known to understand and empathise with followers and whose values align seamlessly with clinicians, is said to practice in a congruent manner. When congruent leadership exists, effective health leadership is more likely than when leaders' are selected for other qualities (Stanley, 2017b). Clinical competence forms the foundation for understanding and empathising with followers and is highly valued in health leadership (Stanley, 2017b). In addition leadership in health is considered to be negotiable, is collaborative, distributed and seldom passive (Barrow et al., 2011; Storey, 2011; West et al., 2015).

The selection of nurses for service in the New Zealand Army and later for more senior leadership roles, is undertaken using the NZDF transformational leadership framework. This framework does not allow for the formal assessment of the congruent leadership characteristics that nursing values. Therefore, it cannot be said that nurses working in the NZDF possess the qualities recognised as most important to not only their profession, but to other healthcare professions. Furthermore, non-health practitioner leaders operating in the NZDF healthcare domain do not necessarily have the experience in healthcare upon which the adequate functioning of health systems depend nor an understanding of the importance for health professionals that the credibility of their leaders is predicated on the alignment of clinician and leader values. This then may

create for nurses confusion over what constitutes quality leadership, what characteristics to role model and what personal strengths nurses should develop. Compounding this confusion lies the dilemma of where nurses' priority of effort should sit; with the organisation or with the patient.

Nurses are recruited into the NZDF as registered health professionals which means that unless they have had previous military service, their understanding of leadership will be based on their experiences of leadership in clinical settings. Nurses attitudes towards military leadership will therefore be influenced by their nursing experiences so what nurses believe constitutes a good leader may not be the same as what other military personnel would describe as a good leader. Although some nurses spoke at length about leadership, they did not explain what they believed good leadership to be. Tony when talking about his own experiences of leadership stated that:

> If you happen to have the luck to deploy with a really good leader, combat leader and they know your pedigree, then despite the fact that you're not actually in command, everything will come to you in terms of the actual military leadership. (p. 7)

That a combat leader possesses the ability to recognise a nurse's "pedigree", suggests that nurses and other military personnel have a common understanding of what good leadership is. If there is common understanding, then nurses who have been appointed to leadership roles using the military framework for rank advancement, might expect their leadership authority to be respected by both non-health personnel and nurses alike, but as described earlier when field ranking nursing officer Alice sought compliance with PDRP directives from junior nurses in her unit, this is not always the case. It was only following multiple reminders that Alice gained the cooperation of the nurses.

Bonnie described the negative effect of command failing to activate juridical processes:

> I went off to see the commanding officer and of course I was really upset: “Oh my God, we've lost two ampoules”, and she basically laughed and said “Yeah”. There were no consequences ... She was, “Oh dear Bonnie, how did that happen?” ... it wasn't right, it wasn’t “Let's stop and reassess, let's sit down now and talk about this and get the medic in and let's go through step by step what's happened to this pack.” It was really, really nothing and I remember walking away. I was a bit tearful 'cause we had hardly slept. You know what it's like on exercise ... you get to the end of it and you're just damn knackered and that's the last thing I wanted to hear was my morphine had gone. But that's what I meant. There didn't seem to be the same accountabilities ... the laissez faire sort of control around some of this stuff that's been going on for years ... there wasn't the accountability that should've been there because we hadn't trained for it to be there. (p. 18)

The laissez faire leadership Bonnie referred to indicates that Bonnie’s commander did not possess sufficient knowledge of medicines management to deal with the situation appropriately. This lack of knowledge resulted in Bonnie’s trust in military leadership being undermined.

Tony was adamant that nurses are better leaders of health professionals than non-nurses because nurses are multi-skilled:

> We're the ones who tend to get the administrators aligned with the social workers, with the occupational therapists, with whoever the referral agency is, with sorting out patients for whatever they need,

> with assisting family when they're in and upset. We're the ones that do all that. And so how that relates in the military is that you're a very good commander from the sense of the softer aspects of command. Nurses tend to be able to pull together a team reasonably well ... so you can very easily pluck a nurse and put them into a command position, and generally they'll do okay in terms of the day to day running of the unit, sub-unit, platoon. (pp. 9-10)

Andrew indicated that it is only nurses who are able to appreciate the complexities involved in preparing nurses to work to the top of their scopes and therefore to optimise the potential of nurses in the organisation:

> I've got a nurse who's been out for one year and we sat down with her and said "Look, we need more intensive care nurses. It's a skill set that we're scarce on and it's really important part of delivering the Role 2 effect." So we're up-fronting by sending her away and she is in ICU for three months full time in her second year of practise. And she'll need to continue to do that. Because it will be two or three days a week at most as she goes on that'll take a lot longer to build it up, that kind of knowledge of experience and currency for her to feel that she's got competence in the intensive care space and I don't think command understands that. (p. 8)

Andrew exemplifies a convergence of military leadership norms with nursing leadership in his proprietorial, authoritarian manner. Andrew has adapted his understanding of nursing skills acquisition to conform to the Army's way of training which is defined in terms of time commitments, not competence achievement, and despite command not

understand nursing competence requirements, because Andrew does understand, he takes control.

Tony described the career trajectory proposed to him by the Army which tends to support the notion that nurses make good military leaders:

> I gave away my clinical nursing at the behest of the organisation ... and the reason for that was because there was an identified hole in health leadership within the Army. And they wanted ... me to step into that breech and they wanted me to do the development. (p. 11)

Tony described the career trajectory that was mapped out for him which included postings to non-nursing roles. Individuals are both objects and instruments of power (Foucault et al., 1979). By agreeing to command's request, Tony reinforced the perceived higher status of non-nurses over nurses by sacrificing clinical leadership in order to enter a G List officer leadership pathway. Yet even after Tony entered that pathway, restrictions were placed on his options that do not exist for others. Tony explained that:

> If you get to Staff College, you only get selected, not everybody goes. So if you've been selected ahead of some G List officers [it becomes] a level playing field at that point, but when nurses depart from Staff College it goes well for a little while ... [but] you're not allowed actually to step entirely over to the G side ... you're somewhere in between. (pp. 12-13)

Tony described his observations of nurses sitting uncomfortably in the "in between" space constantly seeking to connect with the G List officer community they think they are joining. This however does not seem possible:

> The problem is if you do a good job and you actually prove yourself to be a very good military leader ... the rest of the culture's not set up to deal with that paradigm, because you're supposed to be a nurse ... you're only employed to do your specialist thing, so how dare you step out of that box and show that you've actually got the nous to do a fantastic job outside of your specialist area? (Tony, p. 10)

Tony had earlier made the point that "because health in general is marginalised within the organisation there is no effort put into developing leadership of health, or very little comparatively to all the other corps" (p. 6). There are other explanations besides marginalisation for the perceived lack of investment by the Army in nurses' leadership development. It is possible that commanders believe that nurses come into the Army already in possession of leadership skills so need no further investment. Elouise's experience certainly supports this notion: "The biggest difference I noticed when I first commissioned was that people were hugely more into my opinion" (p. 20). Elouise had worked as a NCO prior to commissioning and stated that she does not believe she has fundamentally changed so cannot understand why people trust her so much more now that she is a nursing officer. Another reason why there may be a perceived lack of investment in the development of leadership in health officers is a general misunderstanding of what health needs in its leaders.

An archaeology of the archaic

According to Sion (Sion, 2016), there is an expectation that norms in defence forces will reflect the norms of the societies from which they recruit but that the military often lags behind. The out-dated attitudes that prevail in the NZDF health services reported in chapter six of this research support Sion's assertions. Tony who was particularly vociferous in his opposition to medical hegemonies, laid the blame for perpetuating

hegemonies at those “outside of health” (p. 5) not at doctors, however at the same time Tony implied that although doctors are not to blame for archaic attitudes, they willingly accept their assigned positions. Duncan on the other hand, reported that doctors firmly believe that they should be in charge:

> The doctors and the lieutenant doctor felt that she [the lieutenant doctor] should be in charge of the whole medical contingent. She should have been in charge of the clinical aspects, the medical aspects, but the person in charge of that team should have been the [more senior] nurse who had all that worldly experience, knowledge, understanding. That didn't happen. They promoted the lieutenant ... put the poor nurse down here who was not treated at all well on that whole deployment and it was probably a very, very miserable time for them ... I felt sorry for that nurse because it was a miserable deployment for her. It wasn't probably as good for the team as it could have been. (p. 17)

While leadership was the issue in contention, the competence of the nurse to be a nurse was not questioned. Yet even as Duncan described the lack of recognition for the leadership expertise of the nurse, ultimate concern lay not with the inverted hierarchy per se, but with the impact the inverted hierarchy may have had upon the team.

Tony described how on deployments his leadership skills were recognised only unofficially. Rather than challenge assumptions that doctors must always head health teams, Tony accepted his pseudo-leadership appointment:

> What they'll do is they'll say the doctor's in command, but actually in terms of the day to day running, and this is certainly my experience

> with RAPs over the years; in terms of the actual leadership and the actual day to day running, the actual administration, the actual planning for any sort of operational health support, I'll do all that. So you basically have a figurehead commander and of course they're always going to be the clinical lead because that's where they're the expert and they are the senior person there so yes, they're the clinical lead, no argument with that. In terms of the military leadership side of it, that has in most cases fallen to me within two weeks of deployment, or even quite often while you're on pre-deployment training, because the wider team know me, have worked with me and know that when it comes to actually leading and commanding the situation, that they would certainly have me doing that thank you very much, because they know the doctor actually hasn't got a schmick. (p. 7)

The discourse of competition evident in the relations that nurses have with medical practitioners serves as another example of how institutionally supported competitive attitudes permeate health workplaces, but the discourses have only been permitted to surface because out-dated hegemonic ideologies are perpetuated by command failing to apply authorised hierarchical structures within the military health system. This suggests that G List commanders may be uncertain about what rank might mean in the day to day work of military health professionals and that there is a general absence of understanding that there are differences between military leadership and clinical leadership.

It is a traditional practice in the Army for medical practitioners to be awarded higher rank upon commissioning than that which is awarded to other groups of health practitioners (Joint Support Group Executive Officer for Health, personal

communication, October 21, 2020). Over time this initial seniority progresses doctors ahead of allied health and nursing officers that subsequently benefits doctors when selections are made for health commanders. Although the unequal assignation of rank may advantage some groups and disadvantage others, health professionals may feel that to challenge how rank is awarded within a group to which they do not belong, may not align with the principles of the HPCA Act which specifies that the responsibilities for regulating health professions falls exclusively to the individual health practitioner registration authorities. This situation does not occur for non-specialist officers because the criteria for the assignation of rank is for G List officers is standardised.

An inversion of status for strategic intent

Although it may be thought that it is the softness of a nurse that prevents them from applying juridical power, other forces are also working to prevent senior nurses from actively managing more junior ones. Kerry explained that:

> You expect your senior nurses to be taking on more responsibility, more policy-like appointments, governance appointments, health quality, leadership and management. But within the military when we find ourselves in these roles there's almost this sense of shame or being of less value with our young clinical staff, and I'm thinking particularly nursing officers here. Because I'm [more senior] now and I'm no longer at the cutting edge of clinical, I'm not a clinical expert anymore ... but I certainly feel a sense of being less value because I'm not at the cutting edge of clinical anymore, and there seems to be a reluctance or almost a disrespect that goes with making that decision or being put in that position where you are now going to be more involved in management, policy, maybe education, these other things that don't

> directly but indirectly relate to clinical and service delivery. And I use the word "shame" but I don't use it lightly. It's quite a divide between the military nurses who are still very clinically orientated, and those that are not. In fact to the point where I have a colleague who is now in an OCs appointment and [that person] has said to the military that they would rather give up their crown[22] and become a captain again if it meant they could go back to being an IC within a team and being a small team leader, and remaining clinically orientated. (pp. 21-22)

Status is recognised by both junior and senior nurses to sit with those who occupy clinical appointments and clinical appointments in the NZDF are held almost exclusively by junior nurses. That junior nurses possess higher professional status inverts the effects of the hierarchical structure upon which military discipline is predicated and when this happens the role of the senior nurse is made more complicated because while senior nurses may be legally authorised to exercise military discipline, their reduced status may serve as an impediment to them from doing so.

When the notion that full membership of the RNZNC that was discussed in chapter six means being deployable, and when being deployable means working in clinical practice, then nurses who work in management and leadership will not be thought of as full members of the Nursing Corps. In addition, most deployment opportunities for nurses call for clinical competence so junior nurses are the targeted group for nurse deployments (Defence Health Directorate Workforce Advisor, personal communication, March 20, 2019). It is therefore not surprising then that Kerry would report that shame accompanies promotion.

[22] A crown is the uniform insignia of the rank of major.

A key function of senior nurses in the NZDF is to create the conditions that enable nurses who deploy to be able to deliver safe care whilst they are away. Alice went on to explain that:

> You have people who are doing education, policy, management and research. So there are other ways to use your nursing knowledge and to still be doing nursing practise without doing clinical and a lot of people don't understand that. And so if you're not in a fully clinical role they think that you're not nursing because they don't understand. (p. 8)

Being deployable is central to the value of service personnel because deployability is of necessity, the raison d'être for the NZDF. When deployments hold value, they can be used as a strategy for reward and punishment:

> They wanted to run a surgical programme for the RFS[23] and I was put in charge of that, so I was put in charge of setting up and managing a RFS surgical programme, as well as trying to do the development for the FST.[24] A huge workload. And I was getting it in the neck from everybody about it ... but it was success, it was a successful RFS surgical programme so I thought I did alright there. And I'm not very good at paperwork, so ... there was a lot of paperwork that I struggled with like writing policies ... and so they went off to one of the islands. They took the FST over to practice in and I was told before I even left that I wasn't going to go 'cause I'd been such a bad girl that the surgeon and [another nurse] had decided that I wasn't going to go 'cause I had

[23] Relocatable field surgical facility.
[24] Field surgical team.

> failed in so many areas so at that point ... I thought “Well what's the point?” (Bonnie, pp. 8-9)

Training of personnel is a critical element of operational preparedness and one that must be undertaken in order for the Defence Force to meets its obligations to the Government so the how individuals perform in training is closely monitored (Ministry of Defence, 2016a; New Zealand Defence Force, 2012b, 2017e). Organisational outputs are put at risk when training is viewed as a reward rather than an imperative. Bonnie went on to report that:

> Eight months later [an operational deployment] came up and they wanted to go and I got a phone call from [the CO]: “Bonnie”—I remember it quite clearly—Friday afternoon: “How would you feel? Would you like to actually go?” (p. 9)

Besides the risk of deploying an individual on an operational mission who may not have been adequately prepared, the preparation for deployment—achieving deployability—became more of a prize than the deployment itself. When performance reporting as a surveillance tool does not successfully isolate and punish deviancy, in this case isolate and punish the subject who had not met training requirements, nor those who had contributed to the failure in that person’s training, but is instead ignored, performance reporting loses some of its authority. It is evident in the example provided by Bonnie, that the ineffectiveness of performance reporting as a disciplinary tool of force was noticed because by the time Bonnie deployed, alternative punishment strategies had been put in place:

> There was two completely different factions; there was Karen, most of the medics and other nursing staff, and then there was a smaller group

> that she'd bullied and ostracised. The last six weeks of our [tour] Karen did not speak to me unless she had to in regards to "this patient's coming to you five minutes" or whatever. But outside of that clinical environment she did not speak to me. (Bonnie, p. 15)

Bonnie's marginalisation ultimately led to her resignation from the Army.

Organisational systems of surveillance and processes of reward and punishment that have been designed to optimise the contribution that subjects can make to outputs, could not counteract power relations operating in the social sphere. These relations assumed a dominant role over juridical authority so that discourses of marginalisation that were first evident in the training space were able to be transferred to the deployment location despite the organisation making visible Bonnie's value by deploying her overseas.

Sørensen (2014) claimed that once it becomes apparent that existing techniques are insufficient to ensure the docility of the subject, new prohibition rulings are developed to resource that deficiency. A policy that seeks to address discrimination, harassment and bullying in the NZDF (New Zealand Defence Force, 2015b) has been the military's juridico-discursive response to the types of conduct that appear to have led to Bonnie's negative experience in the military. However, according to Foucault, prohibition rulings do not eliminate discourses that facilitate undesirable conduct. Power will reshape expressions of discourses in response to new rulings but the underlying ideas upon which the original discourses were built may still persist (Foucault, 1990). Systems remain perpetually behind power relations with systems responding only after new expressions of non-compliance have become evident.

Procedures of power for preventing parrhēsiastes

Performance review is an institutional technique that serves the juridical purpose of disciplining subjects through mechanisms of reward and punishment (Foucault, 1991a). The process can therefore be hazardous (Best & Kellner, 1991). Appraisal processes intentionally isolate individual subjects by seeking idiosyncrasies of compliance and non-compliance, and by initiating processes through which deviant conduct can be controlled. Performance review in the military is a significant source of information for career management that can lead to promotion and postings to highly regarded appointments and to roles on operational deployment. When potential benefits exist, performance reviews hold status:

> I've got a senior commander telling me at the moment to turn off all kind of specialised training and just get into reinforcing some of the deficiencies in primary health care and that kind of environment. And that's fine, they can make whatever decision they want, but they don't seem to understand that that comes with a consequence and my report card is about delivering a Role 2 and that is what I'm assessed against. (Andrew, p. 8)

Principles underpinning the prioritisation of effort in the NZDF are described by military doctrine (New Zealand Defence Force, 2012b). Doctrine is designed to enable the flexibility of military capability because the environment in which the Defence Force operates is not stable, (Ministry of Defence, 2016b; New Zealand Defence Force, 2012b). This means that commanders are expected to possess an understanding of the contribution that their section of the Force makes to the overall achievement of military objectives and to ensure that their part of the organisation is prepared and responsive in accordance with doctrinally agreed principles. Doctrine guides how commanders act to

support objectives and allows senior leaders to apply judgement and to seize initiative. Seizing the initiative may result in a change to a previously agreed course of action (New Zealand Defence Force, 2012b). Doctrine therefore empowers commanders to direct their subordinates to change the focus of their efforts to align with those of command's.

What was asked of Andrew was lawful and therefore it was reasonable for Andrew's senior commander to expect cooperation with the change of direction. The report card Andrew referred to was his annual performance assessment. When performance assessments have the potential to reward, they become important so Andrew was reluctant to follow his commander's directive because to do so may have resulted in him failing to meet his key performance indicators which in turn may have an effect on Andrew's future career opportunities.

The consequences Andrew referred to of turning off specialised training will have an impact on the perceived commitment of NZDF personnel within those civilian agencies within which military health professionals undertake some of their training. This may then impact upon the reputation of the NZDF and affect the attitudes of those agencies towards accepting military practitioners into their organisations in the future.

Conversely, the clinical skills maintenance programme agreed to by command might not be an impediment to any temporary cessation of placements because lost time can be recouped later and as previously explained, hours spent in clinical practice are a factor but are not the only means through which competence can be achieved. However while hours may be able to be deferred, a change in practice domains is more problematic. Nurses being required to reinforce deficiencies in unfamiliar specialty areas of practice will involve additional education, orientation, preceptoring and spending time in place if they are to achieve competency. In addition, when nurses

return to their original areas of practice they will not only be required to make up for lost clinical hours, they will also need to re-establish collegial relationships and update themselves on developments within their original specialisation.

Kathy like Andrew, found that efforts to ensure that nurses are competent for their appointed roles is secondary in priority to managing deficiencies in other areas:

> This is not a good time for them to be plucked to be sent off to [another formation] or to be doing this, that or the other thing. This is the two weeks for the exercise for example, were going to be two really good weeks for us to actually be together because we are hardly ever all in the office at the same time, to actually consolidate some of the stuff that being in the Role 2 actually means. (p. 11)

Advising command of the risks that interruptions in training presents seems logical but both Andrew and Kathy were reluctant to provide that advice even though advising command is an important aspect of the nursing officer's role. From what nurses had to say, the provision of advice relates more to clinical aspects of nursing than it does to providing advice on higher level decision-making. Andrew gave advice about the risks that present for patients during a particular search and rescue operation (p. 14), Kerry provided advice on treatment options during a health support operation (p. 10) and Sarah advised command on financial entitlements for patients about to be released from the service on medical grounds (p. 19).

No nurse expressed any reluctance to provide advice on clinical matters which contrasts with how nurses approach the provision of advice on non-clinical matters. Whilst Andrew felt conflicted between complying with a directive and meeting his key performance indicators, and Kathy felt that to raise concerns or to question decisions

might be interpreted as her “not being nice” (Kathy, p. 12), Tony provided a different perspective:

> You are always under the spotlight as a health leader in this organisation ... the minute you show frustration or passionately defend a position when you know you're right ... you're labelled as too forthright, or you're labelled as obstructive. If I'm pointing out that what you've done as a superior is wrong and that we need to take a different path, because the entire culture particularly in the G List community is built on a, almost a class-ified system ... If you've got someone lower down the pecking order publicly questioning a decision you've made. There's no way that you can acknowledge that what you've done is wrong, because in the eyes of all the other guys who are part of that class-ified system you will be seen to be weak, or be seen to be soft round the edges or whatever. Or that ... if you're three steps up the ladder and you've made a command decision and someone three steps down the ladder is able to so easily point out the flaw in it, and also come up with an alternative which is better, then you shouldn't be in that position because this lower pecking order minion has just undermined you. So therefore their immediate reaction is to defend, refuse to budge and then over time you who's dared to put your head above the parapet, you're now in that person's spotlight. (pp. 8-9)

Tony’s synopsis of what happens when he attempts to provide advice, indicates that in his experience, health leaders are singled out for increased surveillance and may therefore be open to increased punishment. This then creates fear in the subject which serves the purpose of moulding health personnel into docile subjects. As a form of

institutionalisation, organisational hierarchies support the suppression of undesired activity so whilst nurses' reluctance to provide advice to command may appear to be about report cards and being nice, underlying power relations that position nurses as inferior and which give exclusive rights to knowledge to G List personnel, provide an invisible barrier to nurses meeting the professional advisory expectations of their roles. Conduct that may lead to heightened scrutinisation, in Tony's experience, is to be discouraged.

When decisions need to be made regarding the utilisation of nursing capability, commanders of necessity must consult with nurses yet the responses they receive may raise more questions than provide answers. Kerry provided an example:

> We had an interesting discussion recently about the role of primary health care with nursing officers, and we were most divided on this issue. Even when I speak to nursing officer colleagues we have differing opinions on this of course and I feel a bit for some of our commanders at times, because I know when [the OC] was seeking out to try and get information out of a group of senior nursing officers individually about where primary health care fits and DMTP fits with nursing officers, we went out to about four different senior nursing officers and got completely different opinions and ideas out of them. It's like well, you're dealing with health professionals. That's going to happen. But it makes it pretty tough on command I think when they sort of go "Why don't you guys just all tell me the same thing?" (pp. 17-18)

Roles performed by individuals in the NZDF have specified outputs against which incumbents are assessed (New Zealand Defence Force, 2015g, 2017e). The NZDF is the

only authorised Armed Force in New Zealand and because the profession of arms and functions performed by its members are permitted solely under the authorisation of the NZDF, regulation of those members and their functions falls to the NZDF (Defence Act 1990, Ministry of Defence, 2016a). Performing the role of a regulator involves the detailed specification for combat forces' competence acquisition and maintenance. Due to the myriad of different trades and professions represented in the NZDF and because many roles are able to be performed by members of different trades or professions, performance review is generic.

Defence Force specialist officers are externally regulated hence the ways in which specialist officers maintain competence and undertake their roles are not specified in the NZDF to the same degree of detail as are those of the profession of arms. Consequently the provision of advice by specialist officers to the NZDF on the employment, configuration of services and utilisation of members of externally regulated professions is crucial if the skills that specialist officers possess are to be optimised for the benefit of the NZDF in a safe and sustainable way. The provision and acceptance of advice is even more important when a professional domain is as complex and dynamic as that of healthcare.

It is accepted that decision making in healthcare cannot be based on an immutable and predictable system (Kuziemsky, 2016) therefore it must be expected as Kerry points out, that differing opinions on the employment, configuration of services and utilisation of nurses will arise. When individuals are permitted the license to exercise judgement, their opinions and therefore the advice they provide, will be shaped by their experiences, the expectations of their roles and as Andrew described, what is written in their report cards. George stated that:

> The reporting is very General List officer driven, all the competencies, that yes, we do need to be measured against as well, but it doesn't give much room for acknowledging that whilst you may be doing some roles, just how much of a background or training or preparation have you actually been given to fulfil those roles. (p. 5)

George's comments take on significance when considered in relation to what Tony had to say about the lack of investment in the development of health leaders. If performance review serves disciplinary power by compelling compliance, and if reporting processes are seeking the exemplification of leadership qualities, and if nurses do not receive the same investment in leadership development as G List officers, then performance review achieves its intent by compelling compliance to reinforce the lesser status of nurses.

Parrhēsiastic processes for professional responsibility

When performance criteria is generic, the nature and quality of work performed by nurses cannot be assessed accurately because measures that are of value to the profession are not incorporated, therefore supplementary instruments are necessary to provide commanders with this knowledge. For nurses the supplementary instrument is the NZDF Nurses' PDRP. Understanding the PDRP and its application in the NZDF involves specialty knowledge, the management of which is formally delegated to nurses through PDRP processes yet as described earlier in Alice's attempts to gain compliance with the programme, some nurses refuse to cooperate. Alice's frustration is evident when she declared that the PDRP is "a professional responsibility. We're all professional people and yet [some nurses] don't think it's important" (p. 6). Alice later stated that one nurse "has never, ever done a PDRP" (p. 12).

The HPCA Act provides for the regulation of health practitioners in ways that permit only those who belong to a profession to make judgements regarding the competence of members of that same profession. The NCNZ has been appointed under the HPCA Act to regulate nurses and the NZDF Nurses' PDRP is Council approved which permits external governmentalities to invigilate NZDF processes. Such invigilation introduces into the military inverse exclusions that may be difficult for non-health practitioners to comprehend, particularly when customary NZDF governmentalities normalise the exclusions of health professionals, not the other way around. The ability for the PDRP to inform commanders of nursing competence is lessened and nurses' autonomy reduced when nurses do not support their professional programmes.

When the NZDF personnel reporting system is predicated on generic competencies, and the status of performance review is high, nursing programmes that do not directly inform career management, even if these programmes are compulsory as the PDRP is, do not possess the same status as performance and development reports and therefore will not attract the same degree of prioritisation.

The perceived lack of value of PDRP may signal to non-nurses that the programme does not in fact hold any value:

> A senior person came to me and told me that PDRP wasn't a necessary thing and that we're not going to have it. And I said "Well hang on a minute, it is a necessary thing. The HPCA, the Nursing Council blah blah blah," and he continued to tell me "No" that wasn't so and then I said "Well do you think you are taking this a little bit personally because really, what's the PDRP got to do with a G List officer?" (Alice, p. 12)

When Sarah found out that command were attempting to allow non-nurses to take up what Sarah believed were exclusive nursing roles, she claimed that "it smacked of madness. It smacked of absolute madness so all they were doing was slowing me down from providing care for these people" (Sarah, p. 17). Sarah activated multiple networks to challenge the decision which, like Alice's confrontation with the senior officer, demonstrates that nurses will emphatically overrule both institutional hierarchical arrangements as well as nurses' subject positioning in order to claim governance over nursing matters. When it comes to issues that affect patients "politics be damned" (p. 17) declared Sarah, the interests of patients comes first.

The team, the rules, or the self: Where lies the truth?

The military ethic of placing the team ahead of self may not always serve the interests of the NZDF. Andrew explained how the application of international humanitarian law on operations can be problematic for medics who are bedded in with soldiers on patrols. Andrew said that "the first thing you're told on basic is 'soldier first, soldier first, soldier first'" (p. 15). The soldier first attitude combines with egalitarianism to create difficulties with compliance to international humanitarian law:

> [Adherence to the Geneva Convention] is certainly a huge issue for the patrol medics who would talk to me about it every time they came back about where the line was as far as what they were trying to do and that sense of being true to your team, rather than being true perhaps to the Wellington based rules of engagement. (Andrew, p. 15)

Being true to the team as Andrew explained involves medics not being jack and doing their share of soldiering functions, some of which are not permitted under the Geneva Convention. Andrew himself was adamant that on operations that:

> You can't waver from your requirements as a health professional in what the Geneva Convention expects from you. That was always very clear. I never felt like we were asked to do things that were breached on purpose but I do think that a lot of the guys didn't quite understand this is from a general military point of view, didn't really quite understand where that line was.
>
> You know, the platoon commanders, the patrol commanders weren't thinking about the strategic impact of telling their medic to take a Red Cross off. When they were telling them to do that, they were just thinking that that would be a better way of patrolling or a safer way of doing that ... if you're a private medic in a platoon or even a section of 10 persons you know that peer pressure and that need to do – basically that absolute need to cover an arc or do what's needed to keep your little patrol safe, it obviously starts to cause I think most medics to bend, not to break as far as what they do in their rules, but to bend and you never know what's going to happen till the heat of the moment. (pp. 15-16)

The encounters of medics have significance for nurses because nurses work very closely with medics. This is the case in garrisons but even more so on operational deployment where single nurses are often embedded with teams of medics (McNabb, 2015). Discourses are technologies of power that operate in social spaces so when subjects are in close association with one another, the ability for discourses to permeate across domains is heightened (Foucault, 1984b). What this means for nurses is that when nurses are exposed to the values, the thinking and the conduct of medics, some of the

thinking and action processes of medics will influence nurses. The reach of power through discourses also extends beyond the medic nurse relationship.

Medics' close contact with combat troops during patrols has, as Andrew indicated, a compounding effect on medics' already strongly inculcated sense of the soldier first mentality. Resistance to peer pressure may be worn down over lengthy patrolling periods where medics must work in isolation from other health professionals so are not readily able to discuss concerns with them. Thus while the relations between combat troops and medics may not unquestionably portent a deviation by medics from legal or ethical practice, they will have an effect. When medics return from patrolling they return to where nurses work which is where discussions ensue between medics and nurses and where ideas, and ideologies, are shared. Thus medics are used by power as an intermediary for the transfer of combat ideologies to nursing.

Chief of the Army states that "being part of Ngāti Tūmatauenga[25] means more than the corps you represent ... it's inherent within each of us" (New Zealand Army, 2020b, p. 3) and "every member is a soldier first" (Harding, 2016, p. 17). Nurses do not often patrol in the way that medics do so are less likely to be subject to the same expectations as medics however, when governmentalities exist that specify that the orientation of all personnel must, to the subordination of all else, apply a warrior attitude (New Zealand Army, 2020b) and when some of nurses' primary connections are with those who subscribe wholly to the soldier first mentality, nurses are susceptible to assuming some of those attitudes.

Nurses are at times required to take on the roles of medics and when they do, they enjoy it. Angela stated that she prepared herself to work as a medic because she "got bored

[25] The New Zealand Army's Māori name translated as the tribe of Tūmatauenga the god of war.

just being down the hill ... I quite like doing field cover" (Angela, pp. 6-7). Kathy who had not received training to take on medics' duties still did:

> I'd get rung up to do live field fire medic cover. And I was like "That's cool, but I don't have a medic pack or any of that stuff". I'm a nurse and a [specialty] nurse so you know, I can at a pinch, I can make my nursing skills work for this, sure. (p. 10)

On one mission Angela was asked to patrol as a medic because "the patrol medic couldn't go, so I said 'I'll go yeah' and that was good, good experience" (p. 14). During the patrol Angela never felt under any pressure to perform tasks that may have not have been legal or ethical however the duration of the patrol was less than a week and because Angela was just covering the absence of the patrol's regular medic, she would not have had the opportunity to develop the same types of relations with other patrol members of that medic. This however was not the case for Elouise who gave an account of what it was like to be posted to spend a longer period of time on patrol:

> When we were out on patrol I would still get out of my truck and stand there with my rifle and protect the [vehicle] I wasn't going to not do any of that, because you have to still do that as a soldier. You have to be there, ready. Like if I was the only one next to the vehicle of course I'm going to look after it and look after myself and watch in a certain direction. But they just can't, they couldn't utilise me as using like a sentry to protect everyone else while they were asleep. (Elouise, p. 8)

While Elouise was firm in that health professionals are not permitted to protect other personnel or facilities, neither are they permitted to protect vehicles that are not used exclusively for the transportation of the sick and wounded or for the transportation of

medical equipment. Here lies an example of the point made by Andrew that there is pressure on individuals to contribute to the safety of the team. Andrew explained that it is not just patrols but base areas that require protection:

> I had to know about the 50 cal[26] which is on top of the Hummer,[27] about how to make it safe, how to make sure that it was fine. I obviously had to fire my Steyr[28] all the time as part of that training as we would go through and you were exposed to the other weapons that you might come across: AK47s,[29] RPGs,[30] things like that ... there was never any inference that I would get up on the 50 cal and start shooting people, but there was also an understanding that if there was no one left alive or capable and that was required, that that would be part of the deal. (p. 15)

The proximity of threat as well as professional isolation, close association with medics and combat troops, lack of knowledge, and not wanting to be thought of as jack, all contribute to conditions where nurses may feel under pressure to work in the ways of soldiers and not in the way of nurses.

Those who set and monitor how any spare capacity of health professionals on operations is utilised are contingent leaders. Nurses as officers are in positions where they are more able than medics to engage with contingent commanders and see it as their responsibility to raise issues relating to international humanitarian law with them. Andrew explained that:

[26] 50 calibre machine gun.
[27] High mobility multipurpose wheeled vehicle.
[28] NZDF personal assault rifle.
[29] Kalashnikov assault rifle.
[30] Rocket-propelled grenade.

> There's less of you ... you tend to sit round the level of command that understand what [health professionals] limitations are and there are just people that are prepared to sit down and have a discussion with you about what [the Geneva Convention] might mean. (pp. 15-16)

Elouise explained that when she was on one overseas operation "we were declared so we wore our red crosses. So we were performing under those restrictions, so we ideally were only there to protect ourselves, our patients and our deployable equipment" (p.7). Elouise believed that training in the law of armed conflict is treated in the military as "just like a technicality" (p. 16). This thinking, when connected with terminology that refers to humanitarian laws as "limitations" and "restrictions", reduces the importance of the rules that govern the practice of health professionals.

In an effort to counter the impression that health professionals use the Geneva Convention as an excuse to shirk work, Elouise like Andrew, would seek opportunities to educate her commanders on the purpose of humanitarian law so commanders would have a better appreciation for how health professionals may work. Yet despite these kinds of efforts, the notion that health professionals have responsibilities not just to their team or to their contingent but to authorities who have a role to play ensuring that the practice of health professionals is both legal and ethical, is not always evident in what nurses had to say about non-health professionals. Some medics were "just told 'you're doing sentry and that's it, full stop'" (Elouise, p. 8). There appears to exist an understanding that health professionals' compliance with international humanitarian law is voluntary and therefore a degree of freedom is permitted in the law's interpretation. Elouise confirmed there is a poor understanding but that "it is something that's hard to get your head around" (p. 8). George also reported low levels of knowledge as

evidenced by him being asked on a deployment “why aren't you doing your sangar duties?” and “why aren't you doing those other military things?” (p. 15).

Yet while nurses report that they encounter difficulties due to non-health personnel’s inadequate knowledge of the provisions of the Geneva Convention, and that medics struggle to navigate through the competing demands of compliance with the Convention and with officers’ instructions, study participants did not provide any accounts of nurses being ordered to depart from their professional obligations. This absence may indicate a respect for nurses’ knowledge of humanitarian law or it may indicate a respect for nurses’ officer status whereby it is not customary practice for G List officers to deliver orders to health officers in domains within which the G List may not be expert. Alternatively the absence may instead be an indication that the types of roles that nurses perform makes them less likely to hold positions where teamwork involves the sharing of tasks where one or more of those tasks present a risk to non-compliance with international codes. George admitted that he had himself worked in a deployed context where a high level of security had been necessary. At the time George had felt under pressure to contribute to sangar duties and had been “teased” (p. 15) for not pulling his weight. However George had resisted the pressure and subsequently made the observation that challenges of this nature only ever come about when health professionals work in close proximity to members of the wider military community. When as George purported, nurses are “busy doing their core business” (p. 15) embedded within health facilities, these types of issues do not arise.

Summary

Chapter seven has explored a range of strategies that nurses employ to consolidate their place in the NZDF. Discourses that factor into nurses’ decision making were examined so that an understanding could be gained of the hidden agenda of power that seeks to

compel the military nurse to become more like a soldier than a nurse. Techniques employed by power such as industriousness, time, loyalty and juridical discipline were examined to reveal how deeply embedded notions of military leadership, combat orientations and the hegemony of medicine serve to problematise nurses' position in the NZDF. Effects of the problematisation of nurses on professional practice were explored as were the ways in which nurses work to prevent incursions into their professional domain.

The next chapter will present further interpretations of military work, and build upon concepts already presented to reveal the nature of ethical conduct and discipline as nurses become more experienced in their Defence Force environment. The ways in which nurses navigate the complexities of their role will be presented with the chapter concluding with an interrogation of the decisions that nurses make that impact upon nurses' professional and military positioning.

Chapter 8: The constitution of a collective of outsiders

Introduction

The previous chapter extended the exploration of nurses' experiences of inculcating into the NZDF. Nurses' determination to be seen to be like other military personnel was exemplified in a range of ways. The raising of the value of military behaviours and the devaluing of characteristics and actions that are important to nursing are an effect of nurses wishing to be seen to be like others. Competition and status continue as underpinning features of nurses' ways of being. Nurses elect to align with or to resist competitive and status assigning norms depending upon the circumstances, but irrespective of choice, unintended consequences follow.

This next and final analysis chapter examines how nurses' collective and individual responses to the NZDF culture impact upon their professional accountabilities and role expectations. Routes to competence and confidence are explored using technologies that examine nurses' work on their selves. In cognisance of the hidden agenda of the knowledge power paradigm, what is not said is described as well as what is so that connections between military governmentalities, culture and opportunities can be seen.

Dual agency is presented as a key theme that shows the effects that the juridical and cultural emphasis on teamwork, and the power relations that target uniformity, have on the ability of nurses to exercise professional autonomy. The success of nurses' techniques of resistance in relation to threats that teamwork presents to patient safety are discussed. Other strategies that nurses employ to manage the challenges that rank and status present to patient wellbeing are revealed. The chapter concludes with an inquiry into how disciplinary techniques contribute to the formulation of a nursing team.

Military truths and personal pedagogies

According to Miskelly and Duncan (2014), proficiency builds confidence and contributes to the formulation of identity. Military nurses travel a variety of routes to gain proficiency with some routes being chanced upon while others are deliberately planned. As described earlier, Angela had selected her own direction by personally identifying gaps in her knowledge. This had led Angela to consider how and where those gaps might best be filled then she set about filling them. Determining within the network of Defence health structures a geographic location where proficiency might best be acquired, was predicated on her already possessing a degree of proficiency.

Knowing what is needed to be known is as Foucault (1990) asserted, dependent upon and limited by, the discourses to which a subject is exposed. Coming to an understanding of the truths that are professed by martial discourses, involved Angela first recognising the existence of those truths, and then applying technologies of the self to find ways to align with them. Chapter six explained the shock and awe experienced by novice nurses when the complexities and exclusionary practices of martial discourses are first encountered, but all nurses in this study progressed through the initial stage of shock by applying the technologies of the self that are so evident in what Angela had to say about wishing to learn more about the military aspects of her role. This process involved nurses moving from their previously exclusive but militarily incompatible nursing subject position, to a new *military* nursing subject position.

It was not until long after Angela had been posted to her new location that she realised that a personal change had occurred. The operational focus of her new unit had demanded the prompt honing of non-nursing skills that Angela had not previously possessed. Despite Angela's careful route-planning, her new learning had not been formally engineered within an organised framework. Although Angela had as

previously shown, been given permission by her OC to go ahead and “just do it” (p. 6), she often did not know what or how to: “I said ‘I don't even know what you're talking about’. I didn't even know how to turn on the computer ... somebody said ‘right, this is what you have to do’” (p. 4). Much of Angela’s military knowledge acquisition needed to be self-identified and self-initiated. For example, Angela recognised she needed assistance with weapon handling so requested the help of a weapons instructor but she said she:

> really didn't get comfortable with using a weapon until I went [on an operational deployment] and that was because I had to handle my weapon every day ... putting it together, cleaning it, reassembling ... that's when it started to make sense. (pp. 8-9)

Learning was consolidated with practice.

Technologies of the self are evident too in Alice’s description of addressing her learning needs. Alice explained that she:

> had that vagueness I suppose and knew I needed to have more in-depth understanding so I would go online and read up stuff so actually if I didn’t know exactly what it was about, I still knew how to find that information. (p. 13)

Of note in what Alice had to say was her use of online resources. This practice suggests that there is a deficiency in the NZDF of information to help nurses learn what needs to be known. Alternatively, if the information is available, it is not accessible to nurses either because it is retained in repositories that nurses do not have access to, or it is retained in places that are not known to nurses. Given that governmentalities of the NZDF involve precise specifications to control ways of working, it is doubtful that the material does not exist. Instead it is likely that the exclusionary and competitive nature of the military environment prevents nurses from accessing the information. To be told 'just do it' does not unlock repositories that are not known about, nor does it equate to mentorship in ways that nurses might recognise.

Other nurses reported that they were required to identify for themselves their own knowledge deficiencies and to initiate plans to address them. Deficiencies did not only relate to the acquisition and maintenance of military and administrative skills, it also applied to nursing expertise. Kathy felt that if she were to become a proficient military nurse she needed to control her own clinical time. In a deviation from regular service arrangements, Kathy negotiated as part of her reviewed NZDF contract for guaranteed clinical time. The decision to preserve clinical time was due in part to Kathy's commander having suggested it but largely because Kathy's experience of military service to that point had, she believed, presented a risk to the competence she needed to deploy in her specialty area of practice. Kathy stated: "I need to keep my skills up [because] I need to do other stuff, so clinical takes a back seat" (p. 6). While Angela had not negotiated a similar arrangement she found other less official ways to maintain her clinical competence: "I would steal myself away and come up and go and work in the medical treatment centre anyway" (p. 6) which suggests that maintaining clinical currency may involve furtive behaviours.

While skills acquisition leads to increased confidence, confidence is reinforced when individuals acquire an understanding of the contextual, community and strategic environments that impact upon the delivery of nursing care (Sørensen & Hall, 2011). The military environment is not static so first learning and then maintaining knowledge of the contextual, community and strategic factors that impact upon care requires nurses to move between different roles. Exercises and operational deployments supplement knowledge and experience gained in garrison postings thus contributing further to the development of confidence. Angela explained: "You don't necessarily talk me through it, but you let me see one, then you let me do one, then I can do it and I can do that for the rest of my life" (p. 12). Angela provided an example of how her previous operational experience had taught her some important skills which she then modelled. The expectation was that others might emulate the behaviour:

> So we were all camped together upstairs with our stretcher beds and ... you'd just get in your dome ... If somebody gets sick then I'll say "okay, this one on nightshift can't come. I'm going to leave now, go and have some sleep and come back and do that one's shift because I found the young ones aren't resilient. (Angela, p. 22)

Exemplifying conduct that supports the team and therefore the achievement of mission objectives, is one way in which nurses are able to 'see one' in preparation that they might 'do one'. Preparing for some types of work that military nurses are required to undertake involves the application of skills learned in a different environments. Several nurses indicated that optimising clinical outcomes for the injured in combat zones is predicated on the successful amalgamation of knowledge of the military environment and nursing expertise acquired in the civilian sector:

> I'm used to seeing sick people. I'm used to seeing, I'm not comfortable with it but yeah, certainly used to seeing people in pain and people bleeding and people that are really unwell, and people whose lives are not guaranteed. And for perhaps some of my junior colleagues, both medical and nursing depending on what their background's been, they may not have had that experience ... We've got to find that middle ground somewhere [between military and nursing preparation] ... we were I think quite lucky that day that I managed to bring those things together, but I did. When I saw the reaction of [others] ... that was pretty overwhelming for them. (Kerry, p. 13)

Kerry's confidence in his own level of expertise created capacity for him to not only concentrate on delivering emergency care in a challenging situation, but to provide emotional support to his uninjured colleagues. Kerry later reflected that learning must be reinforced by practical experience:

> We did an awful lot of being taught things and then going on to teach things without necessarily having the value of experience, which I think was why I was so ... adamant that I needed to get outside of the military to do clinical, you know, to have some experience I guess to hang my learning on. (p. 14)

Applying Angela's pedagogical theory, Kerry's junior colleagues had received on the day they were first exposed to major trauma, a lesson for which Kerry had felt better prepared but for which those others now having had the experience will, with adequate support, be able to 'do' in the future. Experiential learning sits more centrally than formal education in nurses' thinking with few nurses raising education as a key factor in military nursing competence. Experiential learning as attested to by Kerry, involves

successfully amalgamating nursing and military experience however it appears that some nurses defer to focusing on military factors. In discussing what nursing officers require to deploy, Elouise explained that:

> You have to have a current passport. You have to have a security clearance. You have to be medically fit, dentally fit. You have to have a pistol and Steyr AWQ.[31] You have to have a fitness test and it depends on the deployment which fitness test, so you would just do both plus a swim test, plus LOAC which I think is just like a technicality. I think that's it. (p. 16)

It was only upon prompting that Elouise explained the nursing requirements for deployment. The focus of nurses on military factors may not indicate that nurses are unable or refuse to consider nursing competence to be important, but may instead mean that nurses take for granted their professional accountabilities and are learning to apply nursing competencies to the unpredictable military environment. Nurses' focus on military factors may be reinforced by the proximity and influence of surrounding combat forces where, particularly on deployment, the need for competence in martial skills is critical.

Tony described how G List officers influence nurses' overall attitudes of the primacy of war-fighting in the Army:

> They spend 12 months at OCS getting indoctrinated in that mindset and it's very much about that mindset. So with special forces obviously being at the pinnacle. So therefore everybody is gunning to be a combat leader; everyone's gunning to ... earn their first choice as a

[31] Annual weapons qualification.

> corps to go to and most of the class ... will be gunning for infantry, engineers, gunners maybe and then as a second option, logistics, SIGs, those sorts of corps…. there's no active movement against this mindset. (pp. 1-2)

Indoctrinated mind-sets that drive the focus of G List officers onto combat mentalities, connect with the attention that nurses give to military skills, to show how military discourses diffuse across domains. Nurses are in constant association with G List officers so in the manner described by Foucault (1984b), the everyday discourses of one group are given licence to permeate and influence those of another. In this case the combat discourses of G List officers permeate and influence those of nurses.

Tony claimed that nurses "can quite happily go along just doing your job as a nurse and nobody expects you to do anything beyond that" (p. 3) but there is a clear indication that nurses assimilate aspects of the combat mentality and believe that in order to do their jobs as 'military' nurses they must learn about the military component of their employment context, and meet minimum military standards, in order to be accepted as a military nurse.

A confident, or overconfident self?

Despite the complexity and unpredictable nature of their practice environments, nurses expressed little doubt about their abilities to perform well as Defence health professionals. Clinical credibility is a valued nursing attribute that is underpinned by experience and confidence (Stanley, 2017b) but for nurses in this study, confidence was not always underpinned by experience. Several nurses said they had been put in situations where they did not believe they possessed the skills needed for the work to be performed but they carried on anyway. Kathy said when on a humanitarian mission she

was asked to work in an area of practice she had no prior experience in that she “was completely out of [her] comfort zone but it was fine” (p. 16) and she just found out what to do as she went along. When Angela went on her first patrol in a combat area Angela said:

> All I could do was give it my best shot, that’s about all I can say. It's not as though you went out with lots of kit. If we were in that situation, first of all, you knew you're going to have to fight for your life and that’s all you can do. You don't know what your response is going to be really. (p. 15)

Although environmental health is not a domain of expertise of nurses, Duncan held no reservations about being capable of managing an outbreak of gastroenteritis during an exercise overseas. Duncan’s lack of experience was not at all evident in explaining how cases were to be dealt with:

> There was nothing wrong with the kitchens, it was the fact our boys were eating and drinking out and one had to settle the situation down ... it was just about getting to be an international incident between [the country they were in] and so I said to [the OC] “look, surely it has to be that we get as many people on the main exercise as possible”, and I said “I will go through everyone ... if they'd been vomiting in the last 48 hours, haven't eaten fully, still got diarrhoea, da-da-da, they won't be going, because we need to get them fit. If we put them out they're going to relapse and you're not going to get them for the main exercise”. (pp. 9-10)

Duncan did not allow the rank or role of others within the contingent to influence decisions that Duncan believed belonged entirely with the nurse. Neither did Duncan consult with specialist environmental health officers back in New Zealand.

Andrew also recalled being placed in situations where he did not feel confident; again on operations:

> I remember once there was trauma coming in; came right at shift handover and none of the doctors were there and so you end up going from being the nurse supporting the doctor in the trauma to leading the trauma. It's a different context but you simply take a breath and say "Well, there's a way we do this, there's an algorithm, follow the algorithm. Just don't deviate, stay on it". (Andrew, p. 12)

Andrew had claimed that:

> I get a sense that there's a bit of New Zealand culture there. I've always we've always been brought up the number eight wire solutionising and certainly as a new nurse in the military, we were taught about our kind of nurses who'd gone before us, who would you know, get the engineers to do this to make it work or would re-sterilise this, or had come up with a new way of making it right to get the job done. So I kind of went knowing that that was what we had done in the past and that's what we would do. There were times when you would wonder if you were doing the right thing. (pp. 11-12)

The archaeology of the way of the RNZNC nursing officer is an important discourse for nurses to draw upon that is both motivating and, as Andrew explained, inspiring of

innovation. The discourse is a positive and encouraging support to nurses when they're working in adverse and unfamiliar environments.

The number eight wire mentality appears to extend from managing logistical problems to managing experiential deficits. Notwithstanding any such deficits, Duncan felt that it was important for patients to think that nurses are competent because it reassured them, but Duncan also used confidence to increase nurses' status:

> The OC said to me he could not continue because he had really badly blistered feet, and the medics had told him that they couldn't do anything. And I sat down with him and said "Sir, you've come to a nurse". I was plucking whether I could do anything or not but you know, reassurance ... I made him a brew, gave him some cigarettes which we shouldn't do nowadays, and jellybeans. He did his orders. I spent an hour and a half on his feet taping every single blister, dealing with his feet, putting Comfeel on them and everything else; said "Sir, you'll be fine" thinking "cross my fingers and hope". He stood up and went "Oh fantastic Duncan, feel really good" and off he went and finished the exercise. Therefore he had a better appreciation after that of nurses and what nurses could do. (pp. 11-12)

Confidence underpinned Bonnie's views of the suitability of medical equipment being prepared for an operational deployment. Bonnie was angered by a lack of concern for infection prevention and control:

> I knew my [specialisation] and my [specialty] role, and I knew that the standard of the pack-up would've been totally unacceptable in a civilian environment. And we were going off [on a mission] with it,

> and so I stood up for this is and said “this is not correct. This is unacceptable sterility, unacceptable”. (p. 11)

Although Bonnie had been marginalised by her colleagues in the lead up to the mission, that did not prevent her from drawing attention to poor practice. The approach that Bonnie took was unapologetic and uncompromising: “I made everybody unpack the whole FST” (p. 11).

Miskelly and Duncan (2014) claim that confidence has a close relationship with proficiency. A number of nurses wished to provide proof of their proficiency with Alice being particularly precise: “I think I have no issues and no problems with meeting [nursing expectations] and I have always had my practising certificate up to date. I've got current PDRP. I know all about legislation and what applies to us and where we fit in there” (p. 8). Alice went on to explain that:

> At the moment I’m not doing clinical because my job is focused on nursing; therefore I’m using my nursing knowledge and my nursing practise is in that management sector and I have just done a management portfolio PDRP which I've had assessed outside and got the big tick for that ... I’m more than happy that I’m doing what they require me to do. (pp. 16-17)

The question must be asked, who are “they” that are requiring Alice to demonstrate proficiency? ‘They’ are likely to include Alice herself who does not have clear guidance on what she needs to know, nor does she have mentors to advise her. Alice has used as her measure, civilian nursing agencies to confirm her military nursing competence however, civilian nurses do not possess an understanding of the complexities of the military health environment and therefore may not be in a position to judge whether a

military nurse is working at the PDRP level they are seeking nor whether they are working within the law and professional boundaries that pertain to military nursing. It will also be less apparent to civilian agencies than to military nurse assessors if the nursing officer has modified or withheld military evidence in their portfolio.

Nurses' confidence can be seen to extend beyond nursing and into leadership abilities as evidenced by what Tony had to say about nurses working in multidisciplinary teams: "Usually the nurse is actually more qualified [than other health personnel], has greater expertise and has had much more experience in leadership and operational health planning" (p. 7).

There exists a sense that confidence, and projecting impressions of confidence when experience may be lacking, can counteract notions that nurses have little to offer. Yet as time goes on and experience becomes a reality, confidence grows and is reinforced by how others view nurses. George explained that although when nurses first come into the military they are thought by others to be there only by default "as you get older and wiser ... the opinion of [those others] changes" (p. 14). Angela stated that:

> You are more confident because you've raked up a few years in the military, so that when they actually say to you "Right, now you're on the nightshift helping out in the orderly room" that you actually know what they're talking about because you become used to doing that sort of work ... If you had to wake up the RSM[32] of the camp ... you know your way around in the system. (Angela, p. 14)

Thus military nurses' confidence is not only tied to experience, it has an association with gaining the confidence of others because without trust, nurses may not be placed in

[32] Regimental sergeant major. The senior soldier in a regiment or battalion

the roles where they can gain experience, so it seems that nurses feel they must appear confident to begin with.

Procedures of pressure or opportunity? Nurses beyond nursing

Working in an orderly room is just one of many functions that all military officers are expected to perform. Despite their differences in primary roles, the recruitment, selection and promotion processes and criteria are the same for nurses as they are for G List officers. In addition, all officers must be able to demonstrate officer competencies commensurate with their rank so there is an expectation that all officers will be capable of performing roles of a generic nature that are not tied to a particular skillset (New Zealand Defence Force, 2017a). This expectation however does not always extend to specialist officers:

> Yeah, so I did all the work, had all these, all my ducks lined up [to be an escort officer on an operational deployment] and everything was all good to go ... and interestingly, they weren't that happy about me doing it either ... the commander was real straight up and I went to a planning conference with it and he's like ... "Are you the escort officer?" I was like "Yes". He just immediately wasn't sold on the fact that the commander of Joint Force Headquarters should have a specialist officer ... I was actually quite annoyed about it after the meeting and one of my friends was in the meeting with me. She was like "Don't feel bad, he's just, he's just an abrupt kind of person and he was just saying it like it is". *(*Elouise, pp. 5-6)

Although power's prohibitive rulings work to prevent nurses from taking advantage of career opportunities that may seemingly be available to them, some nurses such as

Elouise choose to resist them. When power fails to achieve its intent in its covert form, it must become overt, hence Elouise's commander "just saying it like it is". It does not serve the interests of non-nurses to permit specialist officers to assume roles that will draw them closer to those who hold the status because as discussed in chapter seven, specialist officers are only employed to do their specialty thing and irrespective of how well they perform, they must stay in their lane (Tony, p. 10).

Thus in open fora such as planning conferences, commanders would be expected to counter-resist individuals stepping outside their lanes. Yet despite such resistance, there are certain conditions that remove the restrictions. Extra-regimental posts open up for nurses when no other personnel are available to perform them. While nurses benefit from working in non-nursing roles, unlike their G List officer colleagues they seem unable to plan career pathways that incorporate such roles. Nurses believe they are only there by default:

> The jobs that I've done outside of my nursing role I think I've filled because there hasn't been a G List officer there to take it. I think I would've only been considered for that platoon commander role because it wasn't something I was actively seeking; it was more that there wasn't ... that G List officer to fill that position so then they had a look at who else was there. (George, p. 3)

Although nurses feel they are a last resort, this does not prevent them on principle from accepting the posts. Gaining the opportunity to undertake a different type of work is a primary motivator for nurses joining the Army with nurses expressing these motivations as seeking not just variety but having the opportunity to do things that are "atypical" (Andrew, p. 1), going on "an adventure" (Bonnie, p. 1), working in a domain that is "slightly fringe" (Sarah, p. 1), and being able to be "outside seeing a horizon" (Kathy, p.

1). When extra-regimental appointments are filled by members of health professions, there is a materially negative impact upon health outputs and upon other nurses:

> Too many health professionals are filling non-health professional roles, and while that can be good for the individual and their development, I think we should only consider that ... when we've actually met our own clinical positions being filled and achieving those clinical position outputs. And then when you've got that foundation of doing what you've actually been paid or brought in to do, then we say: "Well what are the wider health leadership governance type things that you could do to support it?". (Andrew, p. 6)

Nurses described health services as being considered "an insurance policy [for which] nobody likes to pay their premiums" (George, p. 15). Placing nurses into non-regimental positions indicates that human resources in the NZDF can at times be limited, and when this happens, choices are made to reduce premiums on the health insurance. When nurses accept extra-regimental appointments, they are signalling to the organisation that they accept the notion that nursing roles are less important than others; an impression that contributes to the diminution of nurses' status. However, while it is evident that filling vacancies in non-health roles is facilitating the NZDF to deliver on its key outputs, the practice also enables nurses to gain knowledge of the wider Defence Force which can then be used to inform the military aspect of military nursing. In addition, possessing a greater understanding of the Defence Force enables nursing officers to turn their view beyond health services and conduct enlightened surveillance externally in order to make comparative judgements between military nurses and other officers. Evidence of this can be seen in Tony's comments regarding OCS creating the

conditions for the marginalising of non-combat officers (pp. 1-2) and George's observations that his nursing colleagues do not commit adequately to their officer responsibilities (p. 13).

Intersecting accountabilities, ethics and dual agency

Governmentalities that support and perpetuate the notion that every member of the Army is a soldier first so must prioritise through their actions the goals of the institution, can be confronting to nurses when the goals of the institution place patients at risk of harm:

> I got sent out in the middle of the night while there was firing going on down by [an area of operation]. So we went out ... there was me and an infantry chap in the vehicle and the driver, plus we had two armoured vehicles which were manned with the 50 cals because it was in the middle of the night, to go and pick up this [civilian] patient. I was told to do everything to stop her coming back in because they were expecting [military] casualties. (Duncan, p. 13)

Due to complications in the patient's condition Duncan elected to disregard the commander's instructions and to return with the patient to the military healthcare facility, yet concerns about the physical condition of the patient needed to be set aside while Duncan faced another dilemma:

> The problem was the whole family then wanted to come to the institution, [we] couldn't cope with the whole family. We could have the mother and no one else, so we were pushing people out of the back of the vehicle, literally pushing people out of the back of the vehicle. (p. 14)

Patient and family-centred care was Duncan believed, compromised. Duncan stated the management of the situation was:

> Not ideal with what had to be done for the patient, but one was also very aware of what was going on at the time from a deployment perspective ... we shortly thereafter had some incidents and some patients come in through, soldiers come through that had been hit. (p. 14)

The rules within which the health contingent operated during that mission stipulated the prioritisation of military personnel over civilians however for nurses, the ethics of prioritising care based on the *potential* for casualties to materialise versus the reality of a patient who has already been accepted into a nurse's care, challenges that nurse's duty of care. The New Zealand Nurses Organisation (2016) advises that once a patient has been received into the care of a practitioner, the patient must receive competent care and the patient and their family must be protected from harm (New Zealand Nurses Organisation, 2016).

Knowledge of the need to comply with military rules is evident in Duncan's comments regarding being aware of what was going on for the deployment at the time. Duncan was not a novice nurse which suggests that as military nurses gain experience, they learn to adjust their prioritisations noting that those prioritisations are influenced by nurses' proximity to combat personnel. The risks associated with non-compliance with the deployment rules may have been too high for nurses to offer resistance, or nurses' learned commitment to military colleagues may be higher than a military nurse's commitment to the principles of clinical triage and their duty of care to patients and their families. However, nurses can be found to be professionally negligent if they do not respect their duty of care (New Zealand Nurses Organisation, 2016).

Nurses repeatedly referred to missions where they were ethically challenged because they were only permitted to provide care to civilians if they had immediate life-threatening conditions:

> The times that I've travelled with the military, my prime responsibility has been the soldiers or person I'm travelling with, not the local population ... When as a health professional you're put in a situation where you are surrounded by a population with high needs that you could be in a position to help in some small way you don't necessarily have the opportunity to do that because your role is the maintenance of the force that you're there with, that that's what you're there for. (Kerry, p. 4)

Even on occasions when deployment rules permit nurses to deliver care to anybody in need, ethical challenges still present. During a patrol on a mission, Duncan provided an account of a group of local civilians who under the mistaken belief that Duncan was going to refuse to provide emergency care to a sick member of their community, threatened to kill him. A local village chief said to Duncan “If you leave this village we will ... end your life” (p. 12). Despite not being competent to perform the gynaecological procedure that was required, Duncan felt compelled to act:

> I'm brand new ... I'd read a book just before I went over that said you can do [the procedure] and that's what they used to do in New Zealand ... And I thought “This girl's going to die if I don't” ... I spoke to the family through an interpreter. Because we had no comms[33] we couldn't get her out to have an emergency [procedure], and said “Do you want

[33] Communications.

> me to try this because she'll die if I don't?" And they said "Yes" and so I did it ... she actually survived. (Duncan, pp. 12-13)

Under sections 151 and 160 of the Crimes Act 1961, everyone who has charge of any other person by reason of sickness has a legal duty to provide the necessaries of life to that person. That can mean that an individual may in order to provide the necessaries of life, extend beyond their scopes of practice but they must when doing so, exercise the standard of care expected of members of their profession (Medical Council of New Zealand, 2006). New Zealand law applies to NZDF personnel when they are deployed so Duncan was legally permitted to deliver the care he did.

In markedly different circumstances Andrew described the difficulties of working in a facility caring for military personnel who had suffered serious injuries while carrying out their duties. Andrew described the cumulative personal effect of seeing multisystem trauma every day over a period of time and how different that is to working in New Zealand (pp. 10-11).

Both Duncan and Kerry had since their experiences, employed technologies of the self to make personal change so that if similar challenges to the provision of ethical and safe care were to present in the future they would be emotionally prepared.

Duncan was still unsure some years after the incident, whether the best choices had been made:

> It's really hard to know isn't it because back then I was doing what I believed was the right decision. This was life or death. This person was going to die if I didn't do anything. We couldn't get her out of the village. We were remote, high in the hills, couldn't get a helicopter in. You know, we've got these guys there, discussion with families, was it

> the right or wrong move? I can't change what I did, but if I confronted it today would I do the same if I was on a deployment? Ooh Lord, I don't know ... [but] I wouldn't do it in New Zealand. (p. 13)

Although the situation had presented a serious personal threat, Duncan's concern had been for the patient and their survival. Kerry's concern was not for himself either but for the people who might have been his patients. The rules to which Kerry had needed to comply had "been a bit of a dilemma for me ... and I felt that at times in [that place] I would love to have been working more with the local population" (p. 4). The issues faced by Duncan and Kerry differ from those of Andrew in that while Andrew did at times wonder whether he had done "the right thing" (p. 12), the main issues Andrew faced were not those relating to the inability to respond in the best possible way to need, but to the emotional cost of responding repeatedly to need. Andrew explained that he saw a lot of what he referred to as "compassion fatigue" (p. 12) which resulted in nurses struggling to maintain professional impartiality.

The effect of constraints on the delivery of optimal health care, whether those constraints are rules-based, environmental or cultural, are not confined to the operational context. They also arise in garrisons back in New Zealand. Duncan described a situation where a patient's wellbeing was jeopardised by the actions of a colleague:

> I had a medic who I felt shouldn't have been in the RAP and that he needed to be brought back probably into the MTC environment for extra training. And that was because a patient had come in and they were about to go into the field and this chap had had a leg injury and could hardly walk on it, and the medic went "Hop on it" which was the bad leg. And the guy did and he was in tears and the medic went

> "You're fine, you can go in the f-ing field". And I took this guy aside and said "You just have a seat". I said to the medic "You know, this is not okay. This is how you examine", and the chap had a fracture, so I actually went and saw the major medical officer and said "I have concerns", and I wrote a minute, but [the medic] stayed where he was. (Duncan, p. 8)

The strong emphasis in the military on personnel pulling their weight may risk those who are sick or injured being thought of as jack. Medics' inculcation into the soldier first mentality may lead to some medics interpreting their role as enforcer of the team ethic. The subsequent actions by Duncan were intended to serve as a mechanism through which concerns about the medic might be managed however those actions also served as an exposé of the ongoing but ordinarily covert struggle that pits the soldier versus the patient first.

Duncan's complaint about the medic to the senior medical officer was a deliberate use of medicine's superordinate place in the health services to gain support for placing the patient first. However Duncan's intentions were unlikely to succeed with or without the support of a medical officer given the strength and breadth of the organisation's culture of soldier first and the insidious nature of the knowledge power paradigm that ensures that the soldier first mentality will infiltrate into places where it does not belong. Any censure of the medic concerned may have been considered a concession to nurses challenging the team ethic. Unlike Sarah's persistence with pursuing her professional ends, Duncan did not repeatedly offer resistance. Sarah was a nurse working as a lone practitioner while Duncan was a lone nurse embedded within a team comprising a nurse, a doctor and a number of medics. This suggests that the need to maintain

cohesion within the team may at times override a nurses' ability to offer sustained resistance on behalf of patients.

Bonnie made the observation that an overall resistance by medics to the presence of nurses in the clinical environment may have its foundations in medics' perceptions that nurses are there to challenge their practice:

> Maybe they perceive that it's us questioning their competency as opposed to us questioning the ethics of actually what they're doing; not that they're competent or not, maybe. Yeah and trying to in a sense educate them, whereas they only take their education from what they learn at health school; therefore [medics believe they] don't need nurses. (Bonnie, p. 20)

When nurses bring ideas to the military health environment and to medics in particular, that patients need to be prioritised ahead of the military team, they are challenging deeply embedded military mentalities. Military values are set against nursing ethics in such a way that nurses must make decisions about whether to activate resistance or not. On operations the risks of resistance appear too high so nurses tend to obey institutional rules but in garrison settings nurses appear more likely to set aside risk and defer to becoming moral agents.

Expectations and resistance: 'We don't need people to be followers'

Teamwork is critical to the delivery of safe care and it also contributes to the development of professional nursing identities (Davis, 2006; Kohn et al., 2000; Thomson et al., 2015). Yet although both military and nursing groups need to be able to cooperate in order for goals to be achieved, a variety of factors associated with the

military environment can create impediments to nurses coming together in cohesive teams. One of these factors is the system that reports on performance.

Sarah recounted as a platoon commander, her personal disquiet when she was required to write a disciplinary report on a senior non-commissioned officer sometime after an operational mission where a disintegration of hierarchical positioning had occurred:

> I'd actually deployed [on an operational mission] with him and he was so super and so supportive of me there, and here I am in this position where rightly a hard report was written on him. But I kind of thought that maybe because he was so senior that the OC could've done that, the senior nurse there. It might've been more appropriate than someone who's just stepped in, this junior lieutenant, so that was a hard part. I mean I did it 'cause that's what you do and uh-uh, but yeah, it still kind of smarts with me a wee bit. (Sarah, p. 3)

Sarah had felt unprepared to deal with this type of assignment stating “they don't really train you” (p. 3) yet the challenge that writing a hard report on a subordinate presents to a manager is not unique to Defence nurses. All military and nursing leaders must be prepared to performance manage their staff however in circumstances such as that which Sarah described, when there has been a disruption to an authorised institutional hierarchy, any subsequent attempt to apply the technologies of that hierarchy is likely to create dissonance. Although as Sarah suggested, resistance is possible, she elected to accept the task because “that’s what you do”. This then indicates that while in the military close bonds can be forged in some circumstance, the strength of the institutional juridical order will ultimately overrule relationships that do not align with that order.

George remonstrated that “the Army talks about honest reporting and so I try to do honest reporting, and when you do that it just stirs up a whole lot of hurt” (p. 6). George claimed that during the appraisal process, nurses had been looking to him to “push the nursing officer cause”. Consequently George had felt pressed to ask himself the rhetorical question “’should I do that because I'm a nursing officer or should I do [something else] because that's a good thing for the [wider] team?” (p. 7). The process of applying technologies of the self revealed to George that his nursing parochialisms were presenting barriers to the cohesion of the greater military team. Such barriers George believed, might be reduced if as discussed earlier, nurses could be inculcated into the military in a standard way (p. 7). This approach George said, might reduce the idiosyncratic and non-military conduct he had observed.

George’s position presupposes that the prioritisation of the wider team is of more importance than is undiscerning loyalty to nursing. Contemplations about team such as those exemplified by George, are not common for nurses who tend not to articulate belonging to or valuing teams; these concepts seem to be taken for granted. Indeed it was not a need to emphasise or de-emphasise his membership of a community of practice that prompted George to examine himself, but a desire to challenge the aberrant behaviour of some nurses with a view to bringing them into line with the accepted conduct for military personnel:

> It was what they were doing [that] I had issue with, rather than [me] trying to subdue or push away nurses, or not factor or weight what they were wanting ... It was more just trying to hold them accountable for their individual actions, irrespective of who they were. (George, p. 7)

Holding nurses to account for their actions constitutes both the execution of juridical authority and the playing out of a technology of power. Nurses conducting surveillance and subsequently being *seen* to challenge other nurses when they are not conforming to the behaviours sought, serves nurse autonomy through nurses retaining the management of one another within the profession however, being seen to challenge other nurses has a secondary effect. As Foucault (1991a) explained, surveillance *makes* individuals want to conform because non-conformance can lead to marginalisation. Nurses' being made under George's surveillance to conform to military expectations reduces the risk that nurses in general will come under external scrutiny. Avoiding the risk of the scrutiny of non-nurses avoids the concern that nurses have that they will be diagnosed as the deviant sacks of shit that was discussed in chapter six.

Nurses stirring up a whole lot of hurt is an important part of the power of power for without resistance, the ability for power to make nurses subscribe to military behaviours would be absent. If nurses do not detect the existence and enforce military behaviours, then the ability for nurses to become 'military' nurses would not be possible.

It would appear from what the more senior nurses in this study had to say about junior nurses, is that novice military nurses expect not to be held to account in performance review for the choices they make. The difficulties reported previously by Alice in relation to nurses not complying with PDRP policy when PDRP are common in nursing, also applied to continuing professional development funding. Professional development funding unlike PDRP, is not a common entitlement in the civilian sector:

> I sent a reminder a few days before [continuing professional development forecasts were] due, just to remind them all and I got a flood because I'd only had about 10, I got a flood that day and the next day and now this week, now that we're into August I'm still getting

> the odd person, “Oh here’s my thing, here’s my thing”. And it’s lucky that the [senior nursing officer] is away because I haven’t given them to [the senior nursing officer], but people who don’t put a forecast in are only going to be eligible for 20% of what they would have been eligible for. (Alice, p. 6)

Alice had stated that nurses are aware that they have professional responsibilities but Alice’s reminders serve to shield junior nurses from the juridical discipline that supports professional self-regulation. Self-regulation is one of the hallmarks of a profession (Nordhaug, 2018) so whilst individuals have professional responsibilities that come with autonomous practice, not enforcing juridical discipline undermines the professionalism of nursing.

A factor that may impact upon the way in which military nurses conduct the performance review of other nurses, is the NCNZ competence requirement for nurses to work in collaborative ways (Nursing Council of New Zealand, 2012c). Whilst discussing how RNZNC members work with military nurses from other countries, Bonnie made the observation that New Zealand nurses prefer to cooperate with colleagues rather than take an oppositional stance:

> The British military nurses are much more hard-nosed about things, whereas the New Zealand nurses, we tend to [take] a more collaborative, softer approach to one another ... we're much more collaborative. We'd rather sit down and talk to someone than order someone to do it. (Bonnie, p. 7)

Taking a softer approach may achieve the desired results however it requires more effort by the petitioner and compliance takes longer than if instructions are decreed.

Certainly compliance with orders is fundamental to military service in that obedience can be the determinant of success in times of extreme and urgent circumstances. If negotiation has become the norm but circumstances arise where absolute obedience is required, it is then more likely that personnel will resist techniques of force. Resistance by health professionals in emergency situations may have serious implications not only for the clinicians involved but also for patients and for the NZDF.

Collaborative practice presents as resistance to military discipline; the interstice between the two discourses is clearly an uncomfortable place for nurses who struggle to find a consistent compromise. Senior nurses permit junior nurses a degree of autonomy in matters of professional practice including permitting resistance to the mandatory demonstration of competence discussed in chapter seven, but they counter-resist attempts by junior nurses' to extend their autonomy into areas that sit outside clinical practice. The reasons for this will become clearer when the rules that nurses apply to rank are examined.

Rank as a mobile concept

Uniformed nurses in the Army are always commissioned officers and with commissioning comes an expectation of continuing advancement in rank. A military team at any given time will comprise a range of differing ranks that represent different levels of expertise however in healthcare teams, because RNZNC members are always commissioned, they are consistently ranked higher than medics who rarely are. Even though there are assumptions of authority inherent in rank, unless unsafe practice or unacceptable conduct is apparent, nurses tend not to let rank interfere in their relationships with medics. George stated that "I've always been one that has welcomed conversations with senior NCOs or if I haven't been doing something that they expect of

me, then I welcome them to come and tell me (p. 14). Kerry spoke of dispensing with the need for rank amongst health professionals:

> I certainly would always want to foster and create an environment for a junior nursing officer coming into the organisation to know that in my mind in any clinical situation there's no rank.[34] You know, I'm more than comfortable that—as actually did happen in [one place]—if I'm put in a resus situation and the most expert person to lead that situation is a medic and they're a sergeant, I don't care. They can lead that situation and I'll do within that situation what they need me to do. (Kerry, p. 20)

Other nursing officers also described not permitting rank to interfere in clinical relationships. Sarah, as described earlier in chapter six, made it clear that she will not obey commanders if they tell her to do things that she believes are not in the best interests of patients (p. 20) and Duncan is also willing to disagree with medical officers, repeatedly if team cohesion is not at risk, to prevent safe patient care from being compromised (p. 17). Both Kathy and Andrew also believe that rank is not needed in clinical situations. Kathy said that nurses do not wait for higher ranking officers to tell them what to do, they just organise themselves (p. 15), while Andrew declared that "turning up with a title but not the ability is essentially setting individuals up… to fail. And we want out patients to get top notch care" (p. 7).

Kerry explained that "everybody needs to be a thinking person. We don't need people to be followers. We need people to be speaking their mind" (p. 20). Kerry was not making a blanket assertion that rank should not apply to health professionals; he was making the

[34] Having "no rank" means that conventional practices relating to military hierarchical structures do not apply.

assertion that rank should not apply in clinical situations. Together these examples indicate that there is a practice amongst nurses of excluding rank from clinical situations to prevent rank from interfering in the multidisciplinary checks and balances that optimise patient care.

Having no rank in any clinical situation adds a layer of complexity to the inculcation of health professionals into the military that is not present for members of non-health corps. In what might be viewed as a binary construct, the willing compliance with service discipline for those belonging to the military must be understood and applied (New Zealand Defence Force, 2015g) however health professionals also subscribe to the professional principle that leadership in any clinical situation should be provided by the individual who is most competent to lead, irrespective of their field or seniority (Stanley, 2017a).

The conflict that is at times evident when nurses resist those who think it is appropriate to apply rank in clinical practice, presents as an interstice where games are played between the opposing discourses of military authority represented by rank authoritarianism, and professional authority represented by congruent leadership. Despite the risks to individual nurses, nurses consistently work in support of professional authority.

Novice nurses may grapple with understanding where rank applies and where it does not. Kerry had made the point that there is so much that nurses new to the NZDF don't know and that they "struggle at every step" (p. 21) so norms of rank that are foreign to civilian nurses as well as to the wider military community must add to that struggle. For new nurses, understanding where what is learnt of rank on introductory military courses and reinforced in wider military settings stops, and where the more familiar

prioritisation of clinical skills begins, may be a grey space that factors into some of the challenges that nurses new to the NZDF experience during their military transition.

Deviating from accepted military discipline for the purposes of achieving military health objectives may also be difficult for non-health personnel to understand and can sometimes be a challenging process for health professionals to work through. Tony made reference to such difficulties:

> You end up with some very heated debates in very time constrained situations, often in the dark hours of the night and not only is it very difficult for all concerned, particularly when you've got to keep living together in close confines; but health end up looking very unprofessional in front of the command team. And that serves to continue the perpetuation of the myth that health is a second rate organisation and that the leaders within health are second rate officers. (Tony, p. 8)

Judgements of the competence of health officers is clearly affected by a lack of understanding of when and why rank deviations should occur and can result as Tony's narrative indicates, in the diagnosis of large-scale deviancy by health professionals. The treatment following a diagnosis of deviancy is described by Tony as the "marginalisation of health in general" (Tony, p. 6).

When inculcation into the military emphasises adherence to rank for the maintenance of discipline, understanding the rules of rank requires the activation of technologies of the self. Kerry made the point that nurses have an obligation to make change by overcoming the impediments that rank presents to quality in military healthcare:

> I think that particularly as I've hit the more senior ranks now and I think probably as a nursing officer as well, that there's an expectation that I will speak my mind, or if I'm uncomfortable with something I will say ... I think at my rank and in my place, if I'm advising command I need to be telling them what I think, and what I really think, not just what I think they want to hear ... it might well be for some of our less experienced colleagues that they do fall into that trap of telling what they think the commander wants to hear, rather than what the commander really wants. (Kerry, p. 17)

"Traps" are disciplinary and serve as motivators for change driving inexperienced nursing subjects to learn through disciplinary techniques how not to take lightly meeting commanders' needs but to instead watch and learn from their more senior colleagues. Coming to know the true nature of satisfying commanders involves the application of advanced knowledge predicated on personal change that Kerry implies, can only come about through experience.

Providing advice is not restricted to advising command. Kerry maintains that health professionals must for the wellbeing of patients, be confident enough to speak candidly to one another and speaking candidly is not however particularly challenging for nursing officers. Sarah provided a good example when she spoke about raising concerns with an individual who Sarah believed was responsible for the problems military nurses were experiencing with clinical placements:

> [A]nother nurse did manage to go in [for clinical experience] ... And then that didn't go well because she got posted [away] and didn't tell the charge nurse that she wasn't coming back ... and [the] charge nurse has said "We don't actually want anyone else" and that again is why it

> was just so awful with that last woman that went in there as a military nurse. And when I see her next I will be having a conversation with her about how really unhelpful that was, because it's not helped the cause of any other nurse trying to get into the DHB. (Sarah, pp. 10-11)

Although the consequences of the actions of the other nurse had already taken effect, Sarah maintained that censure was still called for. This suggests that the purpose of her reproach was not to rectify extant effects but to create conditions that might prevent that nurse, or any others who might be conducting surveillance at the time of the censure, from undertaking actions in the future that would have the potential to produce similar detrimental effects to those described by Sarah. In this way power is exerted by nurses on other nurses in such a way as to regulate behaviour and to reinforce a behavioural norm where consideration for the maintenance of other nurses' competence sits alongside consideration for one's own. This norm raises the value of the nursing collective because not only is nurses' ongoing professional development monitored top down through policy enforcement, it is also monitored through each nurse becoming aware that they are required to set their focus upon the development of others. Furthermore, individuals cannot disregard their own ongoing professional development because others have their focus set upon them.

The RNZNC collective comprises a very small group of nurses. Smaller groups have been found to be associated with higher levels of teamwork while teamwork serves as a catalyst for the development of a sense of belonging and purpose (Finn et al., 2010; Kalisch et al., 2013). Duncan made the point that:

> We are a small group. We've got to be united, got to work together, but then you also look at the fact that we're trying to get strong women

> who can make decisions, who can think on their feet… Does that therefore not make us really a very good team? (Duncan, p. 19)

Duncan's observations weave together well those militarily desirable notions of collective support and dependency with the less desirable but nonetheless deliberately sought after officer leadership characteristics of forcefulness and controlled resistance

Summary

Chapter eight has presented a discussion centred on how nurses adapt their professional competence to the military context. Confidence was analysed and found to be a key attribute that enables nurses to seek out, apply in practice, and guide others to gain competence in military nursing. Confidence is also a factor in how nurses relate to one another with strong personalities featuring. Also presented was evidence that military nurses do not always possess the skills and experience required for them to safely engage in some activities but this does not prevent them from putting themselves forward. The consequences on military nursing of nurses actively seeking out non-nursing roles was examined. Implications of the soldier first mentality in the Army were analysed within the frame of ethical responsibility which was followed by an examination of performance review as a technology of military governmentalities that has an impact upon collaborative practice and teamwork. The chapter concluded with an inquiry into nurses' problematisation of rank and the application of an alternative leadership model in clinical situations.

In the past three chapters I have employed a selection of Foucauldian theoretical techniques to present an analysis of what nurses had to say and importantly, what they did not say, about their experiences in the Army. The next chapter will provide an in-depth discussion of the concepts thus far uncovered by connecting notions of worth with

professional ethics and the governmentality of military service to locate how military nurses work, and how that work helps to formulate their unique identity.

Chapter 9: Ways of knowing and the construction of a new identity

Introduction

My investigation into nurses' experiences working through the dual responsibilities that present with military nursing service has been archaeological in approach. I presented a portrayal of the transition of novice nurses into the Army that problematises the culture of the NZDF in the first of the analysis chapters. Nurses' interpretation of the military culture formed a foundation for my inquiry in the two following analysis chapters. Chapter seven presented nurses' responses to their employment context while chapter eight reported on the strategies that more experienced nurses employ to navigate competing military and professional interests within restrictive Defence Force governmentalities. How nurses' selections, rejections and modifications to expectations assist their navigation was discussed.

In chapter nine I will discuss the connections between the key themes that were raised in the preceding chapters. I consider how nurses' transitions into the Army contribute to the development of characteristics that are important for the roles they are required to perform, and how nurses' perceptions of their status help to shape their development and the way they work. I also discuss the effects and implications that dominant discourses of competition have on nurses' relations with one another and on their roles. I posit that concepts of hierarchy do not remain exclusive tools of juridical authority but are redefined, permitted mobility and allowed to diffuse across borders to emerge as technologies of power. The effects of these technologies on nurses' performative routines and on the wider Defence Force are investigated. The findings of this study are compared with those in the literature and with theoretical concepts.

Identity is a focus in chapter nine. I propose that Defence Force nurses have constructed for themselves a new identity; one that reflects an amalgamation of nursing values with nurses' responses to the cultural norms that surround them. How nurses' sense of identity helps them to navigate professional accountabilities and role expectations is highlighted. Ways that nurses use their perceptions of self to create a nursing collective that reflects the military disposition of needing to belong but which substitutes other military dispositions for clinical proficiency and a focus on patient wellbeing, are featured.

Governmentality of culture

The paramount purpose for both defence and health organisations is service to the New Zealand public. The principal conduits through which this purpose is achieved are the two sectors' employees, yet despite their strategic parallels, the sectors deviate in the ways in which service to New Zealanders is provided. In the health sector it is not the interests of the employing institution that takes precedence for the workers' efforts as it is in the NZDF, it is the interests of individual members of the public. This is because New Zealand's health sector is there to provide for the prioritisation of those who are receiving health services (Health Act 1956; Health and Disability Commissioner Act 1994; Health Practitioners Competence Assurance Act 2003).

Commitment in the NZDF is a value that all personnel are expected to demonstrate (New Zealand Army, 2019; Royal New Zealand Air Force, 2018; Royal New Zealand Navy, 2018). In the Army soldiers and officers must commit to the Army team so that the organisation can become "world-class ... led by professional and trusted leaders ... work[ing] together as one team in serving the interests of all New Zealanders" (New Zealand Army, 2019). Therefore serving the interests of New Zealanders is an effect of the Army team working to accomplish mission goals, not an effect of individuals

working directly with the public. This military focus contrasts with the way in which health employees serve the interests of New Zealanders because most people who work in healthcare work in direct contact with the public.

The Defence Force places considerable emphasis on the need to maintain a culture that enables the development and maintenance of military capability. Successive Defence White Papers refer to the importance that culture plays in key domains such as the coordination and integration of professional skills and capability (Ministry of Defence, 2010, 2016b). Single services seek to instil common values, behaviours and attitudes that reflect not only the unique nature of the differing arms, but how each service contributes to joint military objectives (Ministry of Defence, 2010, 2016b; New Zealand Defence Force, 2015a). The NZDF Leadership Development Framework (New Zealand Defence Force, 2017c) specifies that NZDF leaders must "shape the culture" (p. 20) to reflect NZDF values. A 2015 State Services Commission report referenced a tool under development that would measure the NZDF culture upon which the culture could be progressed (State Services Commission et al., 2015) yet there has been no further reference to this tool in the public domain.

The NZDF Leadership Development Framework requires senior officers to actively manage the Defence culture (New Zealand Defence Force, 2015g). The ability of leaders to do this is however limited because the actions of senior officers constitute just a small measure of the multiplicity of factors that affect cultural productivity. Whilst controlling culture through the utilisation of institutional apparatus creates a compelling motivator for compliance, systems of reward and punishment are not restricted to those that are juridical because power relations also operate within social systems and are both productive as well as disciplinary (Foucault, 1991a). The culture of the NZDF is constantly changing in response to relations between subjects and the constantly

changing subjects themselves. Hence while the actions of senior officers may be a factor in cultural production, culture is formulated through a much wider complex of social arrangements which are directed by disciplinary power.

Institutional mechanisms of surveillance seek to detect the failure of personnel to meet expectations. Significant deficiencies are dealt with through disciplinary processes while those of a lesser nature are reported through performance appraisal. Both management strategies can be career limiting in quite public ways such as non-promotion within expected timeframes and contract non-renewal. Running alongside institutional processes are social mechanisms of surveillance that also seek non-compliance, and which also punish. Social surveillance, while not visible in the way of juridical systems, constitutes an element of disciplinary power that can both reinforce or work against juridical power. The aims of juridical and disciplinary power are to create docile subjects however the constitution of the ideal subject within each system may be in conflict thus subjects must remain vigilant and responsive in order to profile evidence of the desired subject position being sought at any given time.

While all NZDF personnel are answerable to the military's juridical apparatus, those who have most control over the apparatus are senior leaders and it is senior leaders who also control entry to the organisation. The NZDF magazine Force4NZ (2015e) states that "we recruit people who are like us" (p. 11) so a self-perpetuating cycle of uniformity in selection and service exists which is controlled by senior leaders so the influence of senior officers on the organisation's social systems is greater than the influence of others. Those who are seen not to be the same will not be recruited while those whose lack of sameness is not detected at recruitment but revealed later, may not be permitted to remain in the organisation.

Nurses who join the Army are selected for their semblance to the desired military cultural model; a state that was pointed out by some nurses in this study. Challenges for nurses who join the Army are not related to military hierarchical and disciplinary structures. Nursing itself is inherently hierarchical and expects adherence to strict professional codes therefore assimilating to another ranking system does not require the acquisition of new skills because many of these skills already exist (Kim & Oh, 2016; Leong & Crossman, 2015). What is problematic is the condition of being bound by social controls that are governed by covert operations inherent in the uniquely military hierarchical system. Nurses new to the NZDF know that certain social controls exist but the nature of these controls remain for the first few years, frustratingly obscure.

Shock and awe: A tactic of rapid domination

When nurses first join the Army their expectations of service life are not realised. Despite the availability of NZDF recruitment material profiling work in the Armed Forces, and officer applicants undergoing a selection process that includes an initiation to the Army, nurses reported feeling unprepared. Some nurses described immediately regretting their decision and wanting to leave however instead of leaving, they entered into negotiations with themselves that suppressed feelings of discontent and fear and surfaced tenacity. Tenacity appears as a product of the technologies of the self that helps facilitate nurses' transition into the NZDF.

Officer selection processes are designed to reveal underlying personality traits with determination deemed critical because personnel must be able to cope with the adverse conditions that service life can present (New Zealand Defence Force, 2012b, 2015h). However although it is well recognised that adversity is part of military life, it may not be recognised that adversity takes many forms, not just those of a physical nature. The success of the personal characteristic identification processes of the OSB is evident in

that nurses choose to remain in the Army even after they find that being a military nurse is not only significantly different to what they had expected, but that it can also be unpleasant. That a choice needs to be made to remain in the Army provides evidence that the effects of social systems is immediate and that nurses' responses to social relations involve technologies of the self that seek to adjust nurses' disposition to align with a culture that says when the decision is made, the decision is made and individuals must just get on with it.

Nurses need determination to build the resilience they need to maintain their personal wellbeing in challenging environments (Lamiani et al., 2017). Researchers have reported that perseverance helps military nurses to cope with the demands of unrelenting operational workloads, compassion fatigue, and with patient advocacy (Finnegan et al., 2016; Kenny & Hull, 2008; Rivers, 2016). Without necessarily realising it, by exercising the determination needed to persist with their transition from civilian to military nurses, participants in this study had begun to apply a characteristic needed for dealing with operational deployments.

Nurses spoke of feeling shocked, overwhelmed and isolated when they first joined the Army. Geographical isolation occurs when nurses are physically situated away from other nurses in their posted locations and in the NZDF it is not uncommon for only one nurse to be working in a unit. Professional isolation can occur not only with geographical isolation but also when a nurse possesses a specialty areas of practice that is not possessed by colleagues. Physical and professional isolation have been noted to create risk for nurses due to the difficulties isolated practice presents to compliance with professional standards. (Nursing Council of New Zealand, 2012e). For military nurses, isolated practice creates risks for compliance with professional standards and presents a challenge to working ethically.

Multiple forms of isolation

As commissioned military officers, nurses are required to prioritise mission objectives while at the same time observing professional statutes and codes. It is known that at times these two sets of obligations conflict with one another so ethical guidelines have been developed to assist health professionals to work through dual loyalty conflict (see for example Levy & Sidel, 2009; Sparacino & Beam, 2003). It is recommended that health professionals consult with peers to ensure their practice is in accordance with ethical codes, but when the ability to consult is reduced, the ability to navigate the challenges that dual loyalty conflict presents is also reduced (Johnson et al., 2010).

Professional isolation is common in what nurses in this study had to say about their practice. Such isolation carries risk for both nurses and for their patients but while professional isolation is not unique to defence forces, the additional challenges presented by an employment context that is dichotomous to the purpose of health service delivery, heightens that risk (Madden & Carter, 2003). Although nurses in this study spoke about Nursing Corps conferences as an important means for staying connected, when they were working in clinical practice at home or on deployment, they reported relying upon the support of those working in close proximity to them. At times these support people were nurses but at other times, especially on deployment, they were medics and doctors. Few participants mentioned the availability of obtaining nursing support via such means as satellite telephones, electronic mailing or video conferencing.

Collaborating with colleagues is a requirement of competence for registered nurses (Nursing Council of New Zealand, 2012c) but hierarchical structures that exist in health systems are known to impede communication between health professionals (Thomas, 2020), consequently there is a statutory obligation on the part of health employers to

have in place systems and to make available the necessary resources to enable communication and collaboration to occur (Health and Disability Services (Safety) Act 2001). Further to this, employers must have in place systems of clinical governance to enable health practitioners to govern the practice of those who belong to their profession, not only to ensure that patients are kept safe, but to help minimise the risks that isolated practice presents to health practitioners themselves (Health Practitioners Competence Assurance Act 2003; Health Quality and Safety Commission, 2017). From what some nurses had to say about their work, these systems in the NZDF do not appear to be robust.

This study found that nurses new to the Army experience not only geographical and professional isolation, but isolation due to lack of knowledge of military cultural norms. Preoccupation with adhering to military courtesies, wearing the uniform correctly and understanding military lexicon separated novice nurses from their more experienced nursing colleagues and from other military officers. It is not common practice to recruit nursing officers in cohorts nor to assign preceptors to novice nursing officers and because nurses do not attend a SOIC immediately upon commissioning, nurses' transition to military nursing practice is journeyed largely alone.

Peers help nurses to adapt to new work environments by providing informal forums for debriefing and where what has been learned of norms, hazards and aberrant behaviours can be shared (Bochatay, 2018; Chandler, 2012; Kim & Oh, 2016). Peer support has also been found to increase the confidence and competence of nurses taking on new roles and that the creation of opportunities for nurses to connect with peers reduces the anxiety of novice nurses (Edwards et al., 2015; Goodwin-Esola et al., 2009; Henderson et al., 2015). Chargualaf (2016) commented that peer support is equally if not more important for nurse transitions in the military than in the civilian sector due to the

unique state of disequilibrium that nurses experience when they first join an armed service. Chargualaf recommended that nurses new to service be assigned mentors as well as preceptors to reduce the stress they experience when joining the armed forces and to expedite operational preparedness. Other authors have also recommended that nurses enter preceptorship programmes when transitioning into practice but there have also been calls for preceptorship to be applied when nurses change specialty domains (Arrowsmith et al., 2016; Haggerty et al., 2012).

Not having colleagues with whom to share experiences delays the acquisition of knowledge (Edwards et al., 2015). Not knowing what one does not know jeopardises the ability for the subject to conform and when lack of conformity is problematised, the non-conforming subject becomes the deviant subject. When deviancy occurs in a culture that values uniformity and where surveillance is institutionally sanctioned, there is little opportunity for deviancy to avoid detection (Gordon, 1980). The visibility of difference in the NZDF challenges nurse subjects in two ways. Firstly, a feature of military expertise is knowledge that discerns contact with the perceived deviant, the nurse, as a threat that makes the inculcated avoid contact with nurses in order to avoid contamination and the consequential reduction of the expert's expert status. Secondly, those who are deviant exercise their own avoidance behaviours to prevent their deviancy from being exposed to scrutiny, possibly publicly, by experts. Nurses spoke of this problematisation in terms of marginalisation in what they had to say about the perceived value of health service personnel in the NZDF.

The truth about status

The purpose for nurses in the NZDF is not to enable personnel to have a healthy and independent future as in the civilian sector, but to ensure the maintenance of the fighting force (Ministry of Defence, 2016a; Ministry of Health, 2017a; New Zealand Defence

Force, 2015a). New Zealanders rate nurses consistently in the top three trusted professions in the country and in the NZDF are formally described as a respected specialty (New Zealand Army, 2017b; New Zealand Defence Force, 2015f; Research New Zealand, 2017) however military nurses repeatedly reported feeling undervalued by their non-nursing colleagues.

A hierarchy in the Army of corps was said by nurses to exist with combat branches at the pinnacle and combat support services such as health firmly positioned inferiorly. The devaluation of nurses by high status groups caused nurses new to the NZDF surprise and offence and led to nurses feeling second class. Nurses acknowledge that because they do not undertake the extensive initial officer training of G List personnel, it takes them longer to acquire a comprehensive understanding of the workings of the military, but neither time, training nor experience appear to erode nurses' feelings of deficit. This deficit disturbs nurses' sense of self, not only during their transition to becoming military nurses but for some, for the duration of their careers.

The military officer practices a profession (Janowitz, 1960). According to Caforio and Nuciari (1998), a profession is an enterprise underpinned by a specific theoretical doctrine from which arises specialist knowledge, and within which members share common values and norms. Members of professions possess an esprit de corps where individuals "recognise one another as bearers of competences and attitudes typical of that peer group" (Caforio & Nuciari, 1998, pp. 7-8). What nurses had to say in this study indicates that New Zealand combat officers maintain their professional exclusivity by refusing access to those who have not done and do not do what G List officers do.

Foucault's project on discourse provides a mechanism to illustrate how different professions develop language to reinforce their profession's exclusivity and to create

binaries of ‘in’ groups and ‘others’ (Foucault, 1991a). The Special Air Service (SAS) is according to nurses in this study, at the pinnacle of high status military roles. Retired SAS officer Craig Wilson claimed in a 2018 radio interview that “good people” in the Army are those who possess a competitive, aggressive, operational and combat-focussed mentality (Crump, 2018). Such ideas imply that people like nurses who possess characteristics that are diametrically opposite to those described by Craig Wilson, are not good.

Nurses claim that others say they are not needed but while this is a contemporary study, nurses not being needed is not a new narrative. During WWI medics challenged the purpose of recruiting nurses into the Army based on the medics’ belief that they could do so much more than nurses including laundering patients’ clothes, performing veterinary functions and undertaking vehicle mechanics (Rogers, 2003). Rogers asserted that disapproval of nurses permeated throughout the Army with nurses being considered unnecessary usurpers of rank who “don’t do anything but fool around with the officers” (Corporal Wilfred Smith as cited in Rogers, 2003, p. 11). History is important to the Army for its contribution to the pride and purpose of personnel and as the basis for many present day rituals, however those links that connect the present with the past channel not only benefits but discourses of criticism and deficit. Military nurses’ perceptions of low status have their origins in the past with the Army’s uninterrupted existence providing a vehicle for the archaeological continuity of the not needed discourse. When notions of nurses not being needed are combined with ideas that caring characteristics are not those of good people, then nurses will not only feel they are not valued, they will in truth not be valued.

To be needed means possessing skills that make a contribution therefore being needed involves being productive. Being productive and most importantly, being *seen* to be

productive, helps avoid being labelled jack. But because caring is a private endeavour, the work of nursing is largely invisible so nurses busy themselves identifying and performing tasks that can be seen. Busyness is considered to be contributing and therefore helps nurses to feel they are part of the wider military team. A Swedish study conducted by Lundberg et al. (2014) found that military health professionals believed they hold low status because soldiers constantly remind them that "medical personnel do not do anything" (p. 823). In order to counteract notions of non-productivity, the Swedish health professionals sought opportunities to prove themselves by undertaking combat activities. While there was no evidence that NZDF nurses sought to prove themselves in combat activities, they did seek to prove themselves in military skills. Proving themselves to be good if not better than others is a deliberate strategy of nurses to increase their visibility and to counteract notions of nurses' low value.

A number of American studies have reported military nurses feeling more, not less, valued than their civilian counterparts (Foley et al., 2002; Patrician et al., 2010; Zangaro & Kelley, 2010). Most US military nurses work in large healthcare facilities where clinical skills are employed daily and where practice is not dissimilar to that of the US civilian sector (Kelley, 2010). This is distinctively different to the NZDF health system which is small and where unlike in the US, secondary services are not provided to service personnel unless they are deployed.

The Swedish Defence Force is, like the NZDF; comparatively small (Statistica Research Department, 2020) so force size may be a factor in perceptions of status. The roles that nurses perform in small defence forces may bring them into closer proximity to combat troops than do nursing roles in larger militaries. In the NZDF most nurses are expected at some point to work in primary care which is where nurses come into most regular contact with soldiers and from where opportunities for deployment most frequently

arise. It is on deployments that living and working arrangements become notably condensed which may potentiate the problematisation of difference in that deviancy on deployments becomes highly visible and contact with deviants more conspicuous and thus more risky.

Competition as a technique of power

Employment for uniformed personnel of the NZDF is contractual and therefore temporary (New Zealand Defence Force, 2017a, 2017e). Extensions to contracts are based on the value of an individual to the organisation with that value being dynamic and dependant not only on those factors that the organisation rates to be important, but on the value of others in relation to that of the individual. Value is formally assessed not only when individuals are being considered for retention in the service, but also when personnel are competing for contestable rewards such as promotion or deployment.

Career management boards determine career trajectories with decisions being based largely upon competency assessments of the generic NZDF performance and development reports. There is an expectation in the NZDF that individuals will contest rank advancement (New Zealand Defence Force, 2017c) but because there are fewer positions available in higher ranks than in lower, and because there are limited positions available on deployments, all individuals wishing to remain employed by the NZDF or to be considered for promotion or deployment, must make clear that they are of more value to the organisation than are others. Most deployment positions for nurses require contenders to possess current clinical experience so because deployments are sought after, nurses actively pursue clinical currency.

Under these circumstances, surveillance becomes a desirable mechanism for individuals to assess their own worth in comparison to that of others in the knowledge that the

organisation is also conducting surveillance for the allocation of rewards. Individuals then work to improve their performance in those areas where they believe they are deficient while at the same time making more visible those attributes the service person wishes to be seen.

Competition is fostered in the military for its known benefits and its links to desired outcomes. While in the Army competition is said to enhance camaraderie (New Zealand Army, 2020b), in the wider NZDF competition is believed to encourage individuals to strive for higher standards and to build the "will to win" (Ballantyne & Rasmussen, 2013, p. 9) which is directly connected to success in battle (New Zealand Defence Force, 2012b). Rivalry and distinctions between corps is deliberately fostered to increase esprit de corps for the positive effects that it has on outputs however, esprit de corps has a drawback in that it is thought to contribute to elitism and exclusionary practices which can negatively impact upon outputs (Ballantyne & Rasmussen, 2013). Despite its known drawbacks, the Army persists with promoting inter-corps rivalry which suggests that it is advantageous for elite corps to remain in that position.

Competition in the NZDF is focused on the physical with the Defence Force speaking of teams as being only as strong as their weakest members (Harding, 2016). Fitness tests are a means of assessing the ability of all service personnel to meet the physical expectations of their roles, not a means through which individuals are required to compare their physical abilities against those of others. However it is apparent through nurses' reports of fitness testing that surveillance of the performance of colleagues enables the revelation of when an individual is not at the same level as others. This then creates the conditions for competition to materialise. Power as a strategy acts upon the actions of subjects to call for improvements in physical performance. So while physical training instructors may operate as instruments of juridical power by demanding optimal

physical conditioning, nurses work upon themselves to improve their own performance by employing others as both scales upon which performance might be judged, and instruments of competition against which performance might be improved, thus juridical power benefits from disciplinary power.

Leading oneself and being self-reliant are the first steps of military leadership to be applied in both physical and mental domains so that all military groups will be composed of self-led individuals. Service personnel must also demonstrate supportive behaviours that encourage weaker team members to improve (Ballantyne & Rasmussen, 2013; New Zealand Defence Force, 2017e). This notion of supporting others applies however only in certain circumstances. Distinguishing between expectations of self-reliance and expectations of providing or indeed receiving support, can be problematic for those who are new to the NZDF. Nurses face difficulties making those distinctions and in some cases such as during fitness testing, suffer actual disadvantage when expectations are unclear. Competing discourses of support and competition become apparent with the gymnasium being not the only site for their emergence. The workplace also serves as a place for the struggle between support and competition to surface. Competition designed to facilitate camaraderie and improve performance can as nurses reported, have the paradoxical effect of undermining them. Some nurses in this study reported bullying occurring within the health services as personnel sought to gain advantage over others which in one case, led to the resignation of a nursing officer. When camaraderie is undermined, collaboration is affected and when collaboration is not working well, patients are impacted. Furthermore, the loss of experienced nursing officers to bullying represents a failure in leadership and a loss of investment for the NZDF at a time when the organisation is in an increasingly competitive recruitment market (Blackwood et al., 2017; Harfield, 2019).

Contesting deployments

Nurses actively seek opportunities to deploy because operational missions enable them to apply their competencies in contexts that are exclusively military in nature and because deploying fulfils the military nurse's purpose for joining the NZDF. Deployments are therefore highly valued. Operational deployments are where the level of support personnel provide to one other can mean the difference between operational success and failure and between survival and death, so the Defence Force places considerable emphasis on preparing personnel to work as teams (New Zealand Army, 2019). Yet notions of support for the team were notably absent in nurses' reports of seeking selection for deployments. Nurses spoke in terms of vying for deployments and colleagues becoming rivals in a process that is fraught with conflict. For nurses, conflict like competition challenges collaboration and risks damaging relationships upon which safe practice may later depend (Huntington et al., 2011).

Collaboration is not only critical for the safety of patients, it is vital for the mental wellbeing of practitioners (Dow et al., 2019). Finnegan and colleagues (2016) stated that military nurses need to be able trust their colleagues during times of threat and unrelenting workloads but conflict interferes with that trust. Lack of collegial support impacts upon productivity and retention and because significant time and resources are necessary for military nurses to achieve a state of operational readiness, defence forces are particularly vulnerable to nursing workforce losses (Almost, 2006; Zangaro & Johantgen, 2009). Therefore competition for deployment may reduce the Defence Force's operational nursing capability.

Deployment discourses incorporate features not only of prizewinning but of status. Having experience of deployments is permanently manifest in medallic recognition worn as a visible display of success. Badges of worth, or little worth, are perpetually in

the eye of the scrutiniser on a service person's uniform. A whole curriculum vitae, not just containing evidence of deployment but also awards and honours, and rank and role, are in full and colourful view. Thus uniforms facilitate nurses' surveillance of one another and raise the stakes for competitive advantage.

Value for nurses also lies with being judged as competent to deploy. A category of exclusion sits within this realm where nurses who possess the suite of attributes and qualifications necessary for deploying sit separate from nurses who do not possess the same credits. Many deployment competencies can only be acquired through time so being junior creates an automatic exclusion, but being senior also excludes because senior nurses are more often in positions of management and deployments seldom call for nurses who are not currently working clinically. Being deployable enables nurses to access what they described as full membership of the RNZNC, therefore gaining deployability status facilitates a nurse's transition into the Army.

The process of acquiring skills that signal the maturity necessary for deployment is stressful (Chargualaf, 2017). Chargualaf found that pressure to achieve deployability compounds the difficulties United States Air Force nursing officers encounter upon transitioning to military service. Griffiths and Jasper (2008) explained that becoming deployable involves not only competence acquisition but the need to find a balance between the functions of the nurse and the functions of the military officer. Finding that balance enables nurses to concentrate on their nursing roles without distracting concerns about the prioritisation of functions. Griffiths and Jasper, and Chargualaf emphasised that gaining the necessary confidence to deploy takes time. So while New Zealand military nurses described deployability as commensurate with full membership of the RNZNC, gaining deployability is part of the novice nurse's transition to becoming a confident, mature military nursing officer but this process will take time.

Finding the middle ground in leadership

Military command is a discrete style of leadership that has evolved over time to optimise success in battle (Hayward, 2003). Hayward explained that while commanders must possess leadership qualities, command is unique to militaries as it is only in armed forces that rank and juridical systems exist where the authority vested in leaders is reinforced by a separate legislatively sanctioned disciplinary structure. In return for allegiance, commanders take responsibility for ensuring the welfare of their subordinates. Howard (2002) defined military leadership as "the capacity to inspire and motivate; to persuade people willingly to endure hardships, usually prolonged, and incur dangers, usually acute, that if left to themselves they would do their utmost to avoid" (p. 117). This definition infers that disciplinary systems are only necessary as back-ups in the event that a leader is not effective. Harper (2003) believes that the NZDF espouses a style of command that reflects New Zealanders' egalitarian values and that this manner of leadership is one that rejects the use of military discipline to shore up leadership failings (Harper, 2003).

A fundamental requirement of military service that is instilled early in careers is the need for individuals to self-lead (New Zealand Defence Force, 2015g). Self-leading is ensuring compliance at all times with military values and the military ethos. Harding (2016) reported that:

> The Army explicitly tells recruits that they are to "self-lead" in line with soldier "values" not only whilst at work but everywhere: at home, and out in the civilian world ... The idea is that through the routines with which you accomplish basic daily tasks you learn skills that become embodied as dispositions which can then be applied at war. (p. 66)

The implications are that individuals must learn to conduct self-surveillance to ensure that they maintain continuous alignment with the expectations of the organisation. Initial soldier and officer training creates an environment where increasing responsibility for surveillance is transferred from the organisation to the individual.

The Defence Force's leadership development framework describes the importance of leaders coming to understand the relationship between organisational culture and successful leadership (New Zealand Defence Force, 2017c). The framework is comprehensive and is grounded in a position that assumes that leadership can control culture through the conscious reinforcement of stated organisational values. However, because organisations are collections of institutional apparatus, not material entities capable of cerebral functioning, the creation, negotiation and reification of attributes and ideals belong to organisational members, not to the organisation itself. What individuals value are constituted not by what an organisation believes should be valued, but by relations between subjects and the power knowledge dynamic that is reinforced by power's system of covert surveillance. The organisation serves as a surface for the emergence of the power knowledge dynamic as opposed to the postulated controller of culture.

Leadership in nursing reflects the profession's history of having been "born in the church [and] raised in the army" (Dolan, 2016). Hierarchical structures of ecclesiastical and military forms have been reproduced in configurations of nursing leadership however although continuities of hierarchy remain, unlike in the military nursing leaders are identified and selected for their clinical expertise not their leadership competence (Stanley, 2017a). Although as Stanley observed, clinical expertise is important, aptitude in professional practice does not automatically extrapolate to competent leadership. While there is general agreement in the literature that the

determinants of effective leadership in any domain relate to individual characteristics and not to context, Stanley and Carvalho (2017) argue that the culture of health organisations is such that the type of leader needed in health is quite different to that needed elsewhere.

Transformational leadership is the model upon which the NZDF has built the organisation's leadership development and performance evaluation framework. Nursing officers are like all other NZDF employees, required to learn and subscribe to the various ways in which the model is expressed including exemplifying transformational leadership's fundamental premise that leaders must motivate individuals to meet higher order needs through the setting of a vision that provides meaning and a focus for direction (Avolio et al., 1999). Other important features of transformational leadership include the drawing of attention to cultural images, the creation of conditions that lead followers to match cultural norms, and the role modelling of desired behaviours that promote organisational values (Avolio et al., 1999; Kouzes et al., 2004).

Transformational leadership is useful for both nursing and the military because it opens up possibilities for the emergence of phenomena that are not yet known about however, in the military the focus of transformational leadership lies less with the ability of leaders to use their influence to facilitate change and more with driving direction to achieve mission intent (New Zealand Defence Force, 2017c, 2017d). Sometimes that direction can be ethically challenging for nurses. Furthermore, the way in which transformational leadership is universally applied in the NZDF tends to silence other possibilities for leadership such as that of the congruent leader.

Yet despite military systems of surveillance seeking to limit the careers of nurses who fail to demonstrate the qualities of transformational leadership, nursing officers retain and apply in their clinical practice the familiar and effective characteristics of congruent

leadership. Nurses can select from the two sets of leadership styles the most appropriate behaviours for presenting situations. What becomes problematic however, is when nurses expect their commanders to possess those same two sets of understandings.

Consistent expectations by nurses of collaboration and negotiation in decision-making are not met. Examples were provided of occasions where command decisions were made that may have negatively impacted upon nursing competence or patient care, and when commanders refused to take nurses' advice and when challenged about this, became autocratic. Nurses claimed that in some cases the consequences of commanders' intransigence had the potential to adversely affect the reputation of the NZDF. That commanders did not appear to understand these consequences have led nurses to believe that the health services are poorly managed which in turn has adversely affected nurses' trust in command. Lack of trust in command impacts upon nurses' productivity and retention (Lal & Spence, 2016; Rodwell et al., 2017). When nurses do not trust their leaders, they are more likely to present resistance (Jacob et al., 2019)

The ability for NZDF nurses to gain the confidence they feel they need to challenge commanders' decisions is not something that nurses acquire quickly. When nurses are new to the military they are very alert to the military's systems of what Foucault referred to as micro-power (Foucault, 1991a). Micro-power is the non-visible force that arises from the confluence of common behaviours, the expectations of others, and the physical geography around people that compel them to behave in certain ways. So although nurses are professionally obliged to raise concerns if they believe patients may be negatively affected by decisions (Nursing Council of New Zealand, 2012c), and although the New Zealand military leadership style is believed to be egalitarian and therefore one that invites input from subordinates, military juridical norms ensure that micro-power undermines professional obligations and egalitarianism to "guarantee the

submission of ... bodies" (Foucault, 1991a, p. 222). Hence novice nurses resist resisting and submit to command decisions.

As nurses gain more knowledge of the military they become more confident with exercising resistance. Resistance is not passive as evidenced by nurses' descriptions of their actions when commanders refuse to negotiate or collaborate with decision making. Nurses react by repeatedly re-litigating decisions, forging ahead as if permission has been granted, and activating networks to assist with the promotion of a given cause. These behaviours indicate that although there is said to be a culture in the NZDF that when the decision is made the decision is made, nurses do not always just get on with it.

Old contests and new within the traditional paradigm

As baby boomers in New Zealand begin to retire, the ability for health professionals to meet the challenging healthcare needs of an aging population reduces so new ways of working are required (Ministry of Health, 2017b). Nurses have been able to expand and develop new scopes of practice within this context and by employing political means and achieving legislative change, have assumed responsibility for aspects of healthcare that have in the past sat within the domain of medicine (Gilmour & Huntington, 2017). Consequently as Gilmour and Huntington attest, when medical practitioners are not available due to planning, financial constraint or specialty deficiencies, nurses are provided with or create the opportunity to do more.

Traditional hegemonic attitudes towards medicine remain undisturbed within the NZDF even though changes in perspectives and responses to demand have been occurring in the civilian health sector for some time. Although the NZDF is experiencing a shortage of doctors, the dominance of biomedical models in the NZDF prevents nurses from working to the full extent of the registered nurse scope of practice and creates barriers to

enabling nurses to relieve some of the pressure on service delivery by moving into extended or advanced scopes. Nurses reported being refused access to patient's notes, having their advice ignored, being censured for challenging medical officers, and being overlooked in the selection for leadership roles in preference to medical practitioners—even when nurses have more experience. An effect of nurses facing impediments in their practice is a reduction in perceptions of what nurses are able do which then impacts upon their value. When the value of nurses is suppressed, the status of doctors is increased (Wilkinson & Jones, 2016).

The absence of a formal career framework for nursing officers has led some nurses to shape their own career directions and the conditions that enable them to do that. These permissions can only serve to perpetuate competitive dispositions and further interfere with collaborative practice. Argyle (2015) recommended that the NZDF implement what the author referred to as an "induction and training pathway" (p. 62) to improve nurses' orientation and preparation for the roles they are required to perform but to date there is no evidence that this recommendation has been actioned.

The NZDF is not alone in not having in place clearly defined and approved career frameworks. Finnegan et al. (2015) identified challenges that the employment contexts of British military nurses present so have developed a model that can be used to inform careers while Kenward et al. (2017) propose the addition of what are referred to as a 'job plan' to help shore up the lack of specificity in the protection of clinical skills maintenance. Kenward et al. found that although care that is provided by British military nurses is excellent, inconsistencies in employment models create conflict between nurses.

Leadership in the NZDF is equated with rank. When leadership appointments are made, decisions according to nurses, are doctor-centric. When doctors are appointed to

leadership roles ahead of nurses, nurses' leadership qualities are brought into question. Although the criteria for rank advancement for all officers is the same, nurses believe their rank is viewed as honorary only. If discourse exists whereby nurses but not doctors are thought to hold honorary rank, and that this discourse informs decision making, opportunities for leadership roles for nurses will be reduced. If nurses do not routinely hold positions of leadership, medics who form the bulk of health professionals in the NZDF, will not be accustomed to nurses leading and because medics as well as nurses provide nursing care, it may appear that nurses are indeed, not needed; not as health officers nor as providers of nursing care.

However, under the provisions of the HPCA Act, nursing care must be provided either by nurses or under the direction and delegation of registered nurses. That means that medics are not permitted to deliver nursing care unless they have been delegated that responsibility by nurses, so although medics can deliver care under certain circumstances, nurses must lead the delivery. Therefore nurses *are* needed.

At times nurses appear to accept the hegemony of medicine but only if they believe they will have a voice in decisions and that appropriate decisions will be made. When it is in the interests of nurses, such as when nurses cannot agree amongst themselves about an issue or when nurses require allies to promote a cause, they will engage with and exploit doctors' authority which indicates that nurses may at times be parties to the place of medicine in the Defence Force. Yet when nurses believe that the clinical decisions of doctors are not in the best interests of patients, they will not just get on with it but will risk censure and resist doctors.

Compounding the complexities of this situation is the way in which rank overlays autonomy. Cole (2006) asserted that the greater the rank of a service person, the more covert power that person is perceived to possess and because rank facilitates alliances

and increases social capital, it gives the impression that the person who holds higher rank is more expert than they are (Cole, 2006). Doctors typically hold higher rank than nurses, and because rank corresponds with leadership, physician dominance in military health leadership is reinforced. Medical hegemony in the NZDF is further reinforced when the organisation has an authorised director of medical services but no director of nursing services (Defence Health Directorate Workforce Advisor, personal communication, March 20, 2019). Nurses in this study reported occasions when doctors were promoted in order legitimise their leadership, which indicates that medical hegemony in the NZDF is self-perpetuating and therefore difficult to disrupt.

Nurses as parrhēsiasts

Language is thought to express the actuality of an individual's thinking however language may simply *appear* to depict what an individual is thinking. The truth of the military reality is that strategic outcomes are the measure of success (New Zealand Defence Force, 2017d) and nurses' continued employment within that reality is predicated upon the manifestation of conduct that optimises that success. Included in nurses' repertoire of success-optimising behaviours is the employment of phraseology such as 'clinical effects' which is a medicalisation of doctrinal language used to convey how military success can be achieved through the generation of effects. The governmentality of the NZDF posits doctrine as a superordinate set of principles for use from high level strategy through to planning and tactics (New Zealand Defence Force, 2017d) so doctrine forms a constituent of discourses of truth in terms of military strategies for success. The degree of will to truth underlies whether an individual will speak the language of success-making truths (Foucault, 1984b).

Nurses' choice of a military lexicon may indicate either a genuine reconstruction of the self whereby the nursing subject has undergone a process of introspection and personal

change in order to seamlessly conform to military truths, or it may conceal a deliberate deception whereby nurses know what is expected, but instead of initiating personal change, speak as if technologies of the self have been enacted when they have not. Such a deception would serve to assist nurses to maintain as their primary connection the discourses of nursing while at the same time avoiding any censure from military quarters that may result from the detection of delinquency that military scrutiny is constantly seeking. Such a deception would contain rewards in that manifestations of militarily complicit thinking leads to trust. To be trusted benefits military health services in that those who are trusted are able to perform the role of a parrhēsiast which means being able to influence decision-making. Thus the degree of will to manifest military truths is high so nurses assume subject positions that align accordingly.

The will to military truths is a driving force for both nurses and non-nurses but because commanders of health units tend to be G List officers, the truth as understood by combat personnel holds a superior position to the truths of nursing. G List officers undergo extremely challenging training regimes that provide access to an exclusive group whose members share a distinct identity, so those who do not share that same identity are not expected to share knowledge of the same truth that the routines, training and self-discipline of G List officers reveals to them. Therefore when advisors do not belong to the exclusive G List group, and when discourses of deficit coexist with exclusionary practices, the advice of advisors does not automatically hold veracity.

In their roles as parrhēsiastes, nurses reported that commanders' expectations of receiving consistent advice is not always met. Nurses are recruited with different levels and types of experience and undergo different military initiation processes so use different formulae in the composition of their military selves. The consequence of this difference is irregular constitutions of health advice. Health advice is given on

assumptions that health leaders will weigh that advice alongside their existing experience and knowledge of health systems but nurses report that G List commanders possess very little experience or knowledge of health systems with which to draw upon. Consequently nursing officers suffer similar parrhēsiatic punishments as the Athenians described by Foucault (2005). Fault is found with the advisor, not with the decision making ability of the commander.

That nurses provide different advice indicates that despite expectations of uniformity and the will—or at least the manifestation of the will—to military truths, nurses possess independent thinking that to the chagrin of military authorities, manifests in variability. This then suggests that irrespective of military experience, nurses retain the autonomy that is a hallmark of their profession where practice is independent and where nurses are accountable for the services and therefore for the advice that they provide (Nursing Council of New Zealand, 2020d). Within a regime of truth where uniformity is prized, the detection of freedom of thought by those who by their own compliance with uniformity are vested with the authority to police others, can only result in the diagnosis that the RNZNC is deviant which reinforces the notion that those who belong to the RNZNC are outsiders.

Legitimised resistance to nurse competence

Nurses spoke in ways that indicated that they possess a willingness to overcome barriers such as fear, marginalisation and disregard in order to speak up for what is best for patients. Staying connected with others in the nursing profession helps build nurses' confidence and maintain currency with professional knowledge that benefits patients however while the NZDF has in place a suite of professional development entitlements, a range of impediments to engagement with these exist. Barriers to staying professionally connected relate primarily to commanders' lack of support for

competence programmes. The military environment is dynamic and unpredictable so gaining the backing of non-clinical commanders for nursing specific operational preparedness is crucial but cannot be ensured if commanders do not possess a good understanding of competence requirements.

The maintenance of competence is not self-serving as some nurses in this study suspect military personnel think, but a process that serves patients. It is a mandatory requirement for nurses to maintain currency in professional development, competence and time in practice (Nursing Council of New Zealand, 2020e) and because nurses are accountable for their own continuing competence, it is necessary for individuals to identify where any professional deficiencies lie and to take action to address these. The NCNZ maintains vigilance over nurses' conformity with ongoing competence requirements and while physically remote, the NCNZ retains a relationship with nurses through annual practising certificate revalidation processes. Nurses must make a statutory declaration when applying for renewal of their practising certificates that they are competent. If nurses do not declare that they meet competence requirements they will not be issued with the annual practising certificate required for employment, yet if nurses make a declaration and are selected for audit but fail on examination to meet competence requirements, they may be subject to a NCNZ directed competence review (Nursing Council of New Zealand, 2015). Whilst not the intention of the legislation that underpins the competence review process, competence reviews are thought by nurses to be disciplinary because they can threaten careers (Cook, 2013).

Nursing Council of New Zealand audit processes have for military nurses been transferred from the Council to the Defence Force through the Council approved NZDF Nurses' PDRP. This means that although single nurses are not subject directly to NCNZ audit, the transfer of the NCNZ's compliance functions to the NZDF magnifies the

Army's dominion over military nurses and reduces nurses' ability to avoid through physical distance, the detection of resistance to the demonstration of competence.

Hierarchical structures and juridical systems of the NZDF serve as potent tools to compel engagement with PDRP, particularly because military nurses' engagement with the NZDF programme is mandatory. However what nurses had to say about PDRP indicates that resistance legitimising behaviours are common. Nurse resisters gain allies when G List officers and commanders challenge the need for PDRP and reject nurses' efforts to plan and undertake activities related to compliance. The NCNZ is permitted to rescind its approval for PDRP when NCNZ approved PDRP processes are not followed. Consequently it is not only nurses' conformity with competence requirements and patient safety that is at risk when nurses and G List officers resist PDRP processes, it is also the reputation of the NZDF. The NZDF Nurses' PDRP serves as a technology of governmentality that seeks to bridge the gap between nurses' professional accountabilities and the expectations of their roles; a technology that prior to the introduction of the PDRP positioned Council processes at a distance to military nurses. Distance increases vulnerability to nurse resistance but the introduction of a NZDF nurses' PDRP has not eliminated resistance, it has simply become a new site for non-compliance.

An insubordinate truth about rank

Fundamental disciplinary and juridical rules that apply to military rank are accepted by nursing officers only within certain parameters because the Nursing Corps contains its own influential hierarchies. These internal power structures are related to specialty areas of practice, roles and deployability status and, in an interesting emulation of the value of a soldier being determined by his or her proximity to lethal force, by nurses' proximity to patients. Nurses who work in clinical practice hold more value than those who work

in more senior but non-clinical roles due as explained earlier, to senior nurses being in a perceived state of non-deployability. Paradoxically the value of senior nursing officers as viewed by deployable nursing officers, returns senior nurses to a place alongside novice nurses who hold little value because they have yet to gain the experience necessary for operational deployments.

The state of non-deployability of senior nurses inverts the value of rank in unspoken but 'known' ways because nurses who hold management positions hold higher rank than nurses who hold practice positions. Consequently despite resource investment, organisational expectations and financial incentives, there is a reluctance by some nurses to seek promotion to higher rank. Acceptance of promotion to senior nursing leadership roles involves resistance to pressure to remain at the clinical interface. Those seeking promotion do so in the knowledge that promotion involves losses. Loss of deployment opportunities and loss of credibility.

Nurses policing the borders

NZDF performance review processes that underpin promotion are limited to the assessment of generic leadership criteria which does not take into account nursing competence. This situation creates risk for the NZDF in that nurses who have been assessed as possessing transformational leadership competencies may not possess the proficiencies that are important to nursing. Assessment of nurse's performance may be undertaken by any officer, not necessarily a nursing officer, and there is no standard or link within the NZDF performance and development framework to nursing competence evaluation (Defence Health Directorate Workforce Advisor, personal communication, December 13, 2017). This has the potential to result in the promotion of nurses who do not possess the level of competence and therefore the level of collegial respect that is

necessary for effective nursing leadership. That nurses feel that a degree of shame accompanies promotion may be a consequence of this deficiency.

G List officers subscribe exclusively to transformational leadership principles but because few G List officers holding leadership roles in the military health system have experience in civilian health sector, their understanding of the nature of congruent leadership will be limited. Nurses have demarcated a place at the physical border of care delivery environments where the authority of transformational leadership represented by military rank is supplanted by the authority of clinical expertise. Within the clinical practice border each health professional, irrespective of rank, is encouraged to make his or her views known and the practitioner who is most competent to provide clinical leadership will lead. Hence in ways that mirror restrictions on weapons entering treatment centres, restrictions are placed on the entry of military rank into clinical practice areas.

Strategies that nurses employ to resist G List commanders impacting upon clinical practice can be viewed as nurses policing the borders of the health domain in order to protect patients. The corollary of policing the borders is the creation of limitations on the totality of military rank. The existence of a clinical demarcation zone appears to be unique to the New Zealand military environment. The literature is largely silent on the role of rank in clinical practice. Nurses in the British Armed Forces have been reported to substitute warrior and nurse hats for different situations (Griffiths & Jasper, 2008) but rank was not referred to. Van Rensburg and Zagenhagen (2017) found that in the South African Defence Force the assignation of clinical rank,[35] a system that recognises that disparities exist between clinical leadership expertise and military leadership competence, disadvantages nurses because clinical rank is not viewed by non-health

[35] Rank that reflects clinical leadership expertise as opposed to military leadership competence

personnel as having any value. Consequently in South Africa, the ability for nurses to advocate for patient wellbeing outside the health environment is limited. Other research indicates that nurses in some defence forces feel forced to make decisions between prioritising patient care over military work but the focus of these studies tends towards an examination of dual loyalty conflict and its management, not between conflicting hierarchical systems (see for example Chargualaf, 2017; Finnegan et al., 2016).

The construction of a unique identity

Identity has long been accepted as a social construct formed by an individual's intrapersonal interactions with the self and their interpersonal interactions with the world with which they engage (Liu et al., 2005). Identity is not fixed because the social world is in a perpetual state of flux so identity changes according to the way in which individuals respond to change and how those responses impact upon the way the individual views him or herself (LeCourt, 2004). Kahu (2017) states that:

> Identities shape how we experience the world, how we understand what we experience, and the opportunities and challenges we face through life. Not all identities are equally valued, and so identity also determines the allocation of social, political and economic power in society. (p. 13)

Professional identity for nurses has been defined as "how an individual views himself or herself as a nurse who can provide quality care in a responsible manner" (Rasmussen et al., 2018, p. 229). Nurses have been found to actively seek professional identities and because identity is a cultural artefact, the identities of nurses differ with employment contexts (Ball, 2011; Chamberlayne & King, 1996; Horton et al., 2007). Nurses are said to be constantly renegotiating their professional identities throughout their nursing

careers but when nurses' employment changes, there is a compelling need for review (MacIntosh, 2003; ten Hoeve et al., 2014).

Reworking professional identities is necessary when nurses join defence forces because what it means to be a nurse in the military involves amalgamating perceptions of oneself as a nurse with perceptions of oneself as a service person (Griffiths & Jasper, 2008). Acquiring an identity that facilitates the delivery of quality care in military environments takes time and according to MacIntosh (2003), is influenced by the degree of respect and support nurses receive, the level of autonomy they possess, and the extent to which nurses feel they are permitted to exhibit caring behaviours. The development of nurses' new professional identities is believed to be hindered when these factors are inhibited.

New Zealand military nurses' perceptions that they have low status and that caring characteristics in military personnel are not valued, will be impacting upon the development of their new nursing identities however offsetting these factors is the high level of professional autonomy nurses in the NZDF possess. Autonomy is accompanied by agency which facilitates nurses' subjectification, and because subjectification involves self-reflection followed by action, adaptations to nurses' identities are able to be made. Adaptations are according to Rasmussen et al. (2018), critical for successful identity development. Nurses who are adaptable have more self-confidence, provide better care and are more likely to manage challenges in the workplace (Johnson et al., 2012; Ramvi, 2015; Rasmussen et al., 2018).

Foucault asserted that subjectification is not the exercise of a truly free spirit but a process whereby even when an individual possesses the agency to construct their own self, they remain shaped by disciplinary techniques of governing structures and power relations (Rabinow, 1997). For nurses, subjectification involves finding alignment

between the two co-existing paradigms of the military and of nursing. The NZDF paradigm is omnipresent, visible and as Segal (1986) claimed, greedy. The paradigm of nursing is peripheral and by comparison seemingly undemanding, but the profession possesses the authority to threaten nurses' relationships with the NZDF if due regard is not afforded to its systems and processes. Therefore nurses must hold subject positions that take into account both the expectations of their roles and the accountabilities of their profession. Nurses' ongoing employment demands it.

It is important that the identity of military nurses reflects the knowledge that their roles demand. Acquiring knowledge through professional development and education not only prepares a nurse for the type of care that is required, it increases a nurse's confidence and when an employer invests in the professional development of a nurse, that nurse feels valued which improves their self-esteem and leads to greater confidence (Rasmussen et al., 2018; Seo & Kim, 2017). In addition, Rasmussen and colleagues (2018) noted that when a nurse gains knowledge which others in their field already possess, that individual becomes enculturated into the field which then contributes to their sense of belonging.

The suite of professional development resources available to NZDF nurses are taken for granted entitlements that are not always valued and which can become sites for resistance in the struggle that exists between competing nursing and military discourses. Yet the work that senior nurses do to resist resistance by cajoling nurses to comply with policy and to interpret and negotiate terms for competence maintenance, ultimately assists nurses to gain the military nursing expertise necessary for the deployability that they so highly prize. While expertise helps to strengthen identity through the contribution it makes to confidence and then to the development of identity (Miskelly & Duncan, 2014; Rasmussen et al., 2018), the protection of junior nurses by those who are

more senior serves to bind nurses together in a muddled union of competing short-term interests and analogous long-term goals.

Alignment between nurses' roles and practice settings, and nurses' perceptions of their selves, impact upon how deeply nurses' identities become embedded and whether those identities meet the needs of patients (Rasmussen et al., 2018). It follows then that for novice military nurses to deliver the type of care required in their new employment context, and for them to experience satisfaction in their roles, that their identities must change. Transition for nurses in this study was not however entirely transformational because although nurses said they had changed, some things had not changed.

Like nurses in the civilian sector, nurses in this study permit patients' conditions to determine who the most appropriate practitioners are to lead or to deliver care. Yet unlike nurses in the civilian sector who for multiple reasons tend not to challenge poor practice (Beaver, 2017; Johnstone & Kanitsaki, 2006), military nurses are vocal and will exploit multiple avenues to seek redress if they believe the interests of their patients are not being served. Military nurses refuse to allow rank to interfere in clinical practice domains in a way that protects not only patient confidentiality and quality of care but also nurse autonomy. Marking out territory in this way has no parallels in the civilian sector because leadership in the public system is congruent in nature so leaders have considerable experience in healthcare systems so are trusted (Stanley, 2017b).

For nurses new to the NZDF, making sense of and successfully amalgamating the focus of nursing and the focus of military practice can be difficult. The existence of a soldier first mentality in the New Zealand Army was described by Harding (2016) who found that belonging to the Army means that "every member is a soldier first" (p. 17). Being a soldier involves being prepared to place oneself in harm's way and possessing the means and the license with which to harm others. Soldiers are therefore subject to a

strict regulatory system that controls how lethal technologies are employed so colonised within soldiers' service mentalities are constructs of weaponry. The regulatory regime to which nurses subscribe is designed to protect those they work with so unlike their military colleagues, nurses new to the Army will not have a deeply inculcated sense that service involves force thus it can be confronting for them when the welfare of their patients is subordinated to the goals of their employer.

New Zealand military nurses do not readily subscribe to the notion of soldier first. Declining the soldier first mentality frees nurses to concentrate on delivering care under the protection of the Red Cross however nurses' narratives reveal that non-health professional members of the NZDF do not always possess a good understanding of nurse professional priorities, nor a good understanding of health and humanitarian legislation. While some nurses in this study reported voluntarily undertaking activities that are not permitted under the Geneva Convention, they were rarely directed to perform tasks that are not lawful or ethical however, exemptions of nurses from undertaking combat-related activities are viewed by others as nurses not contributing to the team. Feeling connected with a team is an important feature of identity (MacIntosh, 2003) therefore working within the provisions of international humanitarian law serves as an obstacle to the formulation of a military identity. Pressure to demonstrate team membership has been a factor in other defence forces where health professionals have been reported to perform duties that do not comply with international humanitarian law because to not do so would have led to punishment (Finnegan et al., 2016; Foley et al., 2000; Fry et al., 2002; Kelly, 2014; Lundberg et al., 2014). Nurses in this NZDF study resisted such pressure but experienced feelings of marginalisation as a result.

Marginalisation consigns nurses to a position of outsider. A paradoxical effect of feeling an outsider in an organisation where team membership is highly regarded, is the

recognition by nurses of their otherness and the consequential uniting of these nurse others into a team of their own. Members of this nursing team, have constructed a unique identity. A team that values the military dispositions of deployability, competition and hierarchies but one which has substituted the institutional focus on combat with a professional focus on patients. This substitution has created for nurses a new interpretation of military dispositions so that deployability, competitive advantage and hierarchical subject positions are determined by proximity to patients, not proximity to battle.

Limitations of the research

Inherent limitations exist in this research. Firstly, my early assumptions that as a long-serving member of the RNZNC I would have been able to suspend deeply embedded attitudes and insider assumptions about military nursing were unrealistic. I recognised early that a potential for bias existed so I actively sought to enter the interrogatory processes of a full application to the MUHEC. In addition I undertook a period of self-reflection that awakened in me the need for the personal application of technologies of the self so that my subject position during the conduct of this study would remain consistently that of a researcher and not that of a practitioner of military nursing.

Thinking and action processes were constantly vetted however despite my deliberate strategy to overlay the critical theory underpinning this study with evidence, and to present ideas exclusively as a researcher, years of being a subject of military power relations have influenced this project. I recognised what nurses had to say about their feelings and attitudes towards their roles. This recognition may have been apparent to study participants during interviewing so despite the assurances I provided about impartiality and confidentiality, what was revealed to me may not have been revealed in the same way to other researchers. My recognition of what participants had to say was

used subsequently in the research process. I used it to guide me with searching the literature, accessing experts and with seeking members to check my personal interpretation of participants' information. These latter processes would have been accessed differently by other researchers so the final product of this study will have been influenced by my personal perspective.

Each of the 11 participants brought to this study reports based on their own experiences. Power targets relations in the social space so whilst the findings of this study have been based on recurring themes, the relations upon which those themes have been constituted are like the participants themselves, unique. Thus any supposition that the findings of this research will be transferrable will be erroneous.

Summary

Chapter nine traced from a Foucauldian archaeological perspective, the construction of a distinct identity among New Zealand military nurses. This identity is based on nurses' concepts of self that arise during the development of a specialised way of practising that amalgamates nursing expertise and knowledge of the military. I argued that underpinning the constitution of a military nurse identity lie the very cultural components that create impediments to the smooth transitioning of nurses into the NZDF. I claimed that nurses do not retain these military cultural components in their pure form, but interpret them in different ways so that the identity that is constructed differs from that of other military personnel as well as that of nurses elsewhere.

The constitution of a new military nurse identity is not however an end in itself. The group monitor interprofessional relations to ensure that at the core of the knowledge power paradigm lies the wellbeing of patients. The point was made that although the means to patient wellbeing is not always collegial, the contribution that teamwork

makes to support nurses balancing their at times conflicting responsibilities, reflects nurses' inculcation into a selection of fundamental military mentalities. Chapter nine concluded by presenting the limitations of the study.

The next chapter presents the conclusion to this thesis. A return is made to the beginning of the work and the motivations and rationale for the study. The work is reviewed in order to draw together the connections between the different elements that comprise the thesis and to demonstrate how the information presented addresses the gap in the literature of how New Zealand military nurses navigate professional accountabilities and role expectations.

Conclusion

When first I set out on this project to explore how nurses serving in the New Zealand Defence Force navigate professional accountabilities and role expectations, I had some idea of the challenges that working for the NZDF might present. My service as a member of the RNZNC would have I thought, given me insight into the world within a world where nursing officers work and live. It is certainly true that I came into this research understanding some of the ways of working, how to interpret the exclusive, and exclusionary, language, and the multiple and complex systems of governance that operate in the NZDF. What I did not expect was the way in which the application of Foucauldian theoretical concepts would illuminate aspects of NZDF culture that impact upon how military nurses work nor how those nurses 'know' that some things make them behave a certain way, but are unable to articulate why.

Foucault has enabled the hidden agendas of martial discourses to be revealed. The theoretical concepts I chose from Foucault's repertoire show how military discourses impact upon the decisions that nurses make in their routine work at home, and in the extremely non-routine context of the operational deployment. Notions of competition and status have been exposed as subliminal infiltrators of the porous borders of nurses' professional selves. Not being central to military purpose, nor being considered central to military health services, positions nurses in a grey space where they find opportunity to exploit the agency that resides there. Selections are made whereby particular military practices are assessed for their value and either applied through technologies of the self, modified for application, or simply rejected.

Industriousness presented in the guise of not being jack, is for nurses like for other personnel, highly valued. Military discipline on the other hand is seen as largely incompatible with the softness of a nurse so it lies dormant until the conduct of more

junior personnel presents as being beyond nursing's liberalities. Then discipline partners with rank to crush resistance.

Rank does not hold status in clinical settings despite the privilege conferred by rank and its associations with leadership. Nurses were very clear that patient safety, not the indiscriminate following of orders nor the focus on achieving operational goals, lies at the core of their work. Ultimately rank bows to congruent leadership, and collaboration between health professionals, and at times conflict, serve as sites for overarching resistance to military governmentalities. Further resistance to institutional mentalities is presented by nursing officers vehemently guarding against G List officer incursion into clinical spaces and professional practice issues so although power relations position nurses and healthcare as low in military value, interference by non-health professionals in clinical or professional matters is prohibited. Thus congruent leadership conquers the transformational for nurses in clinical practice.

Patterns of thinking and behaviour that modify or reject NZDF governmentalities characterise nursing as a group of outsiders. Military norms that perpetuate competitive conduct and that create unofficial hierarchies permeate the RNZNC to manifest as new interpretations of value and order. Specialty areas of practice, clinical expertise and deployability exist as sites for the assessment of the nursing subject's worth. Foucault would have been impressed with the way in which military nurses remove time from its purpose as a technology of disciplinary power, and twist it to work in the service of nursing. Time for nurses is not for the control of the population, but for spending in clinical practice and in preparation for deployments. Time, in essence, facilitates the acquisition of the skills that help nurses to become what they believe are full members of the RNZNC.

Being a full member of the Nursing Corps means being deployable. Nurses compete for selection for military operations and prioritise the attainment of capabilities that will qualify them for deployment. Criteria are set for general deployability that focus on military skills but which are silent on nursing competence. When a culture exists that socialises warrior proficiency as high value, nurses' attention falls on the attainment of combat skills at the expense of clinical expertise. When combat skills are valued over professional knowledge, when being *seen* to be working hard is valued over invisible work, and when proximity to combat corps becomes condensed as it does on operational missions, individuals and the NZDF can be put at risk. In such circumstances health professionals can in their efforts to align with cultural expectations, compromise international humanitarian law and professional codes.

Within this regime of truth lies a complication that inverts the status of senior nurses. Nurses who work in management and leadership possess higher rank than nurses who work in clinical practice. Achieving higher rank requires nurses to sacrifice working in direct patient contact but because deployment opportunities are rare for nurses who do not work with patients, senior nurses are not considered by other nurses to be deployable. When deployability sits at the pinnacle of value, notions that senior nurses are non-deployable reduces their status. Furthermore, because it is thought that deployability qualifies a nurse for full membership of the RNZNC, non-deployability implies that senior nurses do not qualify.

Compounding this situation is the way in which mandatory competence programmes are situated within institutional governmentalities. Performance review is generic in the NZDF and like the criteria for deployability, nursing competence is not formalised within the assessment system. When surveillance is constantly seeking alignment with

specific transformational leadership criteria, the assessment of nurses' competence as evidenced by PDRP and professional development processes, slips out of view.

The ability of senior nurses to enforce compliance with mandated professional programmes is difficult when the programmes are not supported by commanders and when power relations position senior nurses as subordinate to those who are junior. Perceptions of lower status presents a barrier to senior nurses activating the juridical systems that are available to them. Attempts to transfer responsibility for discipline to non-nurses reduces nurse autonomy which in turn, further reduces the status of military nurses. In addition, when the threat that discipline is not likely to be activated, nurses' competence is impacted. Discipline serves as a motivator for the focus of attention so if nurses do not believe there will be consequences for failing to demonstrate professional competence, their attentions will lie elsewhere.

Despite competence processes holding low status and senior nurses no longer working with patients, military nurses still have expectations that their nurse leaders will be competent clinicians however, nurses can be promoted who do not possess the clinical competence nor the congruent leadership qualities that nurses value because performance review is predicated exclusively on generic military criteria. Nurses also expect their non-nurse commanders to have considerable knowledge and experience in the health sector. When it becomes apparent that this is often not the case, the attitude of nurses towards their leaders is negatively impacted. When negative attitudes are detected by others outside health units, the reputation of the military health service is adversely affected. In addition, when commanders of health personnel do not possess knowledge of healthcare systems, parrhēsiatic processes can be disrupted. Commanders inexperienced in healthcare do not possess the skills necessary to assess and make appropriate health planning and management decisions based on differing nursing

advice. When the advice of nurses is not evaluated alongside existing knowledge and experience, the wellbeing of patients and the safe and legal management of health personnel cannot be assured.

The Defence Force is right to be attentive to culture although not in the way in which the organisation is currently concentrated. Governmentalities that focus on shaping organisational culture to reflect combat ideologies and competition, disregard the unintended disciplinary effects that power relations have on the attitudes of personnel and on their subsequent conduct. Nurses' reports of marginalisation and consequential isolation evidences unofficial hierarchies that privilege combat corps but which locate the position of non-combat corps members as 'others'. While this may not be an effect that the NZDF would be concerned about, for nurses, not feeling valued has implications for competence which can ultimately impact upon high status groups when, as was shown in the introduction to this thesis, injuries occur in combat or indeed, when illness or injury in general materialise.

Adaptations of military governmentalities intended to integrate nurses' agonistic roles of carer and warrior have their imperfections. Industriousness, if not judiciously applied, can compel the nurse to take on responsibilities that do not align with their professional accountabilities. Reluctance to activate discipline can give the impression that nurses are not exercising the conduct expected of military officers. Not being combatants, not being disciplinarians, and not subscribing to transformational leadership ideology all contribute to notions that nurses are not real officers. Further impacting nurses, and the status and reputation of health practitioners in the general, is the way in which the mobility of rank impacts upon different groups of health professionals. The lack of consistency in the awarding of rank, and ongoing regard in the Defence Force for outdated medical hegemonies combine with the nature of the

competitive selves of military personnel, to make relations in the health services an interstice of conflict. The vexed issue of rank for nurses is most vexed for the novice military nurse who struggles to understand the rules of the game of hierarchies when the rules of rank are still being learnt.

The notion that nurses are not real officers combines with the oft repeated refrain that nurses are 'not needed' to reinforce nursing's position as an 'other' on the outside. Outsiders in a world where value lies with those who reside closest to the weapons. Binaries are like judges, everywhere. If the group that is closest to the weapons is most valued, and the discourse of 'soldier first' forms one of the central mores of military thinking, then those who reside furthest from the weapons and furthest from soldiering, are the least valued. Furthermore, those who benefit most from the discourse that nurses are not needed are those who are also tarnished by distance from weapons; doctors and medics. Thus another hidden competitive agenda is exposed.

What is missing in the discourse of nurses not being needed is the voice of legislation. Notions that nursing care can be provided without nurses does not comply with the provisions of New Zealand health law. Nursing is a regulated activity that only nurses are permitted to perform so although many technical skills can be carried out by non-nurses, nurses need to be involved in the assessment of the sick and injured service person, not only to bring humanness to the experience of health and illness, but because service personnel possess the same rights as other New Zealanders to receive care that complies with national standards. The NZDF is not exempt from the requirements of the law which means that contrary to persistent discourses, nurses are needed.

Hence we return to the beginning of this thesis where I posited that the work of nurses is invisible. It is invisible because it sits at the periphery of institutional focus. It is conducted away from the view of others in the privacy of clinics and in the backs of

ambulances, trucks and aircraft. Nursing has its own inclusions and exclusions driven by ethical and professional practices which create safe places for patients so that patients' concerns can remain unseen and unaffected by the probing scrutiny of military governmentalities. Therefore for nurses it is patient first, not soldier.

Recommendations

This research sought out to explore how nurses balance the at times competing demands of soldiering and caring, and although there is a clear expectation by those outside the health services that the military role will take precedence, nurses do not and cannot subscribe to the soldiering philosophy first. The reason for this is that nurses' employment is contingent upon them meeting the requirements of the nursing profession first. Yet despite nurses in this study prioritising nursing ahead of soldiering, technologies arising from the soldier first discourse form insidious and compelling forces that do in fact impact upon the choices that nurses make. The recommendations I have formulated for the NZDF are intended to provide the organisation with an opportunity to work against the forces that negatively impact upon military nurses' professional practice, their practice environment, and their patients.

There are risks of a parrhēsiatic nature that arise with conducting research within a qualitative ontology. When an institution such as the NZDF is required to subscribe to the accountability principles of new public management quantitative methodologies and their associated ability to measure phenomena come to be considered the only valid currency upon which decisions can be based. To provide advice to the NZDF as the recommendations that arise from this research do, raises the risk that the advice will be discounted because it does not 'count' and I as a parrhēsiast will be discredited as not being *able* to count. Yet there are valid reasons for employing an 'other' research methodology in military studies. Employing scientific methodologies to the exclusion of different ways of knowing leads to, as Shirley (2018) and Simons (2009) warned, a restrictive perspective on the world which limits opportunities for finding new ways to work. The intent of critical research is to provide a catalyst for change so I am taking up that challenge. I offer the NZDF the following recommendations which have been

designed to provide the organisation with an opportunity to achieve the difference that Simons and Shirley seek:

Ensure that nurses govern nurses and the delivery of nursing care. In order to comply with the HPCA Act and the Health and Disability Services (Safety) Act, a structure that requires all NZDF nurses to report through to an appointed director of nursing is required. This is necessary to ensure the clinical governance of all NZDF nurses, to minimise the risks associated with nurses working in isolated practice, and to ensure that nursing care that is delivered by medics is done so under the direction and delegation of nurses in accordance with the directions of the NCNZ.

Construct a formal military nursing career framework. To optimise the contribution that nurses can make to the NZDF and to reduce damaging competitive behaviours, it is recommended that the Army introduce a standardised clinical career framework for military nurses. This framework should include processes and support for select nurses to acquire advanced scopes of practice and to become military nurse practitioners.

Provide support to nurses during their transitioning into the Army. Recruiting nurses in cohorts to begin their careers with a SOIC would reduce their isolation and facilitate nurses' knowledge of the military thus hastening their deployability and the development of the military nurse identity. Creating a mentoring and preceptorship programme for novice military nurses would not only assist with expediting nurses' transitioning but reduce the stress that nurses experience when they join the Army.

Provide support during the acquisition of new specialty areas of practice. If nurses are required to assume a new specialty area of practice, it is recommended that they are provided with a formal introduction to the specialty that incorporates a programme of

education, preceptorship and experience. This may involve arranging for formal preceptorship from the civilian sector.

Include professional competence as a criterion for nurse performance review. It is recommended that clinical competence in the form of PDRP be incorporated into the NZDF performance review system and mandated for nursing officers.

Include professional competence as a criterion for nurse deployability. It is recommended that professional competence as evidenced through PDRP, be incorporated into the generic deployment criteria and mandated for nursing officers.

Standardise the assignation of rank for health practitioners. It is recommended that the NZDF standardise the assignation of rank for newly commissioned specialist health officers.

Mandate education of international humanitarian law. To reduce risk to NZDF personnel, coalition partners, and to the reputation of the NZDF, education in international humanitarian law that includes the lawful employment of health professionals, must be mandated for all NZDF personnel. It is recommended that commanders and military health professionals receive advanced education in the provisions of the Geneva Convention.

Mandate the provision of patient safety education to all G List officers who are posted to health units. The present practice of posting G List officers to NZDF health units when they have little or no experience in healthcare presents significant risk to patient safety and to compliance with New Zealand health law. It is recommended that education in patient safety systems be delivered to all G List officers who have been selected for NZDF health officer roles.

Support further research. This project has raised questions that require further investigating. The skills that NZDF nursing officers require to be competent to perform their roles is not clear and there were reports from nurses that they are being required to perform duties for which they were inadequately prepared. It is recommended that research be undertaken to determine the skills required for military nurses to perform specialist nursing roles safely in garrison and on deployment.

Although this research has focused on nursing officers, the findings may have application for military medics and for other specialist officers in the NZDF. Further research to elicit whether this is the case and to identify specificities relating to other professional disciplines is recommended.

An inquiry into the ethical dilemmas experienced by New Zealand military nurses would help to inform conversations and contribute to a military nursing specific ethical framework.

Afterword

Reflecting at the beginning of this thesis on the unnoticed work of New Zealand military nurses, I referred specifically to one nursing officer whose care for the dead and wounded at the Battle of Baghak in Afghanistan, has remained largely out of public view. Surprisingly, an article recently appeared in a national newspaper about that nursing officer's role in the battle. The author of the article claimed that when he heard about the nurse's work he was "astonished" (Bingham, 2020, August 8, p. B1). Bingham declared he was even more astonished that unlike six soldiers there on the day, the nursing officer has never been decorated. When Bingham asked the Army for comment he was advised by the Chief of the Army that "a number of soldiers performed with distinction that day at Baghak…. Whenever our soldiers put themselves in harm's way and serve with distinction, all New Zealanders can reflect with pride on what these men and women do in service for our nation" (cited in Bingham, 2020, August 8). The notion of soldier first presents in multiple forms.

References

ABCA Coalition operations handbook. (2008). (4th ed.). American, British, Canadian, Australian, and New Zealand Armies Program https://info.publicintelligence.net/ABCA-CoalitionHandbook.pdf

Agazio, J. (2010, Apr). Army nursing practice challenges in humanitarian and wartime missions. *International Journal of Nursing Practice, 16*(2), 166-175. https://pubmed.ncbi.nlm.nih.gov/20487062/

Almost, J. (2006). Conflict within nursing work environments: Concept analysis. *Journal of Advanced Nursing, 53*(4), 444-453. https://pubmed.ncbi.nlm.nih.gov/16448487/

Argyle, M. (2015). *The contemporary military nursing practice of nursing officers in the New Zealand Army* [Master's thesis, Eastern Institute of Technology]. DigitalNZ. https://repository.digitalnz.org/system/uploads/record/attachment/779/the_contemporary_military_nursing_practice_of_nursing_officers_in_the_new_zealand_army.pdf

Armed Forces Discipline Act, No. 53. (1971). http://www.legislation.govt.nz/act/public/1971/0053/latest/DLM401063.html

Aronson, N., Sanders, J., & Moran, K. (2006). In harm's way: Infections in deployed American military forces. *Clinical Infectious Diseases*, *43*(11), 1045-1051. https://doi.org/10.1086/507539

Arrowsmith, V., Lau-Walker, M., Norman, I., & Maben, J. (2016). Nurses' perceptions and experiences of work role transitions: A mixed methods systematic review of the literature. *Journal Advanced Nursing*, *72*(8), 1735-1750. https://doi.org/10.1111/jan.12912

Avolio, B., Bass, B., & Jung, D. (1999). Re-examining the components of transformational and transactional leadership using the Multifactor Leadership Questionnaire. *Journal of Occupational and Organizational Psychology*, *72*(4), 441-462. https://doi.org/https://doi.org/10.1348/096317999166789

Baker, M. (2007). Creating order from chaos: Part I: Triage, initial care, and tactical considerations in mass casualty and disaster response. *Military Medicine*, *172*, 232-236. https://doi.org/10.7205/milmed.172.3.232

Ball, E. (2011). A social purpose model for nursing. *Nursing Forum*, *46*(3), 152-156. https://doi.org/10.1111/j.1744-6198.2011.00232.x

Ballantyne, K., & Rasmussen, B. (2013). *Organisational culture review*. New Zealand Defence Force.

Barrow, M., McKimm, J., & Gasquoine, S. (2011). The policy and the practice: Early-career doctors and nurses as leaders and followers in the delivery of health care. *Advances in Health Science Education: Theory and Practice*, *16*(1), 17-29. https://doi.org/10.1007/s10459-010-9239-2

Bassett, J. (1992). *Guns and brooches: Australian Army nursing from the Boer War to the Gulf War*. Oxford University Press.

Beaumont, S., & Allan, H. (2014). Supporting deployed operations: Are military nurses gaining the relevant experience from MDHUs to be competent in deployed operations? *Journal of Clinical Nursing*, *23*(12), 65-74. https://doi.org/10.1111/j.1365-2702.2012.04315.x

Beaver, P. (2017). The challenges of risk control in New Zealand public hospitals. *New Zealand Sociology*, *32*(2), 55-80. https://doi.org/10.1080/1177083x.2018.1561476

Benjamin, K. (2006). *A criterion validation of the New Zealand Army Officer Selection Board* [Master's thesis, Massey University]. Massey University. https://mro.massey.ac.nz/handle/10179/10536

Berry-Cabán, C., Rivers, F., Beltran, T., & Anderson, L. (2018). Description of United States military nurses deployed to Afghanistan and Iraq, 2001-2015. *Open Journal of Nursing, 8*(1), 93-101. https://doi.org/10.4236/ojn.2018.81008

Best, S., & Kellner, D. (1991). *Postmodern theory: Critical interrogations*. Macmillan.

Bill of Rights, (1688). http://www.legislation.gov.uk/aep/WillandMarSess2/1/2/introduction

Bingham, E. (2020, August 8). Love under fire. *Dominion Post*.

Blackbourne, L. H., Baer, D. G., Eastridge, B. J., Renz, E. M., Chung, K. K., Dubose, J., Wenke, J. C., Cap, A. P., Biever, K. A., Mabry, R. L., Bailey, J., Maani, C. V., Bebarta, V., Rasmussen, T. E., Fang, R., Morrison, J., Midwinter, M. J., Cestero, R. F., & Holcomb, J. B. (2012). Military medical revolution: Deployed hospital and en route care. *Journal of Trauma and Acute Care Surgery, 73*(6), S378-S387. https://doi.org/10.1097/TA.0b013e3182754900

Blackwood, K. (2016). Bullying and the 'caring profession'. *Nursing Review, 16*(4), 4-7.

Blackwood, K., Bentley, T., Catley, B., & Edwards, M. (2017). Managing workplace bullying experiences in nursing: The impact of the work environment. *Public Money and Management, 37*(5), 349-356. https://doi.org/10.1080/09540962.2017.1328205

Bochatay, N. (2018). Individual and collective strategies in nurses' struggle for professional identity. *Health Sociology Review, 27*(3), 263-278. https://doi.org/10.1080/14461242.2018.1469096

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Brinkmann, S. (2013). *Qualitative interviewing*. Oxford University Press.

British Army. (2020). *Army nurse: Army Medical Service*. https://apply.army.mod.uk/roles/army-medical-service/army-nurse

Burchell, G., Gordon, C., Miller, P., & Foucault, M. (Eds.). (1991). *The Foucault effect: Studies in governmentality*. University of Chicago.

Burrell, G. (1998). Modernism, postmodernism, and organizational analysis: The contribution of Michel Foucault. In A. McKinlay & K. Starkey (Eds.), *Foucault, management and organization theory: From panopticon to technologies of self* (pp. 14-28). Sage.

Carforio, G., & Nuciari, M. (1998). Introduction to the research. In G. Caforio (Ed.), *The European cadet: Professional socialisation in military academies* (pp. 7-13). Nomos.

Cariappa, M., Dutt, M., Reddy, K. P., & Mukherji, S. (2018). 'Health, environment and training': Guidance on conduct of physical exertion in hot and humid climates. *Medical Journal Armed Forces India, 74*(4), 346-351. https://doi.org/10.1016/j.mjafi.2017.09.017

Carver, R. M. (1989). Morale in battle: The medical and the military. *Journal of the Royal Army Medical Corps, 135*(1), 5-9. https://doi.org/10.1136/jramc-135-01-02

Catley, B., Bentley, T., Forsyth, D., Cooper-Thomas, H., Gardner, D., O'Driscoll, M., & Trenberth, L. (2014). Managing workplace bullying in New Zealand: Perspectives from occupational health and safety practitioners. *Journal of Management & Organization, 19*(05), 598-612. https://doi.org/10.1017/jmo.2014.2

Chamberlayne, P., & King, A. (1996). Biographical approaches in comparative work: The cultures of care project. In L. Hantrais & S. Mangen (Eds.), *Cross-national research methods in the social sciences* (pp. 95-104). Pinter.

Chandler, G. (2012). Succeeding in the first year of practice. *Journal for Nurses in Staff Development, 28*(3), 103-107. https://doi.org/10.1097/NND.0b013e31825514ee

Chargualaf, K. (2016). Situational transitions and military nurses: A concept analysis using the evolutionary method. *Nursing Forum, 51*(2), 125-135.

Chargualaf, K. (2017). Becoming an air force nurse: The experience of transition, a new perspective of a known phenomenon. *Nursing Forum, 52*(4), 254-265. https://doi.org/10.1111/nuf.12193

Clarke, V., & Braun, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Clifford, K. (2007). The challenge of continuing professional development for ADF nurses. *ADF Health, 8*, 57-59.

Cody, R. A., & Maginnis, R. L. (2006). Coalition interoperability: ABCA's new focus. *Military Review, 86*(6), 65-68.

Cole, M. (2006). Power over therapy? Mental health nursing in the Royal Navy. *Mental Health Practice, 9*(9), 28-32. https://doi.org/10.7748/mhp2006.06.9.9.28.c1914

Collen, J. F., O'Malley, P. G., Roy, M. J., & Sessums, L. L. (Eds.). (2013). *Military medical ethics: Experience from Operation Iraqi Freedom*. Ashgate.

Conlon, L., Wiechula, R., & Garlick, A. (2019). Hermeneutic phenomenological study of military nursing officers. *Nursing Research, 68*(4). https://doi.org/10.1097/NNR.0000000000000342

Cook, P. (2013). Seeking support during a competence review. *Kai Tiaki Nursing New Zealand, 19*(1), 32-32.

Cox, C. W. (2005). Shipboard nursing on aircraft carriers: The perceptions of twelve Navy nurses. *Nursing Outlook, 53*(5), 247-252. https://doi.org/10.1016/j.outlook.2005.02.007

Crimes Act, No. 43. (1961). http://www.legislation.govt.nz/act/public/1961/0043/137.0/whole.html#DLM329292

Crump, B. (2018, 15 October). *Bravo Kiwi NZ soldiers in Afghanistan and the Battle of Baghak* [Podcast]. Radio New Zealand. https://www.radionz.co.nz/national/programmes/nights/audio/2018666941/bravo-kiwi-nz-soldiers-in-afghanistan-and-the-battle-of-baghak

Cuellar, E. T. (2009, Dec). Care and meaning in war zone nursing. *Nursing Clinics of North America, 44*(4), 483-493. https://doi.org/10.1016/j.cnur.2009.07.004

Currie, J., & Chipps, J. (2015). Mapping the field of military nursing research 1990-2013: A bibliometric review. *International Journal of Nursing Studies, 52*(10), 1607-1616. https://doi.org/10.1016/j.ijnurstu.2015.06.008

Davidson, A. (1997). Introduction. In A. Davidson (Ed.), *Foucault and his Interlocutors*. Chicago University Press.

Davies, J., & Harre, R. (1990). The discursive production of selves. *Journal for the Theory of Social Behaviour, 20*(1), 43-63. https://doi.org/https://doi.org/10.1111/j.1468-5914.1990.tb00174.x

Davis, J. (2006). The importance of the community of practice in identity development. *Internet Journal of Allied Health Sciences & Practice, 4*(3), 1-8.

Defence Act, No. 28 (1990). http://www.legislation.govt.nz/act/public/1990/0028/latest/DLM204973.html

Denzin, N., & Lincoln, Y. (Eds.). (2011). *The Sage handbook of qualitative research* (4th ed.). Sage.

DePoy, E., & Gitlin, N. (2011). *Introduction to research: Understanding and applying multiple strategies* (4th ed.). Elsevier.

Dolan, B. [@BrianwDolan]. (2016, November 6). *Nursing was born in the church, raised in the army* Tweet. https://twitter.com/BrianwDolan?lang=en

Dow, A. W., Baernholdt, M., Santen, S. A., Baker, K., & Sessler, C. N. (2019). Practitioner wellbeing as an interprofessional imperative. *Journal of Interprofessional Care, 33*(6), 603-607. https://doi.org/10.1080/13561820.2019.1673705

Dreyfus, H., & Rabinow, P. (Eds.). (1982). *Michel Foucault: Beyond structuralism and hermeneutics* (2nd ed.). Harvester.

Drifmeyer, J., & Llewellyn, C. (2004). Toward more effective humanitarian assistance. *Military Medicine, 169*(3), 161-168. https://doi.org/10.7205/MILMED.169.3.161

Dziak, M. (2020). New Public Management. In *Principles of Business: Leadership*. Salem Press Encyclopedia.

Edwards, D., Hawker, C., Carrier, J., & Rees, C. (2015, Jul). A systematic review of the effectiveness of strategies and interventions to improve the transition from

student to newly qualified nurse. *International Journal of Nursing Studies, 52*(7), 1254-1268. https://doi.org/10.1016/j.ijnurstu.2015.03.007

Einarsen, S. (1999). The nature and causes of bullying at work. *International Journal of Manpower, 20*(1/2), 16-27. https://doi.org/10.1108/01437729910268588

Ekfeldt, B., Österberg, R., & Nyström, M. (2015). Preparing for care in a combat environment. *International Journal of Caring Sciences, 8*(1), 1-8.

Elliott, B., Chargualaf, K., & Patterson, B. (2017). Military to civilian nurse: Personal and professional reconstruction. *Journal of Clinical Nursing, 26*(9-10), 1375-1384. https://doi.org/10.1111/jocn.13693

Embrey, K., Gilbert, C., & Taggart, H. (2019). Understanding interconnectedness from a military nurse perspective. *Journal of Holistic Nursing, 37*(2), 113-118. https://doi.org/10.1177/0898010118792137

Employment Relations Act, No. 24. (2000). http://www.legislation.govt.nz/act/public/2000/0024/latest/DLM58317.html

Finn, R., Learmonth, M., & Reedy, P. (2010). Some unintended effects of teamwork in healthcare. *Social Science and Medicine, 70*(8), 1148-1154. https://doi.org/10.1016/j.socscimed.2009.12.025

Finnegan, A., Finnegan, S., Bates, D., Ritsperis, D., McCourt, K., & Thomas, M. (2015). Preparing British military nurses to deliver nursing care on deployment. An Afghanistan study. *Nurse Education Today, 35*(1), 104-112. https://doi.org/10.1016/j.nedt.2014.07.008

Finnegan, A., Finnegan, S., McKenna, H., McGhee, S., Ricketts, L., McCourt, K., Warren, J., & Thomas, M. (2016). Characteristics and values of a British military nurse. International implications of war zone qualitative research. *Nurse Education Today, 36*, 86-95. https://doi.org/10.1016/j.nedt.2015.07.030

Foley, B., Kee, C., Minick, P., Harvey, S., & Jennings, B. (2002). Characteristics of nurses and hospital work environments that foster satisfaction and clinical expertise. *Journal of Nursing Administration, 32*(5), 273-282. https://doi.org/10.1097/00005110-200205000-00007

Foley, B. J., Minick, P., & Kee, C. (2000). Nursing advocacy during a military operation. *Western Journal of Nursing Research*, *22*(4), 492-507. https://doi.org/10.1177/01939450022044548

Fornet-Betancourt, R., Becker, H., Gomez-Muller, A., & Gauthier, J. (1987). The ethic of care for the self as a practice of freedom: An interview with Michel Foucault on January 20, 1984. *Philosophy and Social Criticism, 12*, 112-131. https://doi.org/10.1177/019145378701200202

Foucault, M. (1976). *Madness: The invention of an idea* (A. Sheridan, Trans.). Harper and Row.

Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings, 1972-1977* (C. Gordon, L. Marshall, J. Mepham, & K. Soper, Trans.; C. Gordon, Ed.). Pantheon.

Foucault, M. (1982). The subject and power. *Critical Inquiry, 8*(4), 777-795.

Foucault, M. (1983). Afterword: The subject and power. In H. Dreyfus & P. Rabinow (Eds.), *Michel Foucault: Beyond structuralism and hermeneutics* (2nd ed., pp. 208-226). University of Chicago.

Foucault, M. (1984a). *The care of the self: The history of sexuality* (R. Hurley, Trans.; Vol. 3). Penguin.

Foucault, M. (1984b). The order of discourse. In M. Shapiro (Ed.), *Language and politics* (pp. 108-138). Blackwell.

Foucault, M. (1988a). The political technology of individuals. In M. Foucault, L. Martin, H. Gutman, & P. Hutton (Eds.), *Technologies of the self: A seminar with Michel Foucault* (pp. 145-162). University of Massachusetts Press.

Foucault, M. (1988b). Politics and reason. In L. Kritzman (Ed.), *Michel Foucault: Politics, philosophy and culture* (pp. 57-85). Routledge.

Foucault, M. (1990). *The history of sexuality* (R. Hurley, Trans.; Vol. 1). Penguin.

Foucault, M. (1991a). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). Penguin.

Foucault, M. (1991b). Governmentality. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault effect: Studies in governmentality* (pp. 87-104). University of Chicago.

Foucault, M. (1997). The ethics of the concern of the self as a practice of freedom. In M. Foucault & P. Rabinow (Eds.), *Ethics, subjectivity and truth. Essential works of Foucault, 1954-1984* (pp. 281-302). New Press.

Foucault, M. (2001). *The order of things: An archaeology of the human sciences*. Routledge.

Foucault, M. (2002). *The archaeology of knowledge* (A. Sheridan, Trans.). Routledge.

Foucault, M. (2003). *The birth of the clinic: An archaeology of medical perception* (A. Sheridan, Trans.). Routledge.

Foucault, M. (2005). 10 March 1982: First hour (G. Burchell, Trans.). In F. Gros (Ed.), *The hermeneutics of the subject: Lectures at the College de France, 1981-1982* (pp. 371-394). Picador.

Foucault, M., Morris, M., & Patton, P. (1979). *Michel Foucault: Power, truth, strategy*. Feral Publications.

Fry, S., Harvey, R., Hurley, A., & Foley, B. (2002). Development of a model of moral distress in military nursing. *Nursing Ethics, 9*(4), 373-387. https://doi.org/10.1191/0969733002ne522oa

Fullerton, C., & Ursano, R. (1994). Health care delivery in the high-stress environment of chemical and biological warfare. *Military Medicine, 159*(7), 524-528. https://doi.org/https://doi.org/10.1093/milmed/159.7.524

Gerber, L. (2012). An inside look at correctional health nursing. *Nursing, 42*(4), 52-56. https://doi.org/10.1097/01.NURSE.0000412925.82265.8d

Gergen, K. J. (1997). Crisis in representation and the emergence of social constructionism. In *Realities and Relationships: Soundings in Social Construction* (pp. 30-63). Harvard University Press.

Gilmour, J., & Huntington, A. (2017). Power and politics in the practice of nursing. In J. Daly, S. Speedy, & D. Jackson (Eds.), *Contexts of nursing: An introduction* (5th ed., pp. 183-198). Elsevier.

Golder, B. (2015). Who is the subject of (Foucault's human) rights? In B. Golder (Ed.), *Foucault and the politics of rights* (pp. 61-88). Stanford University Press.

Golightly, J. (2018). NZ Army's human dimension concept: How to enhance the decision making ability of all NZ Army personnel. *Face the future: Concepts on force design, 4*, 19-28. https://www.scribd.com/document/378138500/Face-the-Future-Concepts-of-Force-Design

Goodwin-Esola, M., Deely, M., & Powell, N. (2009). Progress meetings: Facilitating role transition of the new graduate. *Journal of Continuing Education in Nursing, 40*(9), 411-415. https://doi.org/10.3928/00220124-20090824-04

Gordon, C. (1980). Two lectures (C. Gordon, L. Marshall, J. Mepham, & K. Soper, Trans.). In C. Gordon (Ed.), *Power/knowledge: Selected interviews and other writings 1972-1977: Michel Foucault* (pp. 78-108). Pantheon.

Griffiths, L., & Jasper, M. (2008, Jan). Warrior nurse: Duality and complementarity of role in the operational environment. *Journal of Advanced Nursing, 61*(1), 92-99. https://doi.org/10.1111/j.1365-2648.2007.04469.x

Gross, M. L. (2006). *Bioethics and armed conflict: Moral dilemmas of medicine and war*. MIT.

Hagerty, B., Williams, R., Bingham, M., & Richard, M. (2011). Military nurses and combat-wounded patients: A qualitative analysis of psychosocial care. *Perspectives in Psychiatric Care, 47*(2), 84-92. https://doi.org/10.1111/j.1744-6163.2010.00275.x

Haggerty, C., Holloway, K., & Wilson, D. (2012). Entry to nursing practice preceptor education and support: Could we do it better? *Nursing Praxis in New Zealand, 28*(1), 30-39. https://www.nursingpraxis.org/entry-to-nursing-practice-preceptor-education-and-support-could-we-do-it-better.html

Harding, N. (2016). *You bring it, we'll bring it out: Becoming a soldier in the New Zealand Army* [Doctoral thesis, Massey University]. Massey University. https://mro.massey.ac.nz/handle/10179/9896

Harfield, R. (2019). *Overseas nurses neing sought to help with nursing shortage*. Health Central. https://healthcentral.nz/overseas-nurses-being-sought-to-help-with-nursing-shortage/

Harper, G. (2003). A New Zealand way of war and a New Zealand style of command? In G. Harper & J. Hayward (Eds.), *Born to lead?* (pp. 27-38). Exisle.

Harter, N. (2016). *Foucault on leadership: The leader as subject*. Routledge. https://doi.org/10.4324/9781315628738

Hatzfeld, J., & Jennings, B. (2017). Twenty-five years of the TriService Nursing Research Program: Standing on the shoulders of giants. *Nursing Outlook, 65*, S1-S3. https://doi.org/10.1016/j.outlook.2017.06.013

Hayward, J. (2003). Explaining command. In G. Harper & J. Hayward (Eds.), *Born to lead?* (pp. 15-26). Exisle.

Health Act, No. 65. (1956). http://www.legislation.govt.nz/act/public/1956/0065/latest/whole.html

Health and Disability Commissioner Act, No. 88. (1994). http://www.legislation.govt.nz/act/public/1994/0088/52.0/DLM333584.html

Health and Disability Services (Safety) Act, No. 93. (2001). http://www.legislation.govt.nz/act/public/2001/0093/latest/DLM119975.html

Health Practitioners Competence Assurance Act, No. 48. (2003). http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html

Health Quality and Safety Commission. (2017). *Clinical governance: Guidance for health and disability providers*. https://www.hqsc.govt.nz/assets/Capability-Leadership/PR/HQS-ClinicalGovernance.pdf

Henderson, A., Ossenberg, C., & Tyler, S. (2015, May). 'What matters to graduates': An evaluation of a structured clinical support program for newly graduated nurses. *Nurse Education in Practice, 15*(3), 225-231. https://doi.org/10.1016/j.nepr.2015.01.009

Hodgetts, T., & Findlay, S. (2012). Putting role 1 first: The role 1 capability review. *Journal of the Royal Army Medical Corps, 158*(3), 162-170.

Holloway, K., & MacGeorge, J. (2017). *National Nursing Consortium: Guidance for the development of specialty standards.* National Nursing Consortium. https://www.nurse.org.nz/national-nursing-consortium.html

Hook, D. (2007). *Foucault, psychology and the analytics of power*. Palgrave Macmillan.

Horton, K., Tschudin, V., & Forget, A. (2007). The value of nursing: A literature review. *Nursing Ethics, 14*(6), 716-740. https://doi.org/10.1177/0969733007082112

House, C. (2007). *Army nurse officer retention: A qualitative examination of forces influencing the career longevity of Army nurses* [Master's thesis, University of

North Carolina]. https://www.semanticscholar.org/paper/Army-nurse-officer-retention-%3A-a-qualitative-of-the-House/9a15ba0aaa37bc7e55042ca7310f39f27eb52ed3

Howard, M. (2002). A brigadier is only a co-ordinator: British generals in the First World War In G. Sheffield (Ed.), *Leadership and command: The Anglo-American experience since 1861* (pp. 104-146). Brasseys.

Hughes, K. (2015). Challenging government health rhetoric. *Kai Tiaki*, *21*(5), 2.

Huntington, A., Gilmour, J., Tuckett, A., Neville, S., Wilson, D., & Turner, C. (2011). Is anybody listening? A qualitative study of nurses' reflections on practice. *Journal of Clinical Nursing*, *20*(9-10), 1413-1422. https://doi.org/10.1111/j.1365-2702.2010.03602.x

Hutton, P. (1988). Foucault, Freud, and the technologies of the self. In M. Luther, H. Gutman, & P. Hutton (Eds.), *Technologies of the self*. University of Massachusetts.

International Committee of the Red Cross. (1949). *Geneva Convention for the amelioration of the condition of the wounded and sick in armed forces in the field*. https://www.icrc.org/en/doc/assets/files/publications/icrc-002-0173.pdf

International Council of Nurses. (2009). *Prevention and management of workplace violence*. https://www.icn.ch/sites/default/files/inline-files/ICN_PS_Prevention_and_management_of_workplace_violence.pdf

Jacob, E., Ryder, M., & Hendricks, J. (2019). An inductive qualitative approach to explore nurse practitioners views on leadership and research: An international perspective. *Journal of Clinical Nursing, 28*(13-14), 2644-2658. https://doi.org/10.1111/jocn.14853

Janowitz, M. (1960). *The professional soldier: A social and political portrait*. Free Press.

Jenkins, C. L., Elliott, A. R., & Harris, J. R. (2006). Identifying ethical issues of the Department of the Army civilian and Army Nurse Corps certified registered nurse anesthetists. *Military Medicine, 171*(8), 762-769. https://doi.org/10.7205/milmed.171.8.762

Johnson, M., Cowin, L., Wilson, I., & Young, H. (2012). Professional identity and nursing: Contemporary theoretical developments and future research challenges. *International Nursing Review*, *59*(4), 562-569. https://doi.org/10.1111/j.1466-7657.2012.01013.x

Johnson, S. (2015). Workplace bullying prevention: A critical discourse analysis. *Journal of Advanced Nursing, 71*(10), 2384-2392. https://doi.org/10.1111/jan.12694

Johnson, W. B., Grasso, I., & Maslowski, K. (2010). Conflicts between ethics and law for military mental health providers. *Military Medicine, 175*(8), 548-553. https://doi.org/10.7205/milmed-d-09-00119

Johnstone, M. (2017). Ethics in nursing. In J. Daly, S. Speedy, & D. Jackson (Eds.), *Contexts of nursing: An introduction* (5th edition ed.). Elsevier.

Johnstone, M., & Kanitsaki, O. (2006). The ethics and practical importance of defining, distinguishing and disclosing nursing errors: A discussion paper. *International Journal of Nursing Studies, 43*(3), 367-376. https://doi.org/10.1016/j.ijnurstu.2005.04.010

Jumat, J., Bezuidenhout, M., & Neethling, T. (2014). Pre-deployment preparation of military nurses of the South African National Defence Force for participation in peace support operations. *Curationis, 37*(1), 1-9. https://doi.org/10.4102/curationis.v37i1.75

Kahu, E. (2017). Introduction: Identity and citizenship in Aotearoa New Zealand. In T. Cain, E. Kahu, & R. Shaw (Eds.), *Tūrangawaewae* (pp. 11-25). Massey University Press.

Kalisch, B., Russell, K., & Lee, K. H. (2013). Nursing teamwork and unit size. *Western Journal of Nursing Research, 35*(2), 214-225. https://doi.org/10.1177/0193945912439107

Kannampallil, T., Schauer, G., Cohen, T., & Patel, V. (2011). Considering complexity in healthcare systems. *Journal of Biomedical Informatics, 44*(6), 943-947. https://doi.org/10.1016/j.jbi.2011.06.006

Kelley, P., Kenny, D., & Donley, R. (2017). Experiences of vulnerability and uncertainty during the Iraq and Afghanistan wars: Stories of wounded service members and the nurses who cared for them. *Nursing Outlook, 65*(5), S71-S80. https://doi.org/10.1016/j.outlook.2017.08.007

Kelley, P. W. (2010). Evidence-based practice in the military healthcare system. *Nursing Research, 59*(1). https://doi.org/10.1097/nnr.0b013e3181c9764d

Kelly, J. C. (2014). Military healthcare battlefield immunity. *Journal of the Royal Army Medical Corps, 158*(4), 308-312. http://dx.doi.org/10.1136/jramc-158-04-06

Kenny, D., & Hull, M. (2008). Critical care nurses' experiences caring for the casualties of war evacuated from the front line: Lessons learned and needs identified. *Critical Care Nursing Clinics of North America, 20*(1), 41-49. https://doi.org/10.1016/j.ccell.2007.10.013

Kenward, G., Marshall, S., & Irvine, K. (2017). How much is enough? Using Delphi to explore the clinical-contact-time and return-to-practice needs of military nurses. *Nursing Management, 24*(2), 20. https://doi.org/10.7748/nm.2017.e1574

Kiernan, M., Finnegan, A., & Farrell, D. (2013). Role of the military community mental health nurse. *Nursing Standard, 27*(51), 35-41. https://doi.org/https://doi.org/10.7748/ns2013.08.27.51.35.e7725

Kim, M., & Oh, S. (2016). Assimilating to hierarchical culture: A grounded theory study on communication among clinical nurses. *PloS One, 11*(6), 1-18. https://doi.org/10.1371/journal.pone.0156305

King, A. (2014). The digital revolution: Camouflage in the twenty-first century. *Journal of international studies, 42*(2), 397-424. https://doi.org/10.1177/0305829813512885

Koeszegi, S., Zedlacher, E., & Hudribusch, R. (2014). The war against the female soldier? The effects of masculine culture on workplace aggression. *Armed Forces and Society, 40*(2), 226-251. https://doi.org/10.1177/0095327X12460019

Kohn, L., Corrigan, J., & Donaldson, M. (2000). *To err is human: Building a safer health system*. National Academy Press.

Kouzes, J., Posner, B., & Matthew, C. (2004). Putting leading change into practice. *PsycCRITIQUES, 49*(5), 523-526. https://doi.org/https://doi.org/10.1037/004783

Kress, M. (2002). *Operational logistics: The art and science of sustaining military operations*. Kluwer Academic Publishers.

Kuziemsky, C. (2016). Decision-making in healthcare as a complex adaptive system. *Healthcare Management Forum*, *29*(1), 4-7. https://doi.org/10.1177/0840470415614842

Lal, S., & Spence, D. (2016). Humanitarian nursing in developing countries. *Journal of Transcultural Nursing*, *27*(1), 18-24. https://doi.org/10.1177/1043659614536585

Lamiani, G., Borghi, L., & Argentero, P. (2017). When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. *Journal of Health Psychology*, *22*(1), 51-67. https://doi.org/10.1177/1359105315595120

LeCourt, D. (2004). *Identity matters: Schooling the student body in academic discourse*. State University of New York Press.

Ledlow, G., & Stephens, J. (2018). *Leadership for health professionals: Theory, skills, and applications*. Jones & Bartlett Learning.

Leong, Y. M., & Crossman, J. (2015). New nurse transition: Success through aligning multiple identities. *Health Organization and Management, 29*(7), 1098-1114. https://doi.org/10.1108/JHOM-02-2014-0038

Levy, B., & Sidel, V. (2009). The roles and dilemmas for military medical care workers. In B. Levy & V. Sidel (Eds.), *War and Public Health* (pp. 1-17). Oxford Scholarship Online. https://doi.org/10.1093/acprof:oso/9780195311181.001.0001

Lindblad, C., & Sjöström, B. (2005, Jan). Battlefield emergency care: A study of nurses' perspectives. *Accident and Emergency Nursing, 13*(1), 29-35. https://doi.org/10.1016/j.aaen.2004.10.016

Liu, J., McCreanor, T., McIntosh, T., & Teaiwa, T. (2005). Introduction: Constructing New Zealand identities. In J. Liu, T. McCreanor, T. McIntosh, & T. Teaiwa (Eds.), *New Zealand identities: Departures and destinations* (pp. 11-20). Victoria University Press.

Lundberg, K., Kjellström, S., Jonsson, A., & Sandman, L. (2014). Experiences of Swedish military medical personnel in combat zones: Adapting to competing loyalties. *Military Medicine, 179*(8), 821-826. https://doi.org/10.7205/MILMED-D-14-00038

Mabry, R. L., & DeLorenzo, R. (2014). Challenges to Improving Combat Casualty Survival on the Battlefield. *Military Medicine, 179*(5), 477-482. https://doi.org/10.7205/MILMED-D-13-00417

MacIntosh, J. (2003). Reworking professional nursing identity. *Western Journal of Nursing Research*, *25*(6), 725-741. https://doi.org/10.1177/0193945903252419

Madden, W., & Carter, B. (2003). Physician soldier: A moral profession. In T. Beam & L. Sparacino (Eds.), *Military medical ethics* (pp. 269-291). United States Army.

Marshall, B., Craig, A., & Meyer, A. (2017). Registered nurses' attitudes towards, and experiences of, aggression and violence in the acute hospital setting. *Kai Tiaki Nursing Research*, *8*(1), 31-36.

Massey University. (2015). *Code of ethical conduct for research, teaching and evaluations involving human participants*. https://www.massey.ac.nz/massey/research/research-ethics/human-ethics/code-ethical-conduct.cfm

Mattila, J., Tukiainen, S., & Kajalo, S. (2017). Meanings of military ranks. *Defence Studies*, *17*(4), 359-378. https://doi.org/10.1080/14702436.2017.1364967

McCallum, J. E. (2008). *Military medicine: From ancient times to the 21st Century*. ABC-CLIO.

McGibbon, I. (2000). *The Oxford companion to New Zealand military history* (I. McGibbon, Ed.). Oxford.

McLean, D. (2003). *The prickly pair*. University of Otago.

McNabb, S. (2015). *100 years New Zealand military nursing: New Zealand Army Nursing Service - Royal New Zealand Nursing Corps 1915-2015*.

Medical Council of New Zealand. (2006). *A doctor's duty to help in a medical emergency*. https://www.mcnz.org.nz/assets/standards/afd1af693d/A-doctors-duty-to-help-in-a-medical-emergency.pdf

Mialon, S. H., & Yoo, S. H. (2017). Incentives for discrimination. *Journal of Economic Behavior and Organization, 136,* 141-160. https://doi.org/10.1016/j.jebo.2017.01.021

Ministry of Defence. (2010). *Defence white paper 2010*. https://www.defence.govt.nz/assets/Uploads/5a926540dd/defence-review-2009-defence-white-paper-final.pdf

Ministry of Defence. (2014a). *Defence capability plan 2014*. https://www.defence.govt.nz/publications/publication/defence-capability-plan-june-2014

Ministry of Defence. (2014b). *Maximising opportunities for military women in the New Zealand Defence Force*. https://www.defence.govt.nz/assets/Uploads/1b0daa8fb0/maximising-opportunities-military-women-nzdf.pdf

Ministry of Defence. (2016a). *Defence capability plan 2016*. https://www.defence.govt.nz/assets/Uploads/a2938599ea/2016-Defence-Capability-Plan.pdf

Ministry of Defence. (2016b). *Defence white paper 2016*. https://www.defence.govt.nz/assets/Uploads/daac08133a/defence-white-paper-2016.pdf

Ministry of Defence. (2018). *Strategic Defence policy statement 2018*. https://www.defence.govt.nz/assets/Uploads/8958486b29/Strategic-Defence-Policy-Statement-2018.pdf

Ministry of Defence. (2019). *Ministry of Defence: 2019-2023 Statement of intent*. https://www.nzdia.co.nz/wp-content/uploads/2019/10/MOD-Statement-of-Intent-2019-2023.pdf

Ministry of Health. (2017a). *Annual report for the year ended 30 June 2017: Ministry of Health*.

https://www.health.govt.nz/system/files/documents/publications/ministry-of-health-annual-report-for-year-ending-30-june-2017.pdf

Ministry of Health. (2017b). *Challenges and opportunities*. https://www.health.govt.nz/new-zealand-health-system/new-zealand-health-strategy-future-direction/challenges-and-opportunities

Ministry of Justice. (2015). *The New Zealand legal system: A guide to the constitution, government and legislature of New Zealand*. http://www.justice.govt.nz/publications/global-publications/n/the-new-zealand-legal-system/publication

Miskelly, P., & Duncan, L. (2014). 'I'm actually being the grown-up now': leadership, maturity and professional identity development. *Journal of Nursing Management, 22*(1), 38. https://doi.org/10.1111/jonm.12030

Mosher, D., Lachman, B., Greenberg, M., Nichols, T., Rosen, B., & Willis, H. (2008). *Green warriors: Army environmental considerations for contingency operations from planning through post-conflict*. Rand Corporation. https://www.rand.org/content/dam/rand/pubs/monographs/2008/RAND_MG632.pdf

Moskos, C. (1977). From institution to occupation: Trends in military organization. *Armed Forces & Society, 4*(1), 41-50. https://doi.org/10.1177/0095327X7700400103

Mrayyan, M. T. (2005). American nurses' work autonomy on patient care and unit operations. *British Journal of Nursing, 14*(18), 962-967. https://doi.org/10.12968/bjon.2005.14.18.19881

National Nursing Consortium. (2017). *National Nursing Consortium: Specialty standards endorsement*. https://www.nurse.org.nz/national-nursing-consortium.html

Neuhaus, L., Bridgewater, F., & Kilcullen, D. (2001). Military medical ethics: Issues for 21st century operations. *Australian Defence Journal, 151*, 49-58. https://search.informit.com.au/documentSummary;dn=200200481;res=IELAPA

New Zealand Army. (2017a). *Future land operating concept 2035: Integrated land missions*. https://ndhadeliver.natlib.govt.nz/delivery/DeliveryManagerServlet?dps_pid=IE28590627

New Zealand Army. (2017b). *Jobs: Medical and health: Nursing Officer*.New Zealand Defence Force. https://www.defencecareers.mil.nz/army/jobs/medical-and-health/nursing-officer/

New Zealand Army. (2019). *Army today: Vision, mission, ethos and our values*. http://www.army.mil.nz/downloads/pdf/public-docs/2013/vision-mission-ethos-values.pdf

New Zealand Army. (2020a). *Army officer*. https://www.defencecareers.mil.nz/army/careers/browse-roles/army-officer/

New Zealand Army. (2020b). *The way of the New Zealand warrior*. https://www.nzdf.mil.nz/assets/Publications/Way-of-the-New-Zealand-Warrior-2020.pdf

New Zealand Defence Force. (2000). *Defence Force Orders 18* (Vol. 18).

New Zealand Defence Force. (2010). *DM 69 Manual of Armed Forces law* (2 ed., Vol. 1). New Zealand Defence Force.

New Zealand Defence Force. (2011). *A guide to legal compliance for commanders and managers of the New Zealand Defence Force* (2nd ed.). New Zealand Defence Force.

New Zealand Defence Force. (2012a). *Court of Inquiry assembled by Major General A.D. Gawn, MBE, Commander Joint Forces New Zealand into the circumstances in which elements of TU 653.1.1 (OP CRIB) came into contact*

with insurgents in the vicinity of DO ABE, Bamyan province, Afghanistan, while providing in extremis support to the NDS on 4 August 2012 and the circumstances in which the remains of three soldiers were returned to New Zealand following a separate IED attack on 19 August 2012. https://web.archive.org/web/20150123011224/http://nzdf.mil.nz/downloads/pdf/public-docs/2013/coi-report_baghak_redact_reopen_final.pdf

New Zealand Defence Force. (2012b). *New Zealand Defence Force doctrine* (4th ed.). https://www.nzdf.mil.nz/assets/Publications/NZDDP-D-4th-ed.pdf

New Zealand Defence Force. (2013). *The 2013-2014 output plan*.

New Zealand Defence Force. (2014). *NZDF competence framework*. New Zealand Defence Force.

New Zealand Defence Force. (2015a). *The 2015-2018 statement of intent*.

New Zealand Defence Force. (2015b). *Defence Force orders 3* (Vol. 3).

New Zealand Defence Force. (2015c). *Defence Force orders 4* (Vol. 4).

New Zealand Defence Force. (2015d). *The future of NZDF talent management*.

New Zealand Defence Force. (2015e). *New Zealand Defence Force: A force for New Zealand*. http://www.nzdf.mil.nz/

New Zealand Defence Force. (2015f). *The NZDF care plan: A Defence health strategy*.

New Zealand Defence Force. (2015g). *NZDF Defence professional development framework.*

New Zealand Defence Force. (2015h). What makes us the New Zealand Defence Force? *Force4NZ*, (2), 11.

New Zealand Defence Force. (2017a). Career management. In *Defence Force orders 3* (pp. 1-49). New Zealand Defence Force.

New Zealand Defence Force. (2017b). *Fitness requirements*. http://www.defencecareers.mil.nz/army/joining-up/fitness-requirements/

New Zealand Defence Force. (2017c). *Leadership development: Framework, system and programmes: Prospectus*.

New Zealand Defence Force. (2017d). *New Zealand defence doctrine* (4th ed.). New Zealand Defence Force. https://www.nzdf.mil.nz/assets/Publications/NZDDP-D-4th-ed.pdf

New Zealand Defence Force. (2017e). *Performance and development reports*

New Zealand Defence Force. (2017f). *Warfare roles across NZDF*. New Zealand Defence Force.

New Zealand Defence Force. (2018). *Defence health strategy 2025: A better, stronger, healthier NZDF*. http://health.nzdf.mil.nz/assets/Uploads/Defence-Health-Strategy-FINAL.pdf

New Zealand Defence Force. (2019a). *Defence capability plan 2019*. https://www.defence.govt.nz/assets/Uploads/03acb8c6aa/Defence-Capability-Plan-2019.pdf

New Zealand Defence Force. (2019b). *New Zealand Defence Force*. https://www.defencecareers.mil.nz/defence-careers/careers/officers/

New Zealand Defence Force. (2019c). *NZDF Output plan FY 2019/20*.

New Zealand Defence Force. (2020). *Defence careers*. https://www.defencecareers.mil.nz/army/careers/browse-roles/nursing-officer/

New Zealand Nurses Organisation. (2016). *NZNO fact sheet: Understanding duty of care, 2016*. New Zealand Nurses Organisation. https://www.nzno.org.nz/LinkClick.aspx?fileticket=I1m5KZmr6-8%3D&tabid=109&portalid=0&mid=4918

Nordhaug, M. (2018). Partiality and professional ethics in nursing care. In M. Nordhaug (Ed.), *Partiality and justice in nursing care* (pp. 25-42). Routledge, Taylor and Francis.

Nursing Council of New Zealand. (2012a). *Code of conduct for nurses*. https://www.nursingcouncil.org.nz/Public/Nursing/Code_of_Conduct/NCNZ/nursing-section/Code_of_Conduct.aspx

Nursing Council of New Zealand. (2012b). *Competencies for enrolled nurses*. https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx

Nursing Council of New Zealand. (2012c). *Competencies for registered nurses*. https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx

Nursing Council of New Zealand. (2012d). *Competencies for the nurse practitioner scope of practice*.

https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx

Nursing Council of New Zealand. (2012e). *Guidelines: Professional boundaries*.

Nursing Council of New Zealand. (2013). *The future nursing workforce: Supply projections 2010-2035*. Nursing Council of New Zealand. https://www.nursingcouncil.org.nz/Public/Publications/Workforce_Statistics/NCNZ/publications-section/Workforce_statistics.aspx?hkey=3f3f39c4-c909-4d1d-b87f-e6270b531145

Nursing Council of New Zealand. (2014). *Health Practitioners Competence Assurance Act 2003: The health process*. https://www.nursingcouncil.org.nz/Public/concerns/Health/NCNZ/concerns-section/Health.aspx?hkey=d8778c05-3dd5-4724-a3d1-24e911a84710

Nursing Council of New Zealand. (2015). *Health Practitioners Competence Assurance Act 2003: Competence review process*. https://www.nursingcouncil.org.nz/Public/concerns/Fitness_to_practice/NCNZ/concerns-section/Fitness_to_practice.aspx?hkey=7370695f-7104-4ca6-bf82-90be831dc042

Nursing Council of New Zealand. (2019a). *Mahi tapuhi nursing*. https://www.nursingcouncil.org.nz/Public/Nursing/NCNZ/Nursing.aspx?hkey=4c7f36f6-42c3-40fa-b35c-88875eb2dcd5

Nursing Council of New Zealand. (2019b). *The New Zealand nursing workforce: A profile of nurse practitioners, registered nurses and enrolled nurses 2018 – 2019*. https://www.nursingcouncil.org.nz/NCNZ/News-section/news-item/2020/2/Council_publishes_Workforce_Report_2018-2019.aspx

Nursing Council of New Zealand. (2020a). *Approved professional development and recognition programmes*. https://www.nursingcouncil.org.nz/Public/Nursing/PDRPs/NCNZ/nursing-section/PDRPs.aspx

Nursing Council of New Zealand. (2020b). *Meeting the Nursing Council competencies for your scope of practice*. https://www.nursingcouncil.org.nz/NCNZ/nursing-section/Continuing_Competence.aspx

Nursing Council of New Zealand. (2020c). *Recertification audits*. https://www.nursingcouncil.org.nz/Public/Nursing/Recertification_audits/NCNZ/nursing-section/Recertification_audits.aspx

Nursing Council of New Zealand. (2020d). *Registered nurse scope of practice*. . https://www.nursingcouncil.org.nz/Public/Nursing/Scopes_of_practice/Registered_Nurse/NCNZ/nursing-section/Registered_nurse.aspx

Nursing Council of New Zealand. (2020e). *Tohungatanga haere tonu: Continuing competence*. https://www.nursingcouncil.org.nz/Public/Nursing/Continuing_competence/NCNZ/nursing-section/Continuing_Competence.aspx?hkey=6542ac27-9b56-4e89-b7ae-db445c5cb952

Oliker, D. (2017). *Is it competition or bullying?*Psychology Today. https://www.psychologytoday.com/blog/the-long-reach-childhood/201203/is-it-competition-or-bullying

Owen, D. (1994). *Maturity and modernity*. Routledge.

Palmer, C. (2003). The nursing shortage: An update for occupational health nurses. *AAOHN Journal*, *51*(12), 510-513. http://ezproxy.massey.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=106723536&site=eds-live&scope=site

Patrician, P. A., Shang, J., & Lake, E. T. (2010). Organizational determinants of work outcomes and quality care ratings among Army Medical Department registered

nurses. *Research in Nursing and Health*, *33*(2), 99-110. https://doi.org/10.1002/nur.20370

Pierce, P., McNeill, M., & Dukes, S. (2018). An occupational paradox: Why do we love really tough jobs? *Critical Care Nurse*, *38*(2), 52-59. https://doi.org/10.4037/ccn2018919

Public Service Commission. (2010). *Political neutrality guidance*. http://www.ssc.govt.nz/political-neutrality-guidance

Rabinow, P. (1997). Introduction: The history of systems of thought. In M. Foucault & P. Rabinow (Eds.), *Ethics: Subjectivity and truth. Essential works of Foucault, 1954-1984*. New Press.

Rabinow, P., & Rose, N. (Eds.). (2003). *The essential Foucault: Selections from essential works of Foucault, 1954-1984*. New Press.

Ramvi, E. (2015). I am only a nurse: A biographical narrative study of a nurse's self-understanding and its implication for practice. *BioMed Central Nursing, 14*(23), 1-9. https://doi.org/10.1186/s12912-015-0073-y

Rasmussen, P., Henderson, A., Andrew, N., & Conroy, T. (2018). Factors influencing registered nurses' perceptions of their professional identity: An integrative

literature review. *Journal of Continuing Education in Nursing, 49*(5), 225-232. https://doi.org/10.3928/00220124-20180417-08

Reeves, K. (2009). An impossible task: Summing up the value of a nurse. *Medsurg Nursing, 18*(3), 142-143.

RegisteredNursing.org. (2020). *Military nurse.* https://www.registerednursing.org/specialty/military-nurse/

Research New Zealand. (2017). *Trust and confidence in Members of Parliament compared with local councillors, lawyers, journalists and others such as those working in the Ambulance Service, the Fire Service and the Police* [Press release].

Richie-Melvan, S., & Vines, D. (2010). *Angel walk: Nurses at war in Iraq and Afghanistan*. Arnica.

Rivers, F. (2016). US military nurses. Serving within the chaos of disaster. *Nursing Clinics of North America, 51*(4), 613-623. https://doi.org/10.1016/j.cnur.2016.07.004

Rivers, F., & Gordon, S. (2017). Military nurse deployments: Similarities, differences, and resulting issues. *Nursing Outlook, 65*(5S), S100-S108. https://doi.org/10.1016/j.outlook.2017.07.006

Rodwell, J., McWilliams, J., & Gulyas, A. (2017). The impact of characteristics of nurses' relationships with their supervisor, engagement and trust, on performance behaviours and intent to quit. *Journal of Advanced Nursing*, *73*(1), 190-200.

Rogers, A. (2003). *While you're away: New Zealand nurses at war 1899-1948*. Auckland University Press.

Rose, N. (1996). *Inventing our selves: Psychology, power and personhood*. Cambridge University Press.

Ross, M., Smith, K., Ryan, R., Webb, L., & Humphreys, S. (2008). Analysis of after-action reporting by deployed nurses. *Military Medicine*, *173*(2), 210-216. https://doi.org/10.7205/milmed.173.2.210

Royal Navy. (2020). *Naval nurse (qualified)*. https://www.royalnavy.mod.uk/careers/roles-and-specialisations/services/surface-fleet/naval-nurse-qualified

Royal New Zealand Air Force. (2018). *RNZAF mission statement*. New Zealand Defence Force. http://www.airforce.mil.nz/about-us/who-we-are/rnzaf-mission-statement.htm

Royal New Zealand Navy. (2018). *The RNZN's core values and our Navy creed*. New Zealand Defence Force. http://navy.mil.nz/ayn/values/default.htm

Ruff, C., & Roper, K. (2013). *Ruff's War: A Navy Nurse on the Frontline in Iraq*. Naval Institute Press.

Rushton, P., Scott, J. E., & Callister, L. C. (2008). “It's what we're here for": Nurses caring for military personnel during the Persian Gulf Wars. *Nursing Outlook, 56*(4), 179-186. https://doi.org/10.1016/j.outlook.2008.03.010

Scannell-Desch, E., & Doherty, M. (2012). *Nurses in war: Voices from Iraq and Afghanistan*. Springer.

Scannell-Desch, E., & Doherty, M. E. (2010). Experiences of U.S. military nurses in the Iraq and Afghanistan wars, 2003-2009. *Journal of Nursing Scholarship, 42*(1), 3-12. https://doi.org/10.1111/j.1547-5069.2009.01329.x

Segal, M. (1986). The military and the family as greedy institutions. *Armed Forces & Society, 13*(1), 9-38. https://doi.org/10.1177/0095327X8601300101

Senellart, M. (Ed.). (2007). *Michel Foucault: Security, territory, population: Lectures at the Collège de France, 1977-78*. Palgrave Macmillan.

Seo, K., & Kim, M. (2017). Professional identity of Korean nurse practitioners in the United States. *Journal of the American Association of Nurse Practitioners, 29*, 195-202. https://doi.org/10.1002/2327-6924.12439

Shapiro, M. J. (1984). *Language and politics*. B. Blackwell.

Sheard, M., Huntington, A., & Gilmour, J. (2016). Nursing Services in the New Zealand Defence Force: A review after 100 Years. *Journal of Military and Veterans' Health*, *24*(1), 6-11.

Shephard, B. (2001). *A war of nerves: Soldiers and psychiatrists in the twentieth century*. Harvard University Press.

Shirley, D. (2018). A military pedagogical approach: Train and develop for certainty, educate for uncertainty. *Face the future: Concepts on force design, 4*, 65-72.

Simons, M. (2009). *Holistic professional military development: Growing strategic artists* [Doctoral dissertation, Massey University]. http://hdl.handle.net/10179/1544

Sion, L. (2016). Ethnic minorities and brothers in arms: Competition and homophily in the military. *Ethnic and Racial Studies, 39*(14), 2489-2507. https://doi.org/10.1080/01419870.2016.1160138

Sørensen, E., & Hall, E. (2011). Seeing the big picture in nursing: A source of human and professional pride. *Journal of Advanced Nursing, 67*(10), 2284-2291.

Sørensen, M. K. (2014). *Foucault on power relations*. Irenees.net. http://www.irenees.net/bdf_fiche-notions-242_en.html

Southby, J. (2003). Nursing ethics and the military. In T. Beam & L. Spracino (Eds.), *Military medical ethics* (Vol. 2, pp. 661-686). United States Army.

Sparacino, L., & Beam, T. (Eds.). (2003). *Military medical ethics* (Vols. 1-2). United States Army.

Squires, E., & Peach, J. (2020). Effective military leadership: Balancing competing demands. *Canadian Journal of Behavioural Science, 1*(1), 1-10. https://doi.org/10.1037/cbs0000179

Stainback, K., Ratcliff, T., & Roscigno, V. (2011). The context of workplace sex discrimination: Sex composition, workplace culture and relative power. *Social Forces, 89*(4), 1165-1188. https://doi.org/10.1093/sf/89.4.1165

Stanley, D. (Ed.). (2017a). *Clinical leadership in nursing and healthcare: Values into action* (2nd ed.). Wiley Blackwell.

Stanley, D. (2017b). Congruent leadership. In D. Stanley (Ed.), *Clinical leadership in nursing and healthcare: Values into action* (2nd ed., pp. 59-90). Wiley Blackwell.

Stanley, D., & Carvalho, S. (2017). Organisational culture, clinical leadership and congruent leadership. In D. Stanley (Ed.), *Clinical leadership in nursing and healthcare: Values into action* (2nd ed., pp. 109-124). Wiley Blackwell.

Stanton, M., Parker, M., McDougall, G., & Eyer, J. (2017). Reintegration issues of military nurses: A focus group approach. *Best Practice in Mental Health*, *13*(1), 1-19.

State Services Commission, The Treasury, & Department of Prime Minister and Cabinet. (2015). *Performance improvement framework: Review of the New Zealand Defence Force*. https://www.publicservice.govt.nz/assets/Legacy/resources/pif-nzdf-review-sep15_0.pdf

Statistica Research Department. (2020). *Swedish Armed Forces: Statistics and facts*. https://www.statista.com/topics/4256/swedish-armed-forces/

Steele, N. M., Ketz, A. K., Martin, K. D., Garcia, D. M., Womble, S., & Wright, H. (2010). Rewards and challenges of nursing wounded warriors at Landstuhl

Regional Medical Center, Germany. *Nursing Clinics of North America, 45*(2), 205-218. https://doi.org/10.1016/j.cnur.2010.02.004

Storey, J. (Ed.). (2011). *Leadership in organizations: Current issues and key trends* (2nd ed.). Routledge.

ten Hoeve, Y., Jansen, G., & Roodbol, P. (2014, Feb). The nursing profession: Public image, self-concept and professional identity. A discussion paper. *Journal of Advanced Nursing, 70*(2), 295-309. https://www.ncbi.nlm.nih.gov/pubmed/23711235

The Treasury. (2020). *Government finances: Expenditure*. https://www.treasury.govt.nz/information-and-services/financial-management-and-advice/revenue-and-expenditure#:~:text=The%20three%20largest%20areas%20of,Education%3A%20%2415.3%20billion

Thomas, C. (2020). *The impact of communication failures*. Health and Disability Commissioner. https://www.hdc.org.nz/news-resources/search-resources/articles/the-impact-of-communication-failures/

Thomasma, S. (2003). Theories of medical ethics: The philosophical structure. In T. Beam & L. Sparacino (Eds.), *Military medical ethics* (Vol. 1, pp. 23-59). United States Army.

Thompson, S., & Mastel-Smith, B. (2012). Caring as a standard of nursing when deployed military nurses provide services to enemy insurgents. *International Journal for Human Caring, 16*(4), 22-26. https://doi.org/10.20467/1091-5710.16.4.22

Thompson, S., Mastel-Smith, B., Duke, G., Haas, B., Vardaman, S., & Yarbrough, S. (2014). Military nurses caring for the enemy. *International Journal for Human Caring, 18*(2), 61-70. https://connect.springerpub.com/content/sgrijhc/18/2/61

Thomson, K., Outram, S., Gilligan, C., & Levett-Jones, T. (2015). Interprofessional experiences of recent healthcare graduates: A social psychology perspective on the barriers to effective communication, teamwork, and patient-centred care. *Journal of Interprofessional Care, 29*(6), 634-640. https://doi.org/10.3109/13561820.2015.1040873

Tollerud, D., Balmes, J., Bhatnagar, A., Crouch, E., Dominici, F., & Eisen, E. (2011). Long-term health consequences of exposure to burn pits in Iraq and Afghanistan. *Military Medicine, 180*(6), 601-603. https://doi.org/10.7205/MILMED-D-15-00039

Treanor, K. (2008). *The staff, the serpent and the sword: 100 years of the Royal New Zealand Army Medical Corps*. Willson Scott.

Tropp, L., & Pettigrew, T. (2005). Relationships between intergroup contact and prejudice among minority and majority status groups. *Psychological Science 16*(12), 951-957. https://doi.org/10.1111/j.1467-9280.2005.01643.x

Tschudin, V., & Schmitz, C. (2003). The impact of conflict and war on international nursing and ethics. *Nursing Ethics*, *10*(4), 354-367. https://doi.org/10.1191/0969733003ne618oa

Tyler, J., Ritchie, J., Leas, M., Edwards, K., Eastridge, B., White, C., Knudson, M., Rasmussen, T., Martin, R., & Blackbourne, L. (2012). Combat readiness for the modern military surgeon: Data from a decade of combat operations. *Journal of Trauma and Acute Care Surgery*, *73*(2), S64-S70. https://doi.org/10.1097/TA.0b013e3182625ebb

Van Rensburg, G., & Zagenhagen, K. (2017). Serving two masters: Professional role conflict in a military teaching and learning environment. *Journal of Military and Veterans' Health*, *25*(3), 30-35.

van Wijk, C. H., & Finchilescu, G. (2008). Symbols of organisational culture: Describing and prescribing gender integration of navy ships. *Journal of Gender Studies*, *17*(3), 237-249. https://doi.org/10.1080/09589230802204266

Varpio, L., Bader, K., Meyer, H., Durning, S., Artino, A., & Hamwey, M. (2018). Interprofessional healthcare teams in the military: A scoping literature review.

Military Medicine, *183*(11-12), e448-e454. https://doi.org/10.1093/milmed/usy087

Vogt, K. S. (2015). Origins of military medical care as an essential source of morale. *Military Medicine*, *180*(6), 604-606. https://doi.org/10.7205/MILMED-D-14-00492

Vuga, J., & Juvan, J. (2013). Work–family conflict between two greedy institutions – the family and the military. *Current Sociology*, *61*(7), 1058-1077. https://doi.org/10.1177/0011392113498881

Weberman, D. (1995). Foucault's reconception of power. *Philosophical Forum*, *26*(3), 189-217.

Weekes, J. (2017). *Troops slam senior leaders as Army ranks worst in Defence Force job survey.* Stuff. http://www.stuff.co.nz/national/91231081/troops-slam-senior-leaders-as-army-ranks-worst-in-defence-force-job-survey

Weiss, C. (2012). *Respecting human rights and the rule of law*. Fulbright New Zealand. https://www.fulbright.org.nz/publications/2012-weiss/

Wenger, E. (1999). *Communities of practice: Learning, meaning, and identity*. Cambridge University Press.

Werder, M. (2018). NZ Army culture: Developing a learning organisation to adapt to gender diversity. *Face the future: Concepts on force design*, *4*, 55-63. https://www.scribd.com/document/378138500/Face-the-Future-Concepts-of-Force-Design

West, M., Armit, K., Loewenthal, L., Eckert, R., West, T., & Lee, A. (2015). *Leadership and leadership development in health care: The evidence base*. The King's Fund. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf

Wilkinson, J., & Jones, M. (2016). The power of normal. *Nursing Praxis in New Zealand*, *32*(2), 5-7. https://doi.org/10.36951/ngpxnz.2016.005

Willis, E., Carryer, J., Harvey, C., Pearson, M., & Henderson, J. (2017). Austerity, new public management and missed nursing care in Australia and New Zealand. *Journal of Advanced Nursing*, *73*(12), 3102-3110. https://doi.org/10.1111/jan.13380

Wilson, G., Ledson, D., & Robinson, G. (2013). *New Zealand Defence Force external safety management review*. New Zealand Defence Force.

Woodward, R., & Winter, T. (2007). *Sexing the soldier: The politics of gender and the contemporary British Army*. Routledge.

Zägenhagen, K., & van Rensburg, G. (2019). The influence of rankism on the ethical competence of student nurses in a military context. *Scientifica Militaria, 46*(2), 95-107. https://doi.org/10.5787/46-2-1205

Zangaro, G., & Johantgen, M. (2009). Registered Nurses' Job Satisfaction in Navy Hospitals. *Military Medicine, 174*(1), 76-81. https://doi.org/10.7205/milmed-d-04-1307

Zangaro, G., & Kelley, P. (2010). Job satisfaction and retention of military nurses: A review of the literature. *Annual Review of Nursing Research, 28*(1), 19-41. https://doi.org/10.1891/0739-6686.28.19

List of appendices

Appendix A: Massey University ethics notification

Date: 20 July 2016

Dear Maree Sheard

Re: Ethics Notification - **SOB 16/26 - New Zealand military nurses' experiences navigating professional accountabilities and role expectations**

Thank you for the above application that was considered by the Massey University Human Ethics Committee: **Human Ethics Southern B Committee** at their meeting held on **Monday, 18 July, 2016**.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

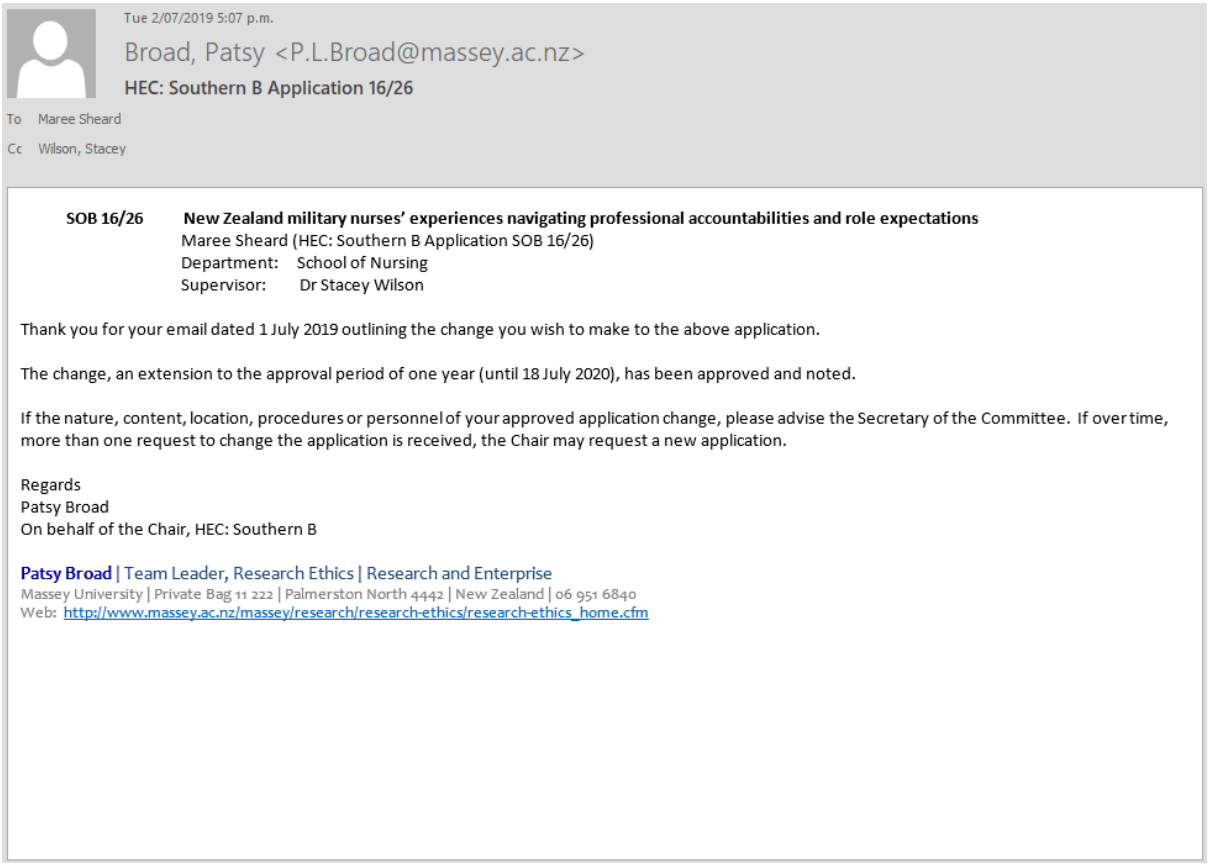
If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Brian Finch
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand T 06 350 5573; 06 350 5575 F 06 355 7973
E humanethics@massey.ac.nz W http://humanethics.massey.ac.nz

Appendix B: Health Ethics Committee: Southern B application



Tue 2/07/2019 5:07 p.m.

Broad, Patsy <P.L.Broad@massey.ac.nz>

HEC: Southern B Application 16/26

To Maree Sheard

Cc Wilson, Stacey

SOB 16/26 **New Zealand military nurses' experiences navigating professional accountabilities and role expectations**
Maree Sheard (HEC: Southern B Application SOB 16/26)
Department: School of Nursing
Supervisor: Dr Stacey Wilson

Thank you for your email dated 1 July 2019 outlining the change you wish to make to the above application.

The change, an extension to the approval period of one year (until 18 July 2020), has been approved and noted.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee. If over time, more than one request to change the application is received, the Chair may request a new application.

Regards
Patsy Broad
On behalf of the Chair, HEC: Southern B

Patsy Broad | Team Leader, Research Ethics | Research and Enterprise
Massey University | Private Bag 11 222 | Palmerston North 4442 | New Zealand | 06 951 6840
Web: http://www.massey.ac.nz/massey/research/research-ethics/research-ethics_home.cfm

Appendix C: New Zealand Defence Force approval to conduct research

UNCLASSIFIED

HEADQUARTERS NEW ZEALAND DEFENCE FORCE
Organisational Research and Development
MINUTE

5000/PB/5/3

12 Apr 16

DHRS

APPROVAL TO CONDUCT RESEARCH: MILITARY NURSE EXPERIENCES

References:
A. DFO 3.14[5]

Background

1. In accordance with Ref A, Maree Sheard has submitted a request to conduct qualitative research to study New Zealand military nurses' experiences navigating professional accountabilities and role expectations. This research will examine the unique conditions, experiences and effects of employment for contemporary military health professionals. It is expected that the subsequent findings will provide guidance on the safe and effective use of military health professionals. Thereby improving recruitment and retention of nurses in the Army and improving care for patients.

2. The researcher is LTCOL Maree Sheard, an Army reserve officer in the Royal New Zealand Nursing Corps. The research sponsor is LTCOL Lee Turner, Director Nursing Services and Director Health People and Processes. This project is a component in Maree's PhD through Massey University, and it is supervised by Professor Annette Huntington (Head of School of Nursing, Massey University) and Associate Professor Jean Gilmour (School of Nursing, Massey University).

Methodology

3. This is a qualitative study using interviews to collect data. The researcher expects to interview 15-25 nursing officers who are currently serving or who have served in the last five years. Information about the research will be introduced at the 2016 RNZNC conference and subsequently participants will be approached via email to request their involvement.

4. The interviews will be recorded and transcribed, and then a Foucauldian thematic analysis will be conducted on the data collected from the interviews. A copy of the PhD thesis will be available on the Massey University research database and the researcher intends to publish the findings in military and/or nursing journals. The researcher will present her findings at NZDF and international medicine conferences. The data will be stored in a locked filing cabinet and password protected on devices.

5. The intended time for data collection is August – December 2016. This is likely to coincide with the Census 16 debrief period but not Census itself. Potential concerns might be mitigated by the small sample size of this survey and that the Census will be finished running.

UNCLASSIFIED

6. The researcher has not provided a complete question set, but has instead noted a couple of open-ended questions and themes around which she intends to ask probing questions.

Confidentiality and Ethics

7. Participation will be confidential and participants will not be identified individually; anonymity of participants will be ensured during the write up of the report. Further, participation in the research will be voluntary and informed consent will be obtained.

Endorsement and Approval

8. I have reviewed this project and am satisfied that all ethical and scientific requirements required by Ref A are met.

9. The researcher is to provide a copy of the research report to Organisational Research upon completion. Additionally, any subsequent publications are to be sent to Organisational Research for review prior to external publishing.

10. It is therefore recommended that DHRS:

    a. **Approve** the proposed research project

M. HARRISS
DEP DIR, ORG PLANNING AND DEVELOPMENT

Enclosures:
1. Research application form

Appendix D: Information sheet for study participants

MASSEY UNIVERSITY
COLLEGE OF HEALTH
TE KURA HAUORA TANGATA

New Zealand military nurses' experiences navigating professional accountabilities and role expectations

INFORMATION SHEET FOR STUDY PARTICIPANTS

I am Maree Sheard and am studying towards a PhD in the School of Nursing at Massey University. My research project explores how nurses, while serving in the New Zealand Defence Force, navigate professional boundaries and role expectations. I have previous research experience in the military nursing domain having conducted a study that examined alcohol consumption in a cohort of military nurses. This research raised questions about how military service may create stressors for nurses. I am interested to find out about the pressures to which military nurses are subjected which may be different to that of their civilian colleagues. In addition to this study, I have also had recently published a review of contemporary nursing services in the New Zealand Defence Force.

Nurses in armed forces have responsibilities to both their defence employers and to nursing regulatory bodies. Compliance with the statutes and codes that govern, support and constrain nursing practice in armed forces can create tensions as nurses seek to balance defence force needs with the delivery of care in accordance with professional standards. There are currently no studies either in New Zealand or internationally that examine how military nurses navigate nursing professional boundaries and defence force role expectations.

Gaining an understanding of the ways in which military nurses balance their dual sets of responsibilities will provide valuable information to defence employers on the safe and effective utilisation of military nurses. A critical part of my research is to talk to military nurses in order to gather the information that will help to achieve this aim.

Invitation

You have been identified as being currently employed or as having recent experience as a military nurse in New Zealand. I would like to speak to you about your experiences serving in the Defence Force as they relate to the ways in which you work or have worked to comply with your nursing regulatory responsibilities while at the same time meeting your commitments to the Defence Force. I expect this to take about an hour at a mutually agreeable time and venue that is private and convenient to you.

With your permission I would like to record the interview and have the recording transcribed by a typist who will sign a confidentiality agreement. A copy of the interview transcript will be returned to you to enable you to confirm its accuracy, or to make any changes. Any information you provide will be used exclusively for the purpose of the study and will be kept in the strictest of confidence with access available only to my supervisors, Annette Huntington and Jean Gilmour, and to me. At no time will information about you or the information you provide, including whether or not you agree to participate in the study, be divulged to representatives of the New Zealand Defence Force beyond the collective findings of the study.

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To ensure your information is kept confidential, your name will be substituted with an agreed pseudonym before your information is analysed. Electronic information will be retained in password protected computer files while any paper copies will be stored in a locked cabinet. In accordance with Massey University policy, after the completion of the research your information will be retained for five years in the Massey University School of Nursing archive and then it will be destroyed unless you would like your voice recording and transcript returned to you. I will provide all participants with a summary of the project findings.

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question,
- withdraw from the study at any time before the data is analysed,
- ask any questions about the study at any time during participation,
- provide information on the understanding that your name will not be used unless you give permission to the researcher,
- be given access to a summary of the project findings when it is concluded,
- ask for the recorder to be turned off at any time during the interview.

If you would like to participate in this research, please contact me either by email or by telephone. If you would like further information about this project, please do not hesitate to contact one of my supervisors or me.

Thank you for taking the time to consider participating.

Researcher
Maree Sheard
Email: [redacted]
Telephone: [redacted]
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Telephone: 04 801 2794 ext. 62487

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 16/26. If you have any concerns about the conduct of this research, please contact Dr Rochelle Stewart-Withers, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83657, email humanethicsouthb@massey.ac.nz.

Appendix E: Participant consent form

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TE KURA HAUORA TANGATA

New Zealand military nurses' experiences navigating professional accountabilities and role expectations

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to the interview being sound recorded. ☐ Yes ☐ No

I wish to have my recordings returned to me. ☐ Yes ☐ No

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ **Date:** _____

Full Name - printed _____

I wish to receive a summary of the research findings. ☐ Yes ☐ No

(If yes, please provide your address and telephone contact details)

Telephone No: .....

Address: .....

.....

.....

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Appendix F: Transcriber's confidentiality agreement

MASSEY UNIVERSITY
COLLEGE OF HEALTH
TE KURA HAUORA TANGATA

New Zealand military nurses' experiences navigating professional accountabilities and role expectations

TRANSCRIBER'S CONFIDENTIALITY AGREEMENT

I ..... (Full Name - printed)

agree to transcribe the recordings provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those required for the project.

Signature: _____ **Date:** _____

Te Kunenga ki Pūrehuroa

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Appendix G: Interview schedule

Interview Schedule

New Zealand military nurses' experiences navigating professional accountabilities and role expectations

Prior to attending the interview participants need to:

- Have been provided with a copy of the participant information sheet
- Understand why they have been asked
- Understand the purpose of the interview
- Know how long the interview will take
- Know exactly where and when the interview will take place

Introductory phase

Cover administrative aspects of interview Welcome participant and introduce myself	*Purpose* Establish rapport Thank participant for their involvement
Confirm purpose of interview and the research	
Consent form	Explain purpose of providing informed consent Gain signed consent
Recording of the interview	Explain purpose of recording interview and of transcribing
Gather demographic information	Date of birth Gender Nursing experience Military experience Rank Operational experience Current employment context
Seek participant questions or concerns	

Interview

Key questions (employ probes in accordance with responses)	*Possible prompts (may not be necessary. Be prepared for information rich responses that would discount the need for prompts)*
Why did you choose to join the military?	Motivation Prior knowledge Expected benefits Possible challenges
What do you understand your role in the NZDF to involve?	Nursing Military Extra-regimental (non-nursing) Training Key relationships
In what ways does the role change with different appointments?	Postings Exercises Deployments Promotion Extra-regimental (non-nursing)
What have been your experiences balancing your nursing role with the expectations of the NZDF?	Meeting nursing outputs Meeting NZDF outputs *(How they see others may balance the two)* Challenges Ways challenges are addressed
In what ways have your experiences influenced your career?	Decisions to shape direction in nursing Decisions to leave nursing Decisions to leave the military Decisions to Corps transfer

Closure

Summarise main interview learnings	*Allow for additional information*
Thank participant	
Explain procedure for review of transcript	
Depart	